PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE MEETING NOTICE

FROM: Leslie Erickson, Program Coordinator II, Quality & Performance Improvement (QI)
DATE: June 11, 2026
SUBJECT: Quality/Utilization Advisory Committee (Q/UAC) Meeting

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

Meeting Time/Date: 7:30 – 9:00 a.m., Wednesday, June 17, 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, QI
DeVido, Jeffrey, MD, Behavioral Health Clinical Director
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
Bottke, Jayme, Regional Director, Northeast
Brincko, Aaron, Director of Provider Relations
Brunkal, Monika, RPh, Associate Director of Population Health
Campbell, Anna, MPH, Policy Analyst, UM Regulations
Cunningham, Aryana, Policy Analyst, Care Coordination
Davis, Wendi, Chief Operations Officer
Durst, Jennifer, Sr. Mgr. of Performance Improvement, QI (SE/SW)
Foster, Troy, Program Manager II, QI (HQIP)
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
Kulkarni, Shreya, Policy Analyst, Regulatory Affairs & Compliance
Morris, Matthew, MD, Regional Medical Director, Auburn
Nakatani-Phipps, Stephanie, Manager of Provider Relations Reps
O'Leary, Hannah, MPH, Manager of Population Health
Power, Kathryn, Regional Director, Southeast
Quichocho, Sue, Manager of Quality Improvement, QI
Smith, Christine, Community Health Needs Liaison, Pop Health
Stark, Rebecca, Regional Director, Chico
Trosky, Renee, Mgr of Provider Relations Compliance, Network Srvcs
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: June 17, 2026 **Time: 7:30 – 9:00 a.m.**

Locations: Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano Room
2525 Airpark Drive, Redding, CA 96002 | Trinity Alps Conference Room
495 Tesconi Circle, Santa Rosa, CA 95401 | Santa Rosa Huddle Room
1000 Fortress St., Chico, CA 95973 | Stony Creek Conference 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* May 20, 2026 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD, MPH, MBA	7:30	5 – 12
2	*Acknowledgment and acceptance of draft minutes of the*			--
	• May 12 Internal Quality Improvement (IQI) Committee – *with one post June 9 IQI approval postscript p. 2*			13 – 21
	• May 19 Quality Improvement Health Equity Committee (QIHEC) Minutes			23 – 38
3	Announcements			--
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Isaac Brown, MHA/MBA	7:36	39 – 51
2	HealthPlan Update	Robert Moore, MD	7:41	--
III.	**Old Business – None**			
IV.	**New Business – Consent Calendar**			
	Consent Calendar	All	7:46	52
	Grievance & Appeals PULSE Report – Issue 17, June 2026 – *direct questions to Latrice Innes*			53 – 63
	Hospital Quality Incentive Program (HQIP) Proposed Calendar Year (CY) 2027 Measurement Set – *direct questions to Troy Foster*			65 – 74
Health Services	**Quality Improvement**			
	MCQP1052 – Physical Accessibility Review Survey			75 – 175
	Utilization Management			
	MPUG3010 – Chiropractic Services Guidelines			177 – 179
	MPUP3111 – Pulmonary Rehabilitation			181 – 186
	MPUP3139 – Criteria and Guidelines for Utilization Management			187 – 191
V.	**New Business – Discussion Policies – Health Services**			

	Item	Lead	Time	Page #
	Synopsis of Changes		--	193 – 196
	Population Health			
	MPNP9007 – Lactation Policy and Guidelines	Christine Smith	8:00	197 – 205
	MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program		8:06	207 – 210
	Utilization Management			
	MCUP3041 – Treatment Authorization Request (TAR) Review Process	Tony Hightower, CPhT	8:12	211 – 229
VI.	**Presentations**			
1	Annual Review of UM and InterQual® Criteria [1]	Tony Hightower / Lorna Grote, RN	8:18	231 – 272
2	Population Health Management Grand Analysis – *see pages 335-372 for PowerPoint presentation* • MPND9001 Synopsis of Changes – *pp. 273-274* • MPND9001 Population Health Management Strategy & Program Description – *pp. 275-333* • Population Health Management 2025 Program Impact Analysis – *pp. 373-413* • Population Segmentation – *pp. 415-422*	DeLorean Ruffin, DrPH	8:33	273 – 422
FYI	**PHM Work Plan**			423 – 462
	Adjournment scheduled for 9:00 a.m. Q/UAC next meets 7:30 a.m. Wednesday, July 15, 2026			

[1] InterQual® is proprietary and so no paper is included in this packet outlining any demonstration by UM staff.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Quality and Utilization Advisory Committee (Q/UAC) Meeting Minutes

Wednesday, May 20, 2025 / 7:32 a.m. – 9:04 a.m.

Fairfield: Napa/Solano Room, Redding: Airpark, Chico: Story Creek

Voting Members Present:	Montenegro, Brian, MD	Strain, Michael, Consumer Member
Choudhry, Sara, MD	Mulligan, Meagen, FNP-BC	Swales, Chris, MD
Gwiazdowski, Steven, MD, FAAP	Murphy, John, MD	Thomas, Randy, MD
Lane, Brandy, Consumer Member	Quon, Robert, MD, FACP	Wilson, Jennifer, MD, MPH
Voting Members Absent: Emma Hackett, MD, FACOG		
Partnership *Ex-Officio* Members Present:	Katz, Dave, MD, Associate Medical Director	
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer	Leung, Stan, Pharm.D, Director of Pharmacy Services	
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI	Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair	
Bontrager, Mark, Senior Director of Behavioral Health	Netherda, Mark, MD, Medical Director for Quality – Vice Chair	
Brown, Isaac, MBA/MHA, Interim Senior Director of Q & P Improvement	Newman, Rachel, RN, BSN, Mgr, Clinical Compliance – Quality Inspections	
Cox, Bradley, DO, Regional Medical Director (Northeast)	O'Connell, Lisa, Director, Enhanced Health Services	
DeVido, Jeff, MD, Behavioral Health Clinical Director	Randhawa, Manleen, Senior Health Educator, Population Health	
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management	Ribordy, Jeff, MD, Regional Medical Director (Northwest)	
Glickstein, Mark, MD, Associate Medical Director	Ruffin, DeLorean, DrPH, MPH, Director of Population Health	
Hightower, Tony, CPhT, Associate Director, UM Regulations	Townsend, Colleen, MD, Regional Medical Director (Southeast)	
Jalloh, Mohamed "Moe", Pharm.D, Dir. of Health Equity (Health Equity Officer)	Ward, Lisa, MD, Regional Medical Director (Southwest)	
Jones, Kermit, MD, JD, Medical Director for Medicare Services	Watkins, Kory, MBA-HM, Director, Grievance & Appeals	
Partnership *Ex-Officio* Members Absent:	Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination	
Guillory, Ledra, Senior Manager of Provider Relations Representatives	Spiller, Bettina, MD, Associate Medical Director	
Guests:		
Beard, Alyssa, RN, Manager of CC Regulatory Performance	Kubota, Marshall, MD, Reg. Medical Director	
Campbell, Anna, Health Policy Analyst, UM Regulations	Matthews, Richard, MD, Regional Medical Director (Chico)	
Cunningham, Aryana, Policy Analyst, Care Coordination	Morris, Matthew, MD, Regional Medical Director (Auburn)	
Devan, James, Director of Quality Management	O'Leary, Hannah, Manager of Population Health, Pop Health	
Durst, Jennifer, Manage of Performance Improvement (Fairfield)	Quichocho, Sue, Manager of Quality Measurement, QI	
Elder, Alaina, M.A. Ed, Mger of Provider Network Teams, Provider Relations	Shamoiel, Shantal, County Child Welfare Liaison, Behavioral Health	
Escobar, Nicole, Senior Manager of Behavioral Health	Smith, Christine, Community Health Needs Liaison, Pop Health	
George, Michael, MD, Associate Medical Director	Stites, Jaylyn, Program Manager II, Provider Relations	
Gual, Kristine, Director of Quality Measurement	Thornton, Aaron, MD, Associate Medical Director	
Jarrett-Lee, Kevin, RN, Associate Director, Utilization Management	Vall-Spinosa, Leah, MD, Med. Dir., Dutton Campus, Santa Rosa CHC	
Katz, Dave, MD, Associate Medical Director	Vo, Kathleen, Pharm. D, Clinical Pharmacist, Pharmacy	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *none made* Approval/ Acceptance of Minutes Announcements	Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 7:32 a.m. Committee scribe Leslie Erickson pulled the Initial Health Assessment (IHA report) from its mistaken presentation placement on today's agenda and instead included it on the consent calendar. • The April 15, 2026 Q/UAC Minutes were approved without any corrections. • *Acknowledgment and acceptance of draft meeting minutes of the* • April 7 Internal Quality Improvement (IQI) Committee Dr. Moore thanked Robert Bides, RN, and his Member Safety (Investigations) team for covering for Leslie during her absence this spring. Special thanks also to Chandler Ackerman. Medical Director for Quality Mark Netherda, MD, announced Rachel Newman, RN, is temporarily assisting Network Services with organizational needs. Jackie Krznarich, RN, supervisor of Clinical Compliance, will lead the Member Safety (Inspections) team during Rachel's reassignment.	Motion to **approve the Q/UAC minutes:** Steven Gwiazdowski, MD, FAAP Second: Brian Montenegro, MD *Approved unanimously* Motion to **accept IQI minutes:** Robert Quon, MD Second: Steven Gwiazdowski, MD *Accepted unanimously*

II. Standing Updates

Quality and Performance Improvement Program – *Isaac Brown, MBA/MHA, Senior Director, Q&PI*

- May is a big month for our large Primary Care Provider Quality Incentive Program (PCP QIP). Checks soon will be mailed out. The PCPQIP team is "excited" by some of the projects we are seeing occur within the network.
- Providers are encouraged to utilize our Partnership Quality Dashboard (PQD) to identify gaps in care and other member needs. Let us know if anything looks out of place.
- Our Consumer Assessment of Healthcare Providers and Systems CAHPS ®) field surveys have concluded for this cycle. Results will be reported later this year.
  - 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 our organization.

Health Plan – *Robert Moore, MD, MPH, MBA, Chief Medical Officer*

- The Governor has released his version of the May budget revise. The new trend is to come up with a shadow" budget that passes the Legislature on time and then the gaps are filled. Revenues appear larger than first expected, so the actual budget when passed is likely to be balanced.
  - The State's intention to carve out the "undocumented" into a separate product line as of Jan. 1, 2027 still needs to be approved. The California Legislature is passing a series of bills to universally cover everyone; however, its Appropriations Committee is expected to quash many to keep the budget balanced. Asset qualifications and transportation proposals may be affected.
  - The Federal government is withholding >$1B from certain Medi-Cal programmatic areas.
- Thirty-four or 35 individuals in June will begin a nine-month leadership training on managing quality, cost, and customer service across different care environments.
- Partnership is continuing with its State-mandated community reinvestments program where we look at our margins at the end of each fiscal year and then reinvest into our communities. Our 14 "legacy" counties have one reinvestment program. Our other 10 counties have another. We are meeting with each county to let them know what monies should be available and for what they may use these funds. We are encouraging our legacy counties to sponsor residencies, and recruitment and retention of primary and specialist providers as means of increasing access.

III. Old Business – None

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
IV. New Business – Consent Calendar (Committee Members as Applicable)		
	Proposed 2027 Perinatal Quality Incentive Program (QIP) Measure Summary – direct *questions to Troy Foster* Initial Health Assessment (IHA) Claims and Encounters Summary – *direct questions to Rachel Newman, RN* **Health Services Policies** Behavioral Health MPBP8005 – Dispute Resolution Between Partnership and BHPs in delivery of Mental Health Care Coordination MPCP2026 – Diabetes Prevention Program MPCP2034 – Transitional Care Services Enhanced Health Services MPAP7004 – Community Health Worker (CHW) Services Benefit Quality Improvement MPQP1038 – Physician Orders for Life-Sustaining Treatment (POLST) MPQP1047 – Advance Directives MPQP1055 – Provider Preventable Condition (PPC) Reporting Utilization Management MPUP3137 – Palliative Care: Intensive Program (Adult) MPUP3144 – Residential Substance Use Disorder Treatment Authorization **Non-Health Services Policy** Network Services MPNET101 – Wellness and Recovery Access Standards and Monitoring	Motion to **approve the slate:** Steven Gwiazdowski, MD Second: Randy Thomas, MD *Approved unanimously* Next Steps: All policies go to the June 10 Physician Advisory Committee (PAC) Q/UAC voter Michael Strain asked about the palliative care benefit from the perspective of a "Medi/Medi member." Dr. Moore explained that if a member becomes Medicare eligible we do not automatically disenroll them from Medi-Cal.
V. New Business – Discussion Policies		
Policy Owner: Behavioral Health – *Presenter: Jeffrey DeVido, MD, Behavioral Health Clinical Director*		
MPBP8003 – Mental Health Services	**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."	*QUAC voters posed no questions.* Motion to **approve as presented:** Brian Montenegro, MD Second: Randy Thomas, MD *Approved unanimously* Next Steps: June 10 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	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. Dr. DeVido noted that Partnership's Call Center is getting closer to "first call resolution," meaning that members have a next appointment before the call is concluded. We are also working with SacValley MedShare to share this resource and to keep on with closed loop referral tracking systems. In response to a question from Dr. Moore, Dr. DeVido said different behavioral health services fall into different buckets of what information can be shared and how it may be shared. Senior Director of Behavioral Health Services Mark Bontrager briefly discussed the Release of Information (ROI) form we and our partners are now mandated to use before sharing information.	
Policy Owner: Care Coordination – *Presenter: Aryana Cunningham, Policy Analyst – Care Coordination*		
MPCP2023 – New Member Needs Assessment	**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." **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)	*QUAC voters posed no questions.* Motion to **approve as presented:** Steven Gwizadowski, MD Second: Randy Thomas, MD *Approved unanimously* Next Steps: June 10 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Policy Owner: Quality Improvement / Behavioral Health – *Presenter: Jeffrey DeVido, MD, Behavioral Health Clinical Director*		
MPXG5003 – Major Depression in Adults Clinical Practice Guidelines	Changes to Flow 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.	*QUAC voters posed no questions.* Motion to **approve as presented:** Jennifer Wilson, MD Second: Chris Swales, MD *Approved unanimously* Next Steps: June 10 PAC
Policy Owner: Utilization Management – *Presenter: Kermit Jones, MD, JD, Deputy Chief Medical Officer*		
MPUP3136 – Microbiota-Based Therapeutics (MBT) **NEW TITLE** *formerly Fecal Microbiota Transplant (FMT)*	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. **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. After discussion, between Q/UAC voters and physicians Briab Montenegro, John Murphy and Chris Swales, Q/UAC voters agreed to strike VI.B.2.a. "~~FMT is limited to centers of expertise~~." (Partnership acknowledged that there is no single criteria for what constitutes a "center of excellence.")	Motion to **approve with one amendment:** Brian Montenegro, MD Second: Jennifer Wilson, MD *Approved unanimously* Next Steps: June 10 PAC
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director of UM Regulations*		
MCUP3104 – Transplant Authorization Process	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)."	*QUAC voters posed no questions.* Motion to **approve as presented:** John Murphy, MD Second: Chris Swales, MD *Approved unanimously* Next Steps: June 10 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Policy Owner: Utilization Management: – *Mark Netherda, MD, Medical Director for Quality*		
MPUP3047 – Tuberculosis Related Treatment	**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." **After discussion Q/UAC agreed to amend the last bubble in the first line of the Attachment A flowchart to read** "Patient give note, signed, with indication that TST/IGRA not indicated."	Motion to **approve with one amendment top of flow chart (Attachment A):** Chris Swales, MD Second: Brian Montenegro, MD *Approved unanimously* Next Steps: June 10 PAC

V. Presentations

Behavioral Health Overview and Grand Analysis: ME7 (Elements E&F) Member Experience – *Mark Bontrager, Sr. Dir., Behavioral Health; Nicole Escobar, Manager of Behavior Health, and Jeffrey DeVido, MD, Behavioral Health Clinical Director*

Mark explained that, in Medi-Cal, behavioral health is a shared responsibility between managed care plans (MCPs) and county behavioral health plans (BHPs) and is now more "equitable" as DHCS is now treating the BHPs as it does the MCPs. Partnership's current coverage, however, is predominately outpatient, non-specialty mental health services (NSMHS), whereas the counties include inpatient amongst a wider array of provider types and specialty mental health services (SMHS). Any member can go to an approved Medi-Cal in-network provider without going through us; however, if they do reach out to our call center, we are required to use the state prescribed screening tools, which will then direct us to direct the caller to either the county or to our own provider network, depending on the score (which indicates whether NSMHS or SMHS is needed). Members can receive services in both systems of care even at the same time as long as services are not duplicative. About 90% of members utilizing the NSMHS benefit do so without first going through Partnership's call center, Mark said.

On the substance use disorder (SUD) treatment side as it relates to managed care coverage benefit, it is limited to screening, brief interventions, and care coordination referral, and transportation to those carved out services. Transportation is specially of help to SUD patients utilizing methadone in their recovery, Mark said..

Looking at a snapshot of mental health utilization in 2025, about 10% of approximately 896,000 members received services in our Carelon NSMHS provider network; 3.7% received SMHS in our county BHPs, and about 1% received services in both systems of care.

The big thing that changed in 2025 was our relationship with Carelon. Starting last fall, we insourced all member-facing activities, including call center, care coordination, grievance and appeals and utilization management. (Carelon does retain network management and claims payment on our behalf.) Note that 2025 NSMHS utilization increased approximately 2% above 2024 as this insourcing rolled out.

Although this analysis's monthly call volume capture does not reflect pre insourcing (i.e., prior to October 2025) numbers, Mark said that Carelon was fielding about 1,200 inbound calls each month. Since insourcing began, inbound calls to Partnership's call center have continued to climb monthly, something Mark deemed "positive" and attributable to both greater utilization and increasing service level. Our outbound calls to close the loop and make sure that our members not only get an appointment but attend it too have also jumped, particularly since February 2026 when Point-Click-Care started alerting us every time a member shows up in the emergency room for a behavioral health related issue. Our team reaches out to these persons as a FUA/FUM response (i.e., follow-up appointment within seven days or 30 days, respectively, of being seen in the ED). In April 2026, we had close to 2,700 inbound calls, and we are trending toward 10,000 outbound calls each month. We hope that one day these outbound calls may decrease as we use different tools, Mark said.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

Partnership by March 2026 was averaging no more than seven seconds to answer a call. Only 1.11% calls were abandoned as we ironed out the problems that occurred earlier by bringing the call center inhouse. The analysis includes Q1 2026 referral flow data between the counties and Partnership. Member feedback generally is positive, not least because whether a call takes five or 15 minutes to resolve, Partnership spends that time to ensure the member leaves the call with a scheduled appointment, Mark said.

Dr. DeVido briefly described transcranial magnetic stimulation (TMS), an evidenced based non-invasive treatment for depression and obsessive-compulsive disorder. TMS is essentially a handheld magnetic resolution imaging (MRI) device to induce some electrical reactions in regions of the brain according to certain protocols for treatment of certain psychiatric illnesses. (It may one day be authorized to treat migraines and other non-psychiatric disorders.) TMS is now potentially payable and "administerable" on both sides (NSMHS and SMHS) of the house. On the NMSHS side, Partnership has had one treatment performed and reimbursed, so a pathway has now been established, Dr. DeVido said. TMS is not currently subject to treatment authorization request (TAR).

Q/UAC voter Randy Thomas, MD, – noting that use of the device is likely more expensive than medications – asked if no TAR being required was a concern. A long conversation followed whether this should change. Dr. DeVido said the provider bears the cost to purchase the hand-held device. Partnership is not now requiring a TAR in keeping with DHCS's desire to improve access. Dr. Thomas wanted to know the reimbursement rate, to which Mark replied that depends on the provider type.

Nicole reported out on our outreach and education plan (OEP) before describing Partnership's member experience (ME-7) responsibilities required by National Committee on Quality Assurance (NCQA) accreditation. As of 2024, Behavioral Health has partnered with various departments to assess the utilization of NSMHS, including looking at trends, gaps in service delivery and areas with low penetration rates. DHCS wants to know if our members are aware of the benefit and how to access it, so on an annual basis, we are required to submit an OEP. We are pleased we have entered our second year and have received first-year approval of our plan, Nicole said. To develop the OEP, we leveraged various data sources, including claims, surveys, and open dialog with members in our community settings. Some of the data has fed into targeting strategies around different communication needs, whether members have geographic access to services, and whether they have access to technology. Is Telehealth an option? The ED? We present to various consumer advisory and health equity committees and also participate in tribal convenings. A longer, detailed document is available on our external website for those interested in learning more.

Nicole described the ME-7, reporting that Partnership is now responsible for two different elements: grievance and appeals, and members surveyed. Partnership's behavioral team is responsible for Element E (Member Perception Survey) and Element F (Interventions, i.e., action plans that address identified barriers and include both plan-level and delegation oversight for goals that are not met). Previously the responsibility of Carelon (April – September 2025), Partnership will be reporting, together with our ongoing insourcing efforts (September 2025 – March 2026), in this cycle.

Nicole said we are continuing insourcing, county coordination/network strengthening and close loop referral tracking. We will be adding and utilizing year-over-year data in future. Dr. DeVido commented that call center training may expand opportunities for staff to help enhance the member experience. Exactly 889 Medi-Cal members responded to the latest Member Experience Survey. From April 2025 through March 2026, 161 grievance and appeals cases were reviewed. Many cases reflected member difficulty navigating the behavioral health system from initial contact through care coordination. Partnership met the established goal of less than one grievance per 1,000 members.

Q/UAC voter John Murphy, MD, noted that insourcing the call center seems to have proven a good idea, but he wondered at the cost. Mark, without going into specifics, replied that our former Carelon delegation financially cost us more. Nicole noted that Partnership is meeting regulatory requirements. Our data tells us this but doesn't include members' perceptions, which we must assess by other means.

The "Regional Model" *aka* "Wellness & Recovery" or "Drug Medi-Cal Organized Delivery System (DMC-ODS)" is a waivered opportunity that we have leveraged since July 2020 to bring SUD services to seven Partnership counties. Nicole said that having now served more than 20,000 members, many of whom still continue in treatment, it is "a pleasure" to review some of the metrics we have maintained over the years: despite the (2025 above 2024) 8.5% increase in members accessing services, and a 15.3% increase in services rendered, we have achieved a timely screening-to-treatment-within-two-days access rate of 96%. Transitions of care between

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levels of service and overall utilization has been able to increase because we have increased provider capacity by >400%, Nicole said.

Looking at our managed care responsibilities to the counties, our administrative challenges have caused us to rethink our capacity and long-term strategic plan. A new contract between the state and the counties for both SMHS and DMC-ODS will become effective Jan. 1, 2027. We will no longer administer the benefit but are committed to a successful transition as the seven counties assume these responsibilities. (All have agreed to do so.) Mark made some closing remarks on executed MOUs. DHCS, he concluded, is highlighting Partnership's work as the State observes June as "Foster Care Awareness month."

Q/UAC unanimously approved this Grand Analysis – Motion to approve: Steven Gwiazdowski, MD / Randy Thomas, MD

Quality Improvement Health Equity Committee (QIHEC) Charter – *Mohamed Jalloh, Pharm.D, Director, Health Equity (Health Equity Officer)*

Dr. Jalloh noted that while we have had a QIHEC policy for some time, we realized during recent audit that there was no official committee charter. We will continue to update this charter for purpose, authority, and staff requisites as necessary.

VI. Adjournment to additional meeting scheduled for 7:30 – 9:00 a.m. June 17, 2026

Dr. Moore adjourned the meeting at 9:04 a.m.

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

Signature of Approval: _____ Date: _____

Chief Medical Officer Robert Moore, MD, MPH, MBA

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, May 12, 2026 / 1:32 – 3:21 PM

Members Present:	Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management
Andrews, Leigha, Regional Director (SW)	Gual, Kristine, PMP, CPHQ, Director of Quality Measurement, QI
Ayala, Priscila, Director of Network Services	Hightower, Tony, CPhT, Associate Director, UM Regulations
Barresi, Katherine, RN, BSN, PHN, Chief Health Services Officer	Innes, Latrice, Compliance Manager, Grievance & Appeals
Beard, Alyssa, RN, Manager of CC Regulatory Performance	Jalloh, Mohamed, Pharm.D, Dir. of Health Equity (Health Equity Officer)
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations	Jensen, Annika, RN, Assoc. Dir. of Clinical Integration, Care Coordination
Bjork, Sonja, JD, Chief Executive Officer	Jones, Kermit, MD, JD, Deputy CMO/Medical Director for Medicare Services
Bontrager, Mark, Senior Director of Behavioral Health, Health Services	Leung, Stan, Pharm.D, Director of Pharmacy Services
Brincko, Aaron, Director of Provider Relations	Moore, Robert, MD, MPH, MBA, Chief Medical Officer (Chair)
Brown, Isaac, MHA/MBA, Senior Director, Q & PI	Netherda, Mark, MD, Medical Director for Quality (Vice Chair)
Brunkal, Monika, RPh, Associate Director of Population Health	Newman, Rachel, RN, BSN, Mgr, Clinical Comp. – Quality Inspections
Campbell, Anna, MPH, Policy Analyst, Utilization Management	O'Connell, Lisa Brundage, MHA, Director, Enhanced Health Services
Devan, James, Director of Quality Improvement, QI	Randhawa, Manleen, Senior Health Educator, Population Health
DeVido, Jeffrey, MD, Behavioral Health Clinical Director	Villasenor, Edna, Senior Director, Member Services and Grievance
	Ward, Lisa, MD, Regional Medical Director (SW)
Members Absent:	Ruffin, DeLorean, DrPH, Director of Population Health
Davis, Wendi, Chief Operating Officer	Townsend, Colleen, MD, Regional Medical Director (SE-Fairfield)
Klakken, Vicky, Regional Director (NW-Eureka)	Vaisenberg, Liat, Director of Health Analytics
Matthews, R. Douglas, "Doug," MD, Regional Medical Director (Chico)	
Guests:	Kubota, Marshall, Associate Medical Director
Akintan, Folo, MBBS/MD, MPH, MBAm Epidemiologist, Pop Health	Kung, Jen, Sr. Health Data Analyst II, Finance
Allen, Angier, Sr. Data Scientist I, Finance	Lee, Donna, Manager of Claims, Claims
Arrazola, Kelcie, Lead Trainer, Provider Relations	Leung, Paul, Sr. Health Data Analyst I, Finance
Bikila, Dejene, Manager of Data Science, Finance	Ling, Samuel, Sr. Health Data Analyst I, Finance
Chebolu, Radha, Sr. Data Scientist II, Finance	Medric, Christy, Sr. Health Data Analyst I, Finance
Clark, Kristen, Manager of Qlty. & Training, Member Services	Moore, Jordan, Education Specialist, Provider Relations
Cunningham, Aryana, Policy Analyst, Care Coordination	Morris, Matthew, MD, Regional Medical Director
Curreri, Nicole, MPH, CHES, Associate Director of Enhanced Health Services	Muncy, Kellie, Manager of Change Management & Configuration
Diaz, Alondra, Project Coordinator I, Care Coordination	Nguyen, Tom, Manager of Health Analytics., Finance
Durst, Jennifer, Senior Manager of Performance Improvement, QI	O'Leary, Hannah, Manager of Population Health
Escobar, Nicole, Sr. Manager of Behavioral Health	Quichocho, Sue, Manager of Quality Measurement, QI
Flournoy, Candi, Project Manager II, QI	Rathnayake, Rasitha, Sr. Health Data Analyst I, Finance
Foster, Troy, Program Manager II, QI	Rednic, Hanny, Program Manager I, UM
Friedman, Greg Allen, Project Coordinator II, Population Health	Roach, Erika, Program Manager I, Network Services
Harris, Vander, Sr. Health Data Analyst I, Finance	Seale, J'aime, PR Lead, Network Services
Hendrix, Hillary, Executive Assistant, Behavioral Health	Sivasankar, Shivani, Sr. Data Scientist, Finance
Horan, Kathleen, Facilities Business Management Specialist, Finance	Stites, Jaylyn, Program Manager II, Provider Relations (Redding)
Isola, Brandy, Manager of Performance Improvement, QI (Chico)	Vance, Brooke, Program Manager I, Network Services
Kim, Amanda, Improvement Advisor, QI (Redding)	Yu, Fei, Sr. Data Scientist I, Finance
Kulkarni, Shreya, Policy Analyst, Regulatory Affairs & Compliance	Zhao, Li Sr. Health Data Analyst I, Finance

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I. Call to Order
• Approval of Minutes
• Announcements
	CMO Robert Moore, MD, MPH, MBA called the meeting to order at 1:32 p.m. from the Fairfield-West office. He welcomed back committee scribe Leslie Erickdon and thanked all those who covered IQI work in her absence, particularly Robert Bides, RN, Cindy Rodriguez, and Chandler Ackerman. "It was well done with a smile, a smile of stress.," he said, adding that this situation exemplifies why "we need to build capacity so (anyone) can take time off."
	• The April 7 IQI Minutes were approved without comment.
	• "Policy review update" will be a standing item for some months to come.
	  o Shreya Kulkarni of Regulatory Affairs & Compliance (RAC) is point of contact for any questions.
	  o RAC wants those responsible for editing policy updates and bringing them to this or other reviewing committees to first refer to template CMP44-A under CMP44 Development, Structure and Formatting of Policies/Procedures (available in Power DMS) as they work.
	• Jan. 1, 2028 is our new target date to go-live with Medicare (i.e., "Partnership Advantage"). After some discussion, it was agreed that all published policies now noting Jan. 1, 2026 or Jan. 1 2027 go-live dates may be changed to Jan. 1, 2028 in Power DMS *if and only if this is the only change to be made* to the policy. (The policy need not first come back through committees if an annual review is not yet due.) *Motion: Anna Campbell/Lisa Ward, MD*
	• If a policy alpha/numeric designation changes from MC to MP (i.e., Medi-Cal to Multi Program) or vice versa, it is the policy owner's responsibility to inform the owners of all "Related Policies" to accordingly update those policies. Power DMS power users may electronically update their published policies without first bringing the policies to committee if this is the only change to be made to the related policy and the policy is not otherwise due for annual review. *Motion: Anna Campbell/Lisa Ward, MD*
	• Anna Campbell noted that – insofar as multiple policies state readers should "refer to website" or says "If you need SUD treatment, go to this webpage" or "If you need P-MEDS, go to this webpage" – she has concerns with Communications' plans to shift our external website from one SharePoint to another and eventually to a new platform. Links could be inoperable by October. She reported that Communications has said they will take this into account if provided a list of such policies. Dr. Moore said policies must always include the link's name and not just point to a hidden URL so that readers can do an internet search if necessary.
		Motion to approve IQI Minutes: Mark Netherda, MD
		Second: Isaac Brown, MHA/ MBA
		• The date of the last RAC review for regulatory compliance with All Plan Letters (APLs) etc. and/or the Department of Health Care Services' (DHCS) review for contract compliance, etc. should be captured in policies.
		• The formatting and placement of this new date will be decided offline this summer before policy point persons must comply (in policies submitted for Aug. 11 IQI consideration).
		• ***Postscript following June 9 IQI approval of these minutes:*** **staff has been informed via several emails that a RAC review date need not be added to policies.**

II. Old Business – None		
III. New Business Consent Calendar (Committee Members as applicable)		
Health Services Policies <u>Behavioral Health</u> MPBP8005 – Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health <u>Care Coordination</u> MPCP2026 – Diabetes Prevention Program MPCP2034 – Transitional Care Services – ***pulled for discussion*** <u>Enhanced Health Services</u> MPAP7004 – Community Health Worker (CHW) Services Benefit MPAP7005 – Street Medicine		Motion to **approve the slate without the three policies pulled for discussion:** Mark Netherda, MD Second: Lisa Ward, MD <u>Next Steps HS Policies</u>:

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	Quality Improvement MPQP1038 – Physician Orders for Life-Sustaining Treatment (POLST) MPQP1047 – Advance Directives MPQP1055 – Provider Preventable Condition (PPC) Reporting Utilization Management MPUP3137 – Palliative Care: Intensive Program (Adult) MPUP3144 – Residential Substance Use Disorder Treatment Authorization **Non-Health Services Policies** Member Services MC341 – Distribution of Member Rights and Responsibilities – Wellness and Recovery Program Network Services – Credentialing MPCR300 – Physician Credentialing and Re-credentialing Requirements – ***pulled for discussion*** MPCR302 – Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements MPCR303 – Applied Behavioral Health and Substance Use Disorder Practitioner Credentialing and Recredentialing Requirements MPCR304 – Allied Health Practitioners Credentialing and Re-credentialing Requirements MPCR500 – Ongoing Monitoring of Sanctions MPPR208 – Provider Notification of Provider Termination, Site Closure or Change in Location Information – ***pulled for discussion; then deferred to June 9 IQI*** MPNET101 – Wellness and Recovery Access Standards and Monitoring MPCR102 – Provider Directory Accuracy MPCR701 – Ancillary Care Services Provider Credentialing and Re-credentialing Requirements MPNET103 – DHCS Subcontractor Network Certification Care Coordination Policy Analyst Aryana Cunningham **pulled MPCP2034 to audible some additional changes**. She noted that this policy will come back after the Department of Health Care Services updates its PHM Policy Guide, Volume I. (This update is expected in July.) Additional changes today include updates to definitions and Dual-eligible Special Needs Plan (D-SNP) language. Anna Campbell asked if the non-specialty mental health services (NSMHS) definition aligned with that in Behavioral Health's related policy. Aryana will align the two accordingly and submit an updated MPCP2034 for the May 20 Q/UAC packet *Motion to approve with verbalized changes: Anna Campbell/Jeffrey DeVido, MD.* Pharmacy Services Director Stan Leung, Pharm.D., **pulled MPCR300 to discuss new provider enrollment in Medi-Cal.** He wondered of VI.B.1.b. and/or c. criteria should be amended to add "active or current active enrollment status in Medi-Cal PAVE" (DHCS's Provider Application and Validation for Enrollment website). Director of Network Services Priscila Ayala agreed to the addition, which will be noted in VI.B.1.c. Stan also noted that the policy cites an incorrect web address. He will provide the correct one to Network Services. *Motion to approve with these changes: Mark Netherda, MD/Stan Leung, Pharm.D. The policy may now advance to the next Credentials Committee meeting for approval.* UM Policy Analyst Anna Campbell **pulled MPPR208 to comment about its attendant forms**. She suggested that what counties in what region should be spelled out. The Eastern Region too should be added to the form. Will this use the same or a different fax number? Further, **this policy now belongs to Network Services and not Provider Relations; therefore, the alpha/numeric designation should be changed**. Priscila will see that Network Services staff look at making these changes. **The policy is deferred today and will be brought back to IQI June 9.**	• May 20 Quality/Utilization Advisory Committee (Q/UAC) • June 10 Physician Advisory Committee (PAC) Next Step Approved Credentialing Policies: • June 10 Credentials Committee

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IV. New Business – Discussion Policies		
Policy Owner: Behavioral Health – *Presenter: Jeffrey DeVido, MD, Behavioral Health Clinical Director*		
MPBP8003 – Mental Health Services	Added related policy: MPBP8007 - Screening and Treatment for Substance Use Disorders • **VI. 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. • **VI. I. G. - Re-Added** "through the diagnosis or treatment of disease, illness or injury" per request from Policy Analyst • **VI. I. N. – Added** "should be performed by PCP." • **VI. I. O. – Added** "as outlined in APL 21-014." • **VI. S. – Added** "Data sharing" section to align with APL 26-004 "Medi-Cal Managed Care Plan Responsibilities For Behavioral Health Data-Sharing" • **VI. 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 Dr. DeVido noted that IQI saw this policy last month with changes related to APL 26-002. Changes this month are largely "boiler plate" data sharing guidance lifted from APL 26-004. "This is all very fresh," he said, adding that some specifics have yet to be addressed. "We have been able to address some needs per DHCS request (e.g., bringing the call center in house to be later today in the Grand Analysis presentation). The benefit is that a caller can now be directly connected to a service provider, what we call 'first call resolution.' We are already working on closed loop tracking systems for each of our 24 counties." We are still working on this and with the (Behavioral Health Plans) BHPs (formerly known as Mental Health Plans or MHPs) in the counties on information exchange – such that we can have automatic bi-directional communication, possibly using SacValley MedShare data exchange. Anna Campbell asked if the policy should still reference Carelon. Dr. DeVido replied he tells everyone to call Partnership; however, Senior Director of Behavioral Health Mark Bontrager noted that Varelon is still an option available to primary care providers seeking consultation. Dr. Moore added that phone numbers, with few exceptions, should not be listed in policies. Web addresses are preferred.	Motion: **approve changes presented today knowing that some Carelon language will be clarified before the policy moves to Q/UAC:** Kristine Gual, PMP, CPHQ Second: Anna Campbell, MPH Next Steps: May 20 Q/UAC June 10 PAC
Policy Owner: Care Coordination – *Presenter: Aryana Cunningham, Care Coordination Policy Analyst*		
MPCP2023 – New Member Needs Assessment	**Policy edits due to APL 26-001 Initial Health Appointment.** Throughout the policy Partnership Advantage effective date has been updated to reflect Jan. 1, 2028. The body of the policy has been updated to reflect Partnership Advantage "Enrollee" instead of Partnership Advantage "Member." • **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	Motion to **approve the policy itself as presented, with the form's header and footer changes as noted:** Anna Campbell, MPH Second: Mark Netherda, MD Next Steps: May 20 Q/UAC

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	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) Aryana presented, adding that this policy has been submitted to DHCS, which thus far has not returned any AIRs. There was some discussion whether the form headers and footers really need to reference "SPDs" (Seniors/Persons with Disabilities), which some IQI members said can be confusing or even offensive to some members. Dr. Moore and Chief Health Services Officer Katherine Barresi, RN, agreed to **change the form header to "Adult Health Risk Assessment" (adhering to the HRA acronym familiar to us) and add the SPD acronym to the footnote to clue in staff as to the form's utility.**	June 10 PAC Senior Director of Member Services and Grievance Edna Villasenor noted the form still must be translated for inclusion in new member packets. Aryana said Communications is aware and will broker this once DHCS has approved our changes. Edna asked that her staff remain apprised.
Policy Owner: Quality Improvement / Behavioral Health – *Presenter: Jeffrey DeVido, MD, Behavioral Health Clinical Director*		
MPXG5003 – Major Depression in Adults Clinical Practice Guidelines	Attachment A flowchart: • **Added reference** to 2023 American College of Physicians (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. Dr. DeVido added that **the flowchart date reading "2025" will be changed to "2026"** before Q/UAC sees this May 20. **Reference to Partnership Advantage will be struck from one flowchart bubble.** This may come back in a future update closer to the D-SNP go-live target Jan. 1, 2028. Dr. DeVido said he was curious how our guideline might compare to an AI discussion, and so he looked at Claude. He was pleased that our policy did not need further work as a result. (Claude did return one additional reference, which Dr. DeVido added.)	Motion to **approve as presented with the flowchart to be amended in two places:** Kristine Gual, PMP, CPHQ Second: Anna Campbell, MPH Next Steps: May 20 Q/UAC June 10 PAC
Policy Owner: Utilization Management – *Presenter: Mark Netherda, MD, Medical Director for Quality*		
MPUP3047 – Tuberculosis Related Treatment	**Section VI.B:** Guidance for Directly Observed Therapy was updated, and a link was provided to a California Department of Public Health (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."	Motion to **approve as presented:** Lisa Ward, MD Second: Kristine Gual Next Steps: May 20 Q/UAC June 10 PAC

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	Dr. Netherda thanked former Yuba/Sutter County Public Health Officer Phuong Luu, MD, for the suggestion on the attachment. He also thanked Associate Medical Director Teresa Frankovich, MD, Regional Medical Director (Santa Roa) Lisa Ward, MD, and UM Policy Analyst Anna Campbell for their contributions.	
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations*		
MPUP3136 – Microbiota-Based Therapeutics (MBT) **NEW TITLE**(formerly Fecal Microbiota Transplant [FMT]	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. **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. After Tony went through the synopsis, Anna noted that the title change was made at the behest of Deputy CMO Kermit Jones, MD. Dr. Netherda explained that patients can still receive a familial donor but that a lab-grown option I now available where indicated.	Motion to **approve as presented:** Anna Campbell, MPH Second: Jeffrey DeVido, MD Next Steps: May 20 Q/UAC June 10 PAC
Policy Owner: Utilization Management – *Presenter:*		
MCUP3104 – Transplant Authorization Process	This policy was updated to address an APL revision. **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 were 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)." Dr. Moore noted that we became aware of the new DHCS nomenclature during our recent audit, which is one reason why we now have "policy wranglers."	Motion to **approve as presented:** Mark Netherda, MD Second: Lisa Ward, MD Next Steps: May 20 Q/UAC June 10 PAC
V. Presentations		
QI Update – *Isaac Brown, MPH/MBA, Senior Director, Quality Improvement and Performance*		
• May is a big month for primary care providers to learn about what they have earned this past year though participating in the PCP Quality Incentive Program (PCP QIP) and to also see specific data, including where care gaps exist, via the Partnership Quality Dashboard (PQD). • We have finished our survey cycle for our regulated Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and should be sharing that in our August meetings. As you know, the member experience has been a big topic of conversation throughout the organization and so we are looking forward to updating our baseline of where we are at. A quick example: We recently went to a Joint Leadership Initiative (JLI) for Western Sierra. They mentioned our mobile mammography event. One of the things they have done is actually expand their event to include several cancer screenings. (This is an effort we are pushing more broadly to have	

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more care gaps closed.) At that JLI, they also discussed our colorectal cancer screenings. They sang our praises, in particular, Chandler Ackerman, who did a fantastic job for our team.

- A number of QI Trilogy deliverables are coming due, some of them today. Please reach out to the QI Trilogy team if you have questions or need training in your role as a business owner, contributor, or sponsor for one or more of these deliverables.

Individual Health Appointment (IHA) Calendar Year 2025 Claims and Encounters Summary – *Rachel Newman, RN, Manager, Member Safety Inspections Team*

The Initial Health Appointment is trying to get members in to be seen by their PCP within 120 days (or there could be a 365-day lookback period). It now includes the member risk assessment, which includes social determinants of health (SDoH). We also encourage at least two provider outreach attempts to members. We review that documentation during site review. For methodology, our report accounts for three months of claim lag and four months of continuous enrollment. The claim submission for what we scored this year was 42.20%; however, claims are hard to pull without doing medical record review because there is not one billing code for IHA. For measurement year 2024, there were 2,763 records that qualified for an IHA during the medical record review. Of those, we had 92.2% compliance. That's a better rate and a much better reflection of where we are actually at, Rachel said.

There are many different education and training efforts that occur, including a big collaborative meeting, operational meetings with our providers and Provider Relations. The report breaks down the data for each of our regions: the two lowest were Auburn and Fairfield and the highest was Chico, although they were fairly close: 38.6% to 45.7%.

IQI members posed no questions. *No IQI approval of this report is required. Q/UAC will be asked to accept it on its May 20 consent calendar.*

Behavioral Health Overview and Grand Analysis: ME 7 Member Experience – *Mark Bontrager, Senior Director, Behavioral Health, Nicole Escobar, Manager of Behavioral Health, and Jeffrey DeVido, MD, Behavioral Health Clinical Director*

Mark explained that, in Medi-Cal, behavioral health is a shared responsibility between managed care plans (MCPs) and county behavioral health plans (BHPs), which are also managed care plans federally known as "pre-paid inpatient health plans." Partnership "manages this bifurcation as best we can through several different bites of the apple," Mark said. We have a different coverage, predominately outpatient, non-specialty mental health services (NSMHS), whereas the counties include inpatient amongst a wider array of provider types and specialty mental health services (SMHS). Any member can go to an approved Medi-Cal in-network provider without going through us; however, if they do reach out to our call center, we are required to use the state prescribed screening tools, which will then direct us to direct the caller to either the county or to our own provider network, depending on the score (which indicates whether NSMHS or SMHS is needed). Members can receive services in both systems of care even at the same time as long as services are not duplicative.

On the substance use disorder (SUD) treatment side as it relates to managed care coverage benefit, it is limited to screening, brief interventions, and care coordination referral, and transportation to those carved out services. Mark noted this is "significant" because a number of our members receive daily dosing for their medical assisted treatment, and this impacts their transportation needs.

Looking at a snapshot of mental health utilization in 2025, about 10% of approximately 896,000 members received services in our Carelon NSMHS provider network; 3.7% received SMHS in our county BHPs, and about 1% received services in both systems of care.

The big thing that changed in 2025 was our relationship with Carelon. Starting last fall, we insourced all member-facing activities, including call center, care coordination, grievance and appeals and utilization management. (Carelon does retain network management and claims payment on our behalf.) Note that 2025 NSMHS utilization increased approximately 2% above 2024 as this insourcing rolled out.

Although this report's monthly call volume capture does not reflect pre insourcing (i.e., prior to October 2025) numbers, Mark said that Carelon was fielding about 1.200 inbound calls each month. Inbound calls have continued to climb monthly through Partnership's call center, something Mark attributes to increasing service level and greater utilization. "We see this as a positive," he said. Our outbound calls to close the loop and make sure that our members not only get an appointment but attend it too have also jumped, particularly since February 2026 when Point-Click-Care started alerting us every time a member shows up in the emergency room for a behavioral

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

health related issue. Our team reaches out to these persons as a FUA/FUM response (i.e., follow-up appointment within seven days or 30 days, respectively, of being seen in the ED). In April 2026, we had close to 2,700 inbound calls, and we are trending toward 10,000 outbound calls each month. We hope that one day these outbound calls may decrease as we use different tools.

Partnership by March 2026 was averaging no more than seven seconds to answer a call. Only 1.11% calls were abandoned as we ironed out the problems that occurred earlier by bringing the call center inhouse.

The report includes Q1 2026 referral flow data between the counties and Partnership. The numbers indicate that about 90 percent of our members go directly to a provider. They don't necessarily contact us first. We want it that way because "we want folks to have unfettered access to mental health care," Mark said Today, a majority of members leave the call with an appointment in hand, sometimes by us going directly into a provider's system and sometimes with a "warm handoff to a front office individual at a practice."

Dr. DeVido briefly described transcranial magnetic stimulation (TMS), an evidenced based non-invasive treatment for depression and obsessive-compulsive disorder. TMS is essentially a handheld magnetic resolution imaging (MRI) device to induce some electrical reactions in regions of the brain according to certain protocols for treatment of certain psychiatric illnesses. (It may one day be authorized to treat migraines and other non-psychiatric disorders.) TMS is now potentially payable and "administerable" on both sides (NSMHS and SMHS) of the house. On the NMSHS side, Partnership has had one treatment performed and reimbursed, so a pathway has now been established, Dr. DeVido said. TMS is not currently subject to treatment authorization request (TAR).

Nicole reported out on our outreach and education plan (OEP) before describing Partnership's member experience (ME-7) responsibilities required by National Committee on Quality Assurance (NCQA) accreditation. As of 2024, Behavioral Health has partnered with various departments to assess the utilization of NSMHS, including looking at trends, gaps in service delivery and areas with low penetration rates. DHCS wants to know if our members are aware of the benefit and how to access it, so on an annual basis, we are required to submit an OEP. We are pleased we have entered our second year and have received first-year approval of our plan, Nicole said. To develop the OEP, we leveraged various data sources, including claims, surveys, and open dialog with members in our community settings. Some of the data has fed into targeting strategies around different communication needs, whether members have geographic access to services, and whether they have access to technology. Is Telehealth an option? The ED? We present to various consumer advisory and health equity committees and also participate in tribal convenings. A longer, detailed document is available on our external website for those interested in learning more.

Nicole described the ME-7, reporting that Partnership is now responsible for two different elements: grievance and appeals, and members surveyed. Partnership's behavioral team is responsible for Element E (Member Perception Survey) and Element F (Interventions, i.e., action plans that address identified barriers and include both plan-level and delegation oversight for goals that are not met). Previously the responsibility of Carelon (April – September 2025), Partnership will be reporting, together with our ongoing insourcing efforts (September 2025 – March 2026), in this cycle.

Nicole said we are continuing insourcing, county coordination/network strengthening and close loop referral tracking. We will be adding and utilizing year-over-year data in future. Dr. DeVido commented that call center training may expand opportunities for staff to help enhance the member experience. Exactly 889 Medi-Cal members responded to the latest Member Experience Survey. From April 2025 through March 2026, 161 grievance and appeals cases were reviewed. Many cases reflected member difficulty navigating the behavioral health system from initial contact through care coordination. Partnership met the established goal of less than one grievance per 1,000 members.

The "Regional Model" *aka* "Wellness & Recovery" or "Drug Medi-Cal Organized Delivery System (DMC-ODS)" is a waivered opportunity that we have leveraged since July 2020 to bring SUD services to seven Partnership counties. Nicole said that having now served more than 20,000 members, many of whom still continue in treatment, it is "a pleasure*"* to review some of the metrics we have maintained over the years: despite the (2025 above 2024) 8.5% increase in members accessing services, and a 15.3% increase in services rendered, we have achieved a timely screening-to-treatment-within-two-days access rate of 96%.

Looking at our managed care responsibilities to the counties, our administrative challenges have caused us to rethink our capacity and long-term strategic plan. A new contract between the state and the counties for both SMHS and DMC-ODS will become effective Jan. 1, 2027. We will no longer administer the benefit but are committed to a successful transition as the seven counties assume these responsibilities. (All have agreed to do so.) Mark made some closing remarks on executed MOUs.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

Dr. Moore asked if, in a couple of years, we will be assessing how well the counties do. Mark replied that we can certainly look at utilization. Dr. Moore noted that our members think Partnership does all of Medi-Cal benefits, and we don't.

Isaac Brown asked about the call center: are the visits we schedule in-person or virtual? What's the mix? Mark responded that our modality mix is nearly 60/40 in-person to telehealth. It's even higher in-person for children and youth with families.

IQI approved this report, which will presented again at Q/UAC on May 20. Motion to approve: Isaac Brown/Anna Campbell

Proposed Calendar Year 2027 Perinatal QIP Measure Set – *Troy Foster, Program Manager II, QI*

It is proposed that our contract with Datalink remain a gateway measure for 2027. Providers new to the QIP would have until June 30, 2027 to complete requirements for incentive payment eligibility.

For our clinical measures (Measure 3 – Timely Prenatal Care and Measure 4- Depression Screening at First Prenatal Visit with Late Entry to Care > 14 weeks gestation) – extractions will continue on a monthly basis with some exceptions for manual submission for some new providers.

Measure 6 (Timely Comprehensive Assessments) will move from current monitoring status to an actual incentivized measure in 2027. Troy briefly outlined the target specifications.

Epidemiologist Folo Akintan, MD, wondered why only one post-partum visit and asked if it could be more. Dr. Moore explained this refers to the perinatal case management assessment, which we need to remember to differentiate from the medical case management assessments. With the perinatal, the *minimum* bar would be one visit in each of the three trimesters plus one-post-partum visit. As a package, that is worthy of incentive, Dr. Moore said.

No IQI approval of this proposal is required. Q/UAC will be asked to accept it on its May 20 consent calendar. Final approval rests with PAC June 10.

Quality Improvement Health Equity Committee (QIHEC) Charter – *Mohamed Jalloh, Pharm.D., Director of Health Equity (Health Services Officer)*

Dr. Jalloh noted that while we have had a QIHEC policy for some time, we realized during recent audit that there was no official committee charter. We will continue to update this charter for purpose, authority, and staff requisites as necessary. *IQI accepted the charter: Kristine Gual/Mark Netherda, MD – We will ask Q/UAC to approve this on May 20.*

VI. Adjournment

Dr. Moore adjourned the meeting at 3:21 p.m. IQI will meet next Tuesday, June 9, 2026.

Respectfully Submitted by Leslie Erickson, Program Coordinator II, Quality Improvement

Approval Signature: *Date:*

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

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4665 Business Center Drive
Fairfield, California 94534

MEETING Minutes

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

Date: 5/19/2026 **Time**: 7:30 a.m. – 9:00 a.m.

Facilitator: Mohamed Jalloh, Pharm D

Coordinator: Bethany Hannah

Meeting Locations:

- Webex

Attendees: Aaron Brincko; Amanda Kim; Amanda McNair; Anthony Sackett; Arlene Pena; Ben Spencer; Candy Stockton; Cathryn Couch; Bethany Hannah; Christine Smith; Dawn Cook; Denise Whitsett; DeLorean Ruffin, DrPH, MPH; Folo Akintan; Hannah O'Leary; Isaac Brown; Jason Cunningham; Jesus Hermosillo; Kermit Jones; Kimberly Robertello; Kory Watkins; Leila Romero; Liat Vaisenberg; Lilly Merino; Manleen Randhawa; Mark Bontrager; Mark Netherda; Marshall Kubota; Michele Grupe; Melissa Schumann; Mohamed Jalloh; Monika Brunkal; Naz Sattari; Nicole Curreri, MPH CHES; Sunshine Jackson; Sydni Aguirre; Valerie Padilla; Vicquita Valazquez; Stan Leung, Sue Lee; Kristine Gual; Robert Moore, MD; Sue Quichocho; Tiffany Tryan; Tony Hightower; Wendy Starr;

Absent: Sonja Bjork; Whitney Haggerson; Amanda Smith; Hendry Ton, MD; Ian Kim; Kimberly Robertello; Noemi Doohan; Rachel Newman; Rocio Rodriguez; Rebecca Stark; Shannon Boyle; Latrice Innes; Nisha Guppta; Anna Cambell; Robert Bides; Shahrukh Chishty; Nicole Escobar; Heather Eset; Greg Allen Freedman; Jaymee James; John Lemoine; Sue Quichocho; Dorian Roberts; Tim Sharp; Amy Turnipseed; Edna Villasenor; Kory Watkins; Bridget Gast; Dana Codron; Monica Ferguson; Katherine Barresi; Priscila Ayala; Katheryn Power, Vicky Klakken; Wendi Davis; Monica Ferguson; Chloe Ungaro; Kristina Coester; Ledra Guillory; Lisa Wada; Tiffani Thomas; Chloe Ungaro; Kristina Coester; Ledra Guillory; Dana Constantino; Sydni Aguirre; Denise Rivera; Emily Wellander; Eugene Durrah; Eva Julian; Jeffrey DeVido; Kelly YoungsStone; Liz Romero;

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External Advisory Members

Name	Affiliation	Org Type	3/17/26	5/19/26	7/21/26	9/15/26	11/17/26
Jason Cunningham, MD Chief Executive Officer	West County Health Centers	FQHC	X	X			
Eugene Durrah Equity Services Manager	Solano County	County	X				
Ian Kim Family Physician	Communicare + Ole	FQHC					
Hendry Ton, MD Associate Vice Chancellor	UC Davis	Health System					
Shandi Fuller, MD Maternal Child and Adolescent Health	Solano County	Public Health Department					
Eva Julien Senior Manager, Quality Improvement	Providence	Health System					
Valerie Padilla Director of Quality and Patient Safety	Open Door Community Health	Health System	X	X			
Arlene Pena Senior Program of Quality Improvement	Aliados Health	Community Based Org	X	X			
Jeremy Plumb Systems Director, Quality Division	Northbay Medical Center	Hospital					
Lelia Romero Health Program Specialist - Health Equity	Lake County	Public Health Department	X	X			

Robin Schurig, MPH, CPH Executive Director	Health Alliance of Northern California	Community Based Org					
Candi Stockton, MD Health Officer of Humboldt County	Humboldt County	Public Health Department	X	X			
Tiffani Thomas Case Manager	Solano County Superior Court	Local Government					
Brandon Thornock Chief Executive Officer	Shasta Community Health Center	Health System					
Denise Whitsett Quality Improvement Coordinator	Community Medical Centers	Health System	X	X			
Cathryn Couch Chief Executive Officer	CERES Community Project	Community Based Org	X	X			

Agenda Topic	Notes	Action Item
Agenda Item 1 **Welcome/ Introductions/Roll Call/ Minutes Review** *Speaker: Mohamed Jalloh, Pharm.D*	A. Dr. Jalloh welcomed everyone to the meeting as well as took a roll-call for external members. B. Bethany confirmed that quorum had been met, as 7 external members attended. C. Motion to approve meeting minutes from March 2026. 1st: Cathryn Couch 2nd Denise Whitsett	Motion to approve meeting minutes from March 2026. 1st: Cathryn Couch 2nd Denise Whitsett
Agenda Item 2 **CMO Health Plan Updates**	A. QUAC (Quality utilization advisory committee) updates; Quality improvement programs and primary care provider quality incentive program payment for measurement year 2025. The final payments	

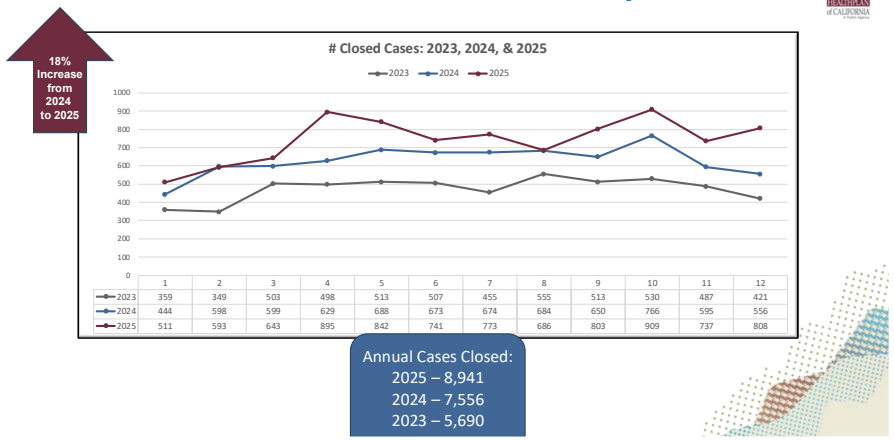
Agenda Topic	Notes	Action Item
Speaker: Kermit Jones MD, JD on behalf of Robert Moore, MD, MPH, MBA	will be distributed by the end of this month. The PCP QIP team is working with EDW, (the enterprise data warehouse) to process manual payment and data adjustment before they sign off on those final payments. B. The organization has been through an end-to-end assessment of our member experience with an external consultant. The consultant has given us some recommendations on how to fill gaps on our member experience. C. The regional medical director meeting series is complete. During these meetings, they met with providers and community leaders where they listened to issues and shared updates on policy, public health measures, and ways to improve relationships for the sake of our members. They had meetings in Fairfield, Chico, Santa Rosa, Ukiah, and Truckee at Tahoe Forest Hospital. D. As of April 1st, the state changed the GLP1 prior authorization criteria to not require a TAR for metabolic dysfunction. Now you just have to put the right diagnosis code on the description and it will work. E. Partnership is looking at doing a periodic review of Partnership's medical equipment distribution services (PMEDs program), this is the program where blood pressure cuffs, scales, nebulizers and so on are send directly thorough partners to members in a low cost way, working with Pharmacies to move this forward. F. Partnership is watching closely the Rural Health Transformation grant program. The application was received by CMS and $3 million will be distributed this year with 20% used by the consultants. These grants will most likely be sent out in June. Our regional directors will be working with our providers and organizations that desire to apply for	

Agenda Topic	Notes	Action Item
	these grants in these specific areas; clinical staff, IT system enhancements, and OB access.	
Agenda Item 3 **HEO Health Plan Health Equity Updates** *Speaker: Mohamed Jalloh, Pharm.D*	A. NCQA made significant changes to the Health Equity Accreditation. They changed the name from Health Equity Accreditation to Health Outcomes Accreditation. B. DHCS made it clear that they will no longer require health plans to maintain NCQA Health Equity Accreditation after the current contract period. However, DHCS appreciated the original intent of the original Health Equity Accreditation, so they are looking to hold health plans accountable to many previous expectations. The state will be assessing the need for updates to contract language to ensure some of those original elements of Health Equity Accreditation are embodied in their contract requirements. They will be working with Health Equity Officers to coordinate engagement and potential contract language changes and implementation to ensure alignment with expectations that health plans really maintain the goals of structure of the prior health equity requirements. They will share clear communication on the contract update process and notify Partnership in advance of any anticipated major modifications, timelines, or implementation expectations. C. In the interim Partnership will still be using its Health Outcomes Accreditation for the next survey year until further direction from the state is received. D. Partnership is exploring issues regarding TGI Care access. Dr. Jalloh met with some external advisory members to learn about challenges people are facing as well as what solutions have been implemented. Looking to share some of this information internally and see how we can provide support to our members externally as well.	

Agenda Topic	Notes	Action Item
Agenda Item 4 **Grand Analysis Presentation** *Speaker: Kory Watkins, MBA-HM*	A. Kory Watkins presents a grand analysis on Grievance & Appeals 2025 data. B. The Grievance & Appeals (G&A) department ensures that members' concerns are heard, addressed, and resolved in alignment with regulatory standards and health plan policies. They manage member grievances and appeals with a focus on timeliness, fairness, and improving overall member experience. C. G&A works with the Transportation department, Compliance department, Quality Improvement team, Medical directors, Member services, and Provider Relations. D. The overview of the process: A case is received, there is a clinical assessment, member is contacted and sent an acknowledgement letter, case is investigated, resolution letter is sent and phone call to the member. E. There are two types of grievances: Standard: Member complaints about dissatisfaction with services, care, or experiences. Exempt: Member concerns that are resolved quickly without the formal grievance process. F. Kory shares a 3-year comparison of the annual caseload. It is trending upwards with an 18% increase from 2024-2025.	

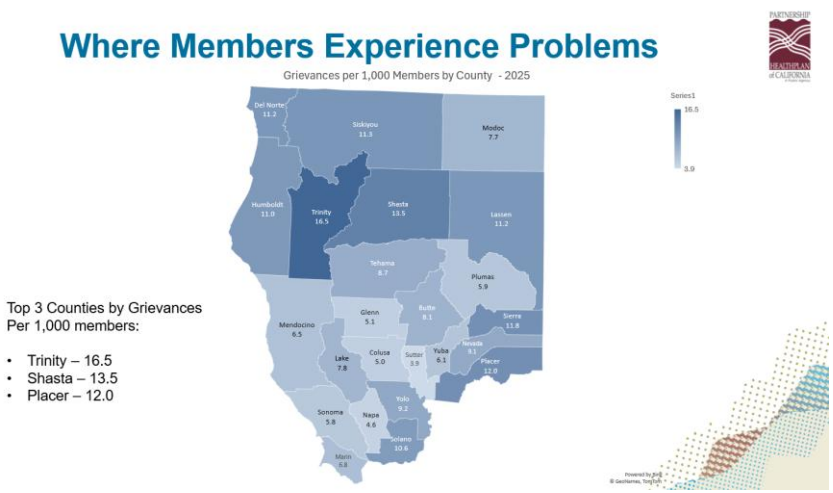
Agenda Topic	Notes	Action Item

Annual Case Volume – 3 Year Comparison

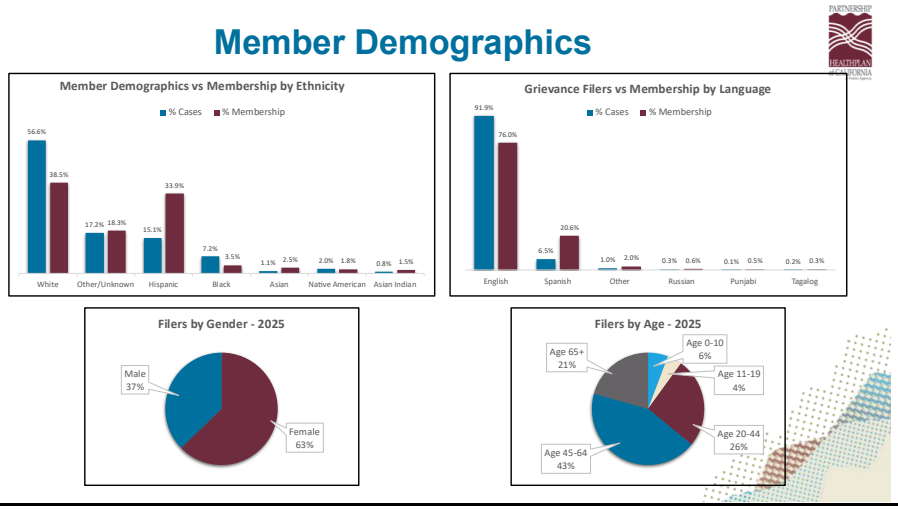


G. Kory broke down the case volume by case type. In 2025 there were 5,836 grievances, 1,920 exempt, 980 appeals, and 205 state hearings.
H. Kory shares how cases were received; 90% by phone, 6.4% via email, 1.8% via mail, .8% via fax, and .1% in person.
I. Only .5% of all cases were classified as expedited in 2025
J. Clinical grievances 33% vs. non-clinical grievance 67%
K. Clinical appeals 71% vs non clinical appeals 29%
L. Kory shares a map of where members experience problems. The counties with the highest number of grievances are Trinity, Shasta, and Placer.

Agenda Topic	Notes	Action Item



M. Kory shared the demographics of those members who filed a grievance. In 2025 63% of those who filed a grievance were female, 37% were men.



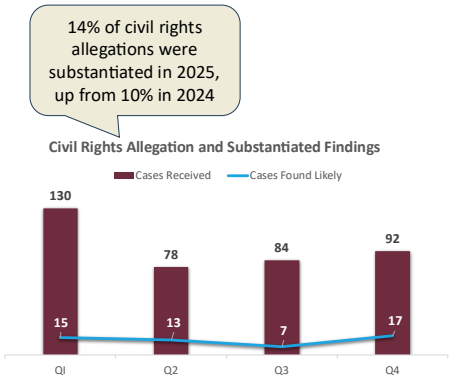
Agenda Topic	Notes	Action Item

N. The top grievance concerns by category are, Transportation 50%, Provider service 25%, Access 15%, and Partnership service: 10%

O. Transportation related grievance concerns are broken down into non-medical transport which account for 81% of the transportation related concerns and non-emergency medical transport accounted for 19% of the transportation related concerns. The 5 most common issues in both categories are: missed rides (17%), late driver arrivals (12%) driver behavior issues (11%) poor transportation company customer service (8%) and scheduling difficulties (8%). Partnership provided 1,562,928 rides in 2025 and received 5947 transportation concerns, representing less than .4% of total rides.

P. Kory shared discrimination allegations – with a civil rights focus. 14% of civil rights allegations were substantiated in 2025, up 10% from 2024.

Discrimination Allegations - Civil Rights Focus

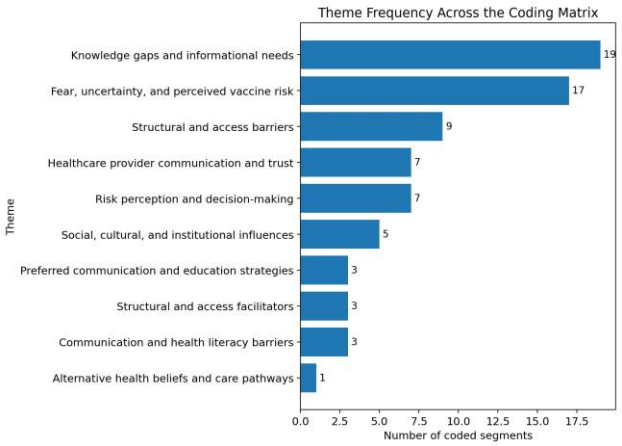


Type of Civil Rights Concern	Total Concerns Reported
Disability	135
Race or Ethnicity	89
Limited English Skills	39
Language Assistance Services	32
Age	25
Gender	14
Religion	12
Gender Identity	8
Sexual Orientation	8
Auxiliary Aids and Services	7
Basis of Sex	6
Gender Expression	3
Nationality	3
Character Associations	2
Genetic Information	1
Total	384

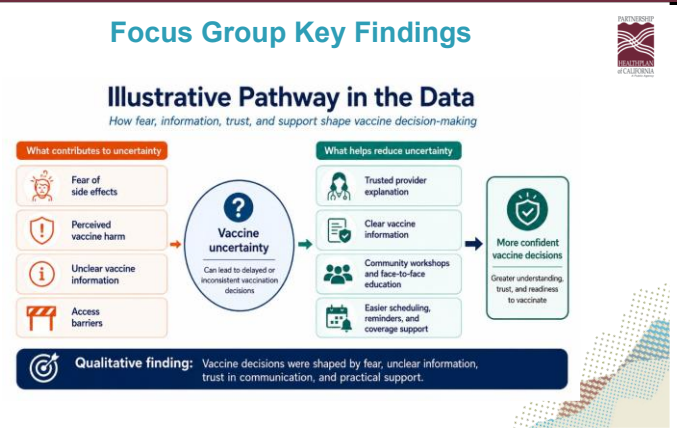
Note: Members May alleged discrimination for many reasons. This slide only reflects allegations that fall under federally protected civil rights laws.

Q. Dr. Jalloh raises the question of why disability is the highest on this chart. Kory states it could be because disability is a broad umbrella that

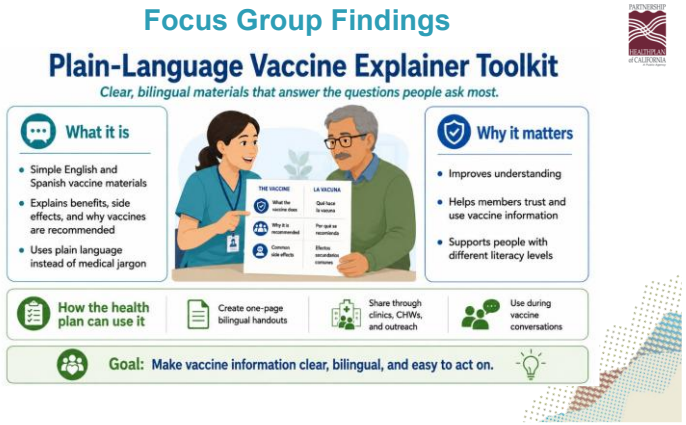
Agenda Topic	Notes	Action Item
	lots of things full under it. She gives an example of someone bringing their service animals and is denied being able to bring their animal. Dr. Netherda comments that some of disability could be temporary disability as well.	
Agenda Item 5 **Grand Analysis Discussion and Vote** *Speaker: ALL*	A. Dr. Jalloh asked QIHEC members if there is any data points they would want included in a future analysis of Grievance and Appeals. B. Cathryn Couch brought up having a separate assessment of if there is any correlation with grievances and member satisfaction scores.	Motion to approve the Grand analysis. 1st Jason Cunningham 2nd Cathryn Couch
Agenda Item 6 **Community and Member Voice Presentation** *Speaker: Jesus Hermosillo, MPH*	A. Jesus conducted two focus groups on Vaccine hesitancy in the Santa Rosa region on 4/24/26 and 5/01/26. The setting was at Alliance Medical Center, in person. The demographics of the 9 participants is Hispanic/Latino ages from 23-55+. Topics discussed were knowledge and perceptions around vaccines, decision making processes around vaccines, and communication and trusted sources around vaccines. Key findings were fear of side effects or long-term harm, low trust in provider communication, and access and system navigation. Facilitators to vaccination involve simple direct bilingual vaccine information, trusted provider or CHW conversations, and community based education. B. The focus groups brought about Key themes across the coding Matrix.	

Agenda Topic	Notes	Action Item
	Focus Group Key Findings  C. 5 top themes include: • Knowledge gaps and informational needs • Fear, uncertainty and perceived vaccine risk • Structural and access barriers • Healthcare provider communication and trust • Social, cultural, and institutional influences D. Participants expressed a need for some type of visual aid explaining the benefits of getting vaccinated. E. Cathryn Couch comments that the issue of health care provider communication and trust is the most important thing that underlies patient satisfaction. F. Jesus shared an illustrative pathway from the data he collected. The pathway shows what helps reduce vaccine uncertainty.	

Agenda Topic	Notes	Action Item



G. Jesus shared a graphic of what the focus group attendees are asking for – a toolkit with visual illustrations to reduce vaccine hesitancy.

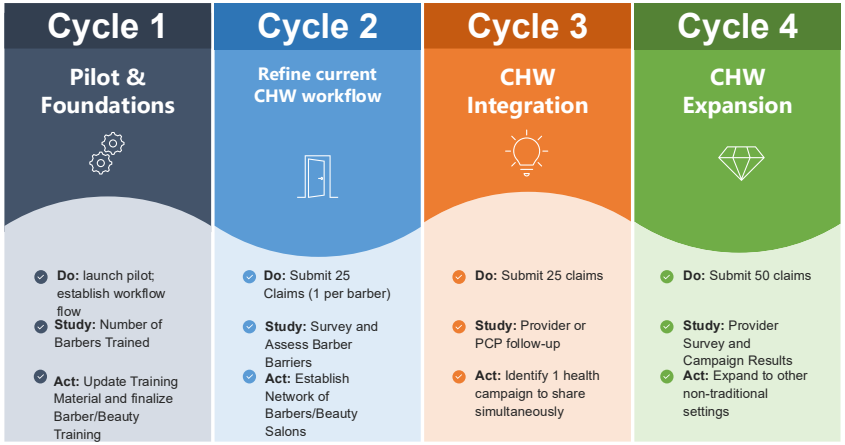


H. Dr. Jalloh asked Jesus if anyone has provided feedback on the VIS forms that are handed out after the vaccine is given. Jesus shares that they mentioned that the material they received was written material that lacked the visual aid component that they were wanting to be included.

Agenda Topic	Notes	Action Item
	I. Candy Stockton comments that they are required to give out VIS pages, which are issued by the federal government CDC and they could be changed or updated to include information that does not align with California recommendations. She cautions building on those documents because it is unknown if they will remain reliable. Dr. Jalloh asks if Dr. Stockton has heard of anyone making their own versions of these documents, to which Dr. Stockton was unsure. Dr. Stockton said they are thinking about their options on what paperwork they could hand out in addition to the VIS page.	
Agenda Item 7 **Health Equity Policy Discussion** *Speaker: Mohamed Jalloh, Pharm.D*	A. On a year-to-year basis, QIHEC will provide an "equity" review of policies/procedures. B. Dr. Jalloh shared the Committee Charter with the committee. C. Candy Stockton asked to be able to get more time to read the document. D. Dr. Jalloh stated that we could vote on the committee charter at the next QIHEC meeting to give members a chance to review it. E. Dr. Jalloh asked the group if there were any policies that they would like reviewed by QIHEC, to which there were none.	
Agenda Item 8 **Tribal Disparities Projects Updates** *Speaker: Tribal Liaison, Sunshine Jackson*	A. Sunshine introduces the Tribal Perinatal Program (TPP) The goal of the program is to support Tribal communities and achieve the best possible outcomes for Native Americans in Northern California. B. There are currently 6 Tribal health programs fully contracted, 3 contracts in process and one in the application process. C. This upcoming year will be focusing on PPC 1st visit within 21 days and 2 postpartum visits. D. Sunshine will be setting up a meeting cadence with each Tribal Health Program to discuss 2023-2024 data, PPC measures, future trainings, impacts and continued support.	

Agenda Topic	Notes	Action Item
	E. Sunshine is developing a Partnership prenatal and postpartum passport. F. Sunshine is working with Amanda McNair and Aja Monroe to create a Tribal Maternal photoshoot. G. Sunshine is working with Dr. Moore and Dr. Townsend to create a more detailed PP on the PHPS program to deliver Tribal Health Programs.	
Agenda Item 10 **Disparities Projects Updates** *Speaker: Mohamed Jalloh, PharmD*	A. Dr. Jalloh introduced the Barbershop CHW Program (CLIPS). The purpose of this project is to train local barbers to act as community health workers and screen clients for high blood pressure. They key things they will be doing is screening people for high blood pressure, providing basic health education, and reconnecting them back to the medical home. B. Our vendor: Oben Health/Roots Clinic – Identifies Barbershops and trains barbers as CHWs, provides EHR software and directly pays Barber C. We have trained 14 Barbers already in Solano County, we are looking to train more Barbers and beauticians this upcoming June. D. There are two options of referral pathways: 1. Oben → Clinic. We screen patients in Barbershops; Route them directly to your clinic 2. Clinic → Oben. You refer patients with uncontrolled conditions; we engage and support them in the community. E. Dr. Jalloh shares the cycles for the Barbershop project.	Motion to approve Barbershop CHW Program (CLIPS) project 1st Jason Cunningham 2nd Densie Whitsett

Agenda Topic	Notes	Action Item



F. Cathryn Couch feels it is important to continue to share this information.
G. Jason really likes the project and wonders how we can standardize this as it grows and takes off, he feels it will be hard to have consistent implementation.
H. Dr. Jalloh shares that it has been challenging to get people into the clinics.
I. Cathryn states that Series and Providence in Sonoma County has a 5-year grant to reduce health disparities and cardiovascular disease, and this is a program they have been talking about, she would like to meet offline and discuss further with Dr. Jalloh. She can also connect Dr. Jalloh with Dr. Monica Ferguson at Providence to discuss it further.
J. Dr. Kubota brings up the point that those who are being screened but don't have hypertension still need to be seen and may have other needs.

Agenda Topic	Notes	Action Item
Agenda Item 13 **New Committee Member Vote** *Speaker: Mohamed Jalloh, Pharm.D*	• There were no new members to vote in at this time.	
Agenda Item 14 **Adjournment** *Speaker: Mohamed Jalloh, Pharm.D*	Next meeting: **July 21, 2026** • **7:30 a.m. -9:00 a.m.**	

PARTNERSHIP HEALTHPLAN of CALIFORNIA

QI DEPARTMENT UPDATE
JUNE 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** • Payments for the 2025 PCP QIP were sent the week of May 25th before the end of May deadline. The PCP QIP team is currently working on measure development for MY2027 which is earlier than prior years due to the new contract amendment requirements. Provider comment period will be earlier this year so it is important that providers be prepared to review measures and offer feedback before Q3 advisory group.
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** • The Palliative Care QIP has wrapped up payment for 2025 Measure Period II (July – December) with a total payout of $1,450,200.
PERINATAL QUALITY INCENTIVE PROGRAM (PQIP)	**Program Overview** The Perinatal QIP offers financial incentives to participating Comprehensive Perinatal Services Program (CPSP) and select non-CPSP providers providing quality and timely prenatal and postpartum care to Partnership members Program Update **Program Update** • The Fostering Connections with Perinatal Providers WebEx series kicked off in April. Dr. Townsend facilitates these meetings with perinatal providers to touch base on current progress in the PQIP and describe the services available to pregnant and postpartum members through Partnership. The meetings between April and September will occur with providers that need extra support to improve perinatal services. • The 6-month measure set was approved by PAC in April. Utilizing data from DataLInk is option one for Measures 3 and 4, therefore a team is looking into the best way to use data from DataLink to determine timely prenatal visit counts for the Perinatal QIP 6-month bridge period that will start July 1-December 31, 2026.
ENHANCED CARE MANAGEMENT QUALITY	**Program Overview**

INCENTIVE PROGRAM (ECM QIP)	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** • ECM QIP is currently under measurement development and is working with the ECM team to track any programmatic updates.
HOSPITAL QUALITY INCENTIVE PROGRAM (HQIP)	**Program Overview** The Hospital QIP offers financial incentives to improve performance related to Readmissions, Advance Care Planning, Clinical Quality, Patient Safety, Operations and Efficiency, and Patient Experience **Program Update** • The HQIP 6-Month Bridge Set covering the period of July 1 – December 31st was approved by PAC in May. The Bridge Set is an abbreviated set to help us transition to a calendar year program starting January 2027. No measures were added to the set, but three were removed as they were not compatible with the 6-month timeframe. The 2027 measure set will go to IQI in June and PAC in August. Many Hospitals have worked to improve their 7-day follow up rates. The current average rate is 39.6%, which is above the full points target for the measure. Substance Use Disorder Referrals are also up with the average being 40.6% of qualifying members receiving follow-up MAT or prescription for Buprenorphine within 60 days of discharge.
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** • The EXT team has been sending friendly reminders to providers to submit their QAPI plans and attestation forms. This month, our team will host a Technical Work Group session to gather insights on potential updates for the upcoming measurement period. • Additionally, we are collaborating with the Provider Relations team to organize EXT luncheons for our providers. These luncheons will serve as an opportunity to strengthen engagement, provide program updates, share best practices, and address questions in a more interactive setting. The sessions will also create space for open dialogue, allowing providers to share feedback, highlight challenges, and discuss strategies to improve performance.

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** • No new updates for PQD or eReports in June following the PQD launch in 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 new updates for PQD or eReports in June following the PQD launch in May.

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** • The final submission for the non-clinical PIP is scheduled for August 6, 2026
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:** Continuing interviews with high performing practices in WCV and IMA. Started outreach to practices with low performance in DEV to provide one-on-one education based on their specific challenges. TFL data received from DHCS and under review by the HEDIS team. Completed W30+6 pilot in Siskiyou County and looking for another rural hospital to partner with. • **Women's Health & Perinatal:** Providers have been identified for outreach and engagement due to low PPC Pre Timeliness of Prenatal care performance and high

	third next available appointments. Fostering Connections provider meetings are in progress. Shasta County perinatal care coalition planning is underway with representatives from 3 health centers. • **Chronic Disease:** Using county-level data and a partnership with UC Davis, we support Tehama County clinics with targeted education, technical assistance, and workflow improvement for colorectal cancer screening. The team meets monthly to review progress and community outreach opportunities. Next meeting for Tehama County will be held June 8th, with an introduction into Butte County meeting happening 5/29/26. • **Behavioral Health:** BH workgroup meetings have been on a temporary hold since April as we focus on improving data and aligning with the regional model. Department updates are being shared via email.
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** • 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. • Fall 2026 cohort kicks off on 9/1. Registration is open through 08/25/2026. **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** • Attendance at the 2026 Improving Measure Outcomes (IMO) webinars, occurring February through April, ranged from 52-72 attendees, with each session representing 31-45 unique organizations. Of attendees who completed the post session evaluations for all six webinars, 100% selected *Strongly Agree* or *Agree* when asked if the webinar was relevant and useful. **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 ABCs of Quality Improvement was offered via three in-person sessions this fiscal year. Attendance ranged from 24-63 attendees, representing 16-22 unique organizations. Of attendees who completed post session evaluations, 95%-100% of respondents were *Extremely Satisfied* or *Satisfied* with this course. **Microlearning** **Program Overview** These short, focused modules deliver key concepts in easily digestible formats. **Program Update** • The Pre-visit Planning microlearning module is in final production and nearing completion. This microlearning will focus on how proactive chart review and early outreach can reduce day-of disruptions, support quality care, reduce care gaps, and enhance the patient and staff experience.
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** • No meetings scheduled for June
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 –** o Napa/Solano/Yolo/ meeting scheduled for 6/2/2026 o Santa Rosa meeting scheduled for 6/2/2026 o Santa Rosa Small Health Center Quality Meeting scheduled 6/25/2026 • **Chico and Auburn Regions –** o No meetings scheduled for June • **Redding and Eureka Regions –** o Eureka Region meeting scheduled for 06/09/2026 o Redding Region meeting scheduled for 06/02/2026

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

QI PROGRAM & PROJECT MANAGEMENT

ACTIVITY	UPDATE
CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS® (CAHPS) PROGRAM -MEDI-CAL PRODUCT LINE & ORG GOALS – FY 24/25 MEMBER EXPERIENCE AND ACCESS | *ORG GOALS – FY 25/26 MEMBER EXPERIENCE*	**Program Overview** Oversees NCQA Accreditation requirements for Member Experience (ME) 7 (Elements C and D). Conducts annual regulated CAHPS® surveys for Medi-Cal members and non-regulated surveys to assess patient experiences. Results drive improvements in care quality and member experience. **Program Updates** ***CAHPS® Regulated Measurement Year (MY) 2025 / Report Year (RY) 2026 Survey*** • Our certified survey vendor, Press Ganey, has routed the regulated survey data to NCQA for official validation. Once data integrity is confirmed, the finalized raw survey results will be available. • Preliminary Year-Over-Year Survey Respondent Rate Comparisons:

	• Adult Population
	  o 2024-2025 - 15.4% (3,375/511)
	  o 2025-2026 - 14.2% (2,700*/380)
	*Sample size reduced to from 3,375 to 2,700.
	• Child Population
	  o 2024-2025 - 15.8% (5,000/783)
	  o 2025-2026 - 14.1% (5,000/703)
	• As a proactive step, the Partnership CAHPS team engaged ACAP CAHPS Collaborative participants, including sister plans, to assess broader market trends. Feedback indicated a shared decline in response rates across plans, suggesting this was not an isolated trend. At a high level, this downward trend appears to be influenced by factors such as increasing survey fatigue and recent Medi-Cal eligibility changes, which may be impacting overall member engagement.
	
	Fiscal Year 2025/2026 Organizational Goal 5: Member Experience (MX)
	• Fiscal Quarter 4: (On-Track | Estimated Complete 80%): Goal activities continue through the end of this month, led by champions from four departments: Transportation, Member Services, Population Health, and Quality Improvement.
	• For more insights on goal progress and milestone accomplishments, please visit the OpEx|PMO internal goal dashboard (Partnership4Me, under Smart Links).

EQUITY & PRACTICE TRANSFORMATION PROJECT	**Program Overview**
	The DHCS Equity and Practice Transformation (EPT) Program is a statewide initiative aimed at advancing health equity while reducing COVID-19 driven care disparities. During the three (3) year program, practices receive payments for achieving population health milestones that enable the implementation of improvements across their infrastructure, data capabilities and care management processes to promote patient well-being, health equity and whole-person care.
	
	Currently, 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, included:
	  ○ 2026 PhmCAT
	  ○ Milestone 3: Empanelment Policy & Procedure
	  ○ Milestone 4: Data Governance & HEDIS Policy & Procedure

	○ Milestone 6: Data Implementation Plan ○ Milestone 8: Disparity Reduction Plan ○ One Model of Care Document (Milestones 9-12) • Provider Portal was open for deliverable submissions beginning 04/01/2026 and closed on 05/01/2026 at 5:00 PM PST. • Currently 3 providers are at risk for being removed from the program, for not submitting the required deliverables by 05/01/26: Chapa-De Indian Health Program, Baechtel Creek Medical Clinic and K'ima:w Medical Center • Notices went out to these providers, and they were given a deadline extension until 06/19/2026 to complete outstanding deliverables. • PHLC is working on a deliverable submission report for the May 2026 deliverables, which should be available by June 2026. • The 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. • The next CaTS Report for MY 10/1/24-09/30/2025 will be due on 07/31/2026.
EXPANDED COUNTIES REINVESTMENT IN QUALITY (E-RIQ)	**Program Overview** *The Expansion Counties Reinvestment in Quality (E-RIQ) program is a strategic $2 million investment to improve health outcomes and member experience across the ten expansion counties: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Tehama, Yuba, and Sutter.* *Funding is allocated through two pathways:* • ***Phase I: $500,000 (****$50K allocated to each county) to strengthen community-based engagement and access across priority focus areas* • ***Phase II: $1.5 million*** *for Provider opportunities to drive measurable improvements in quality priority measures through targeted initiatives and activities.*
PREVENTIVE CARE BRIDGE PROJECT (FORMERLY: LOCUM PILOT INITIATIVE)	**Overview of the Preventive Care Bridge Project** The Preventive Care Bridge Project was developed as a short-term solution to address access challenges by providing targeted locum support with the goal of improving performance on preventive care measures, specifically well-child visits and cervical cancer screenings. By proactively guiding providers to maximize the locum resources through clear onboarding, scope alignment, and data tracking, the pilot explores a potential model for supporting improved measure performance, reducing withholds and sanctions associated with unmet benchmarks, and enhancing the overall member experience. **Project Update** • The project resulted in the development of a set of *Locum Tenen Implementation Tools* and other resources designed to help provides more effectively integrate locum staffing into preventive care models. These resources are published on the Partnership website for ongoing access and use. The implementation model and

supporting tools are also being shared through presentations at regional quality meetings to promote awareness and adoption across provider organizations.

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	2	3	3	0
Chico	2	7	7	0
Eureka	9	16	19	0
Fairfield	3	4	4	0
Redding	10	11	11	1
Santa Rosa	1	1	1	0
Plan Wide	**27**	**42**	**45**	**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.

- Scheduling for FY 26/27 Q1 (July - September) is currently in process.

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

- Three new provider organizations were distributed a total of 5 LeadCare ll POC devices.
  - 1 device for Achieve Community Health Center
  - 2 devices for Elica Health Centers

	○ 2 devices for Pediatric Medical Associates • One provider organization has an MOU in development to receive one LeadCare II POC device. ○ 1 device for Midha, Sanjiv MD
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** • 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 complete and the document is now ready for Committee and Board review. • Submissions for the 2025-2026 QI Program Evaluation were due 05/29/2026 and internal reviews are underway. • Initial notices for the 2026-2027 QI Work Plan were sent 06/04/2026 with submissions due 06/18/2026. • Live QI Trilogy trainings have been scheduled with invites sent to Sponsors, Business Owners, and Contributors: ▪ 2025-2026 QI Program Evaluation 05/13/2026

	▪ 2026-2027 QI Work Plan (Goal Submissions) is scheduled for 06/04/2026 at noon
SAGE GRANT	**Program Overview** The *Systems Advancement for General EHR* (SAGE) Grant is designed to assist healthcare providers in implementing or upgrading their EHR systems, to help modernize and enhance their ability to deliver high-quality, efficient, and member-centered care. This grant will help providers overcome common barriers to EHR adoption by offering financial support and implementation guidance. The recipient of the SAGE grant, Kimaw Medical Center, signed the agreement on 12/05/2025. 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** • The January-June Progress Check-In with Kimaw and Partnership is scheduled on 06/15/2026.
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. All QI D-SNP related project plans can be found on the Partnership Advantage Share Point Project plan site. • The D-SNP team has developed introductory level educational content for QI team members about Medicare, dual special needs programs and Medicare Stars. The content is being reviewed by T&D as we prepare to develop it into a series of micro learnings.
ACTIVITY	**UPDATE**
QUALITY ASSURANCE AND PATIENT SAFETY	
ACTIVITY	**UPDATE**

POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: 4/27/2026 TO 5/29/2026	**Program Overview** To identify, report, and manage Potential Quality Issues (PQI), to determine opportunities for improvement in the provision of care and services to our members, and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity. **Program Update** • 32 referrals were received with 27 coming from Grievance and Appeals, 2 from Utilization Management, 1 from Care Coordination, 1 from Pharmacy and 1 from an Associate Medical Director • 25 cases were processed and closed • 123 cases are currently open • 2 cases were discussed at Peer Review Committee (PRC) on 5/20/2026 and there are 3 cases awaiting PRC review. • 1 case was sent to an external Subject Matter Expert (MRIoA) for review • Two nurses from the Member Safety team attended the Cal HQ Kickoff: Partnering for Progress meeting in Sacramento on April 30, 2026. The meeting focused on strengthening collaboration between health plans and hospitals to improve quality outcomes by reducing healthcare acquired infections statewide.
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR)	**Program Overview** Site Review and Medical Record Review performed for monitoring of providers. **Program Update** • No new updates

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** • MY2025 HealthPlan Accreditation (HPA) final rates were approved by our HPA Auditor, the HPA audit is locked. • MY2025 Managed Care Accountability Set (MCAS) final rates have been submitted and awaiting auditor approval. • Medical Record Review and Validation audit passed at 100% for both HPA and MCAS with first submission. • The Annual Summary of Performance reports will be posted on our Partnership website in August 2026.

HEDIS® Program Overall	**Program Updates** • No new updates

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** • MY2025 final rates have been approved and locked for NCQA HealthPlan Accreditation audit. • MY2025 final rates for the DHCS Managed Care Accountability Set (MCAS) audit have been submitted and are pending auditor approval. Final rate approval is anticipated by 06/152026. • The Medical Record Review and Validation (MRRV) audits for both HPA and MCAS passed at 100% with first submission.
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** • No new updates
NCQA Health Plan Accreditation (HPA) and Health Outcomes Accreditation (HOA)	• No new updates

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

QUALITY/UTILIZATION ADVISORY COMMITTEE (Q/UAC)

Consent Calendar

June 17, 2026

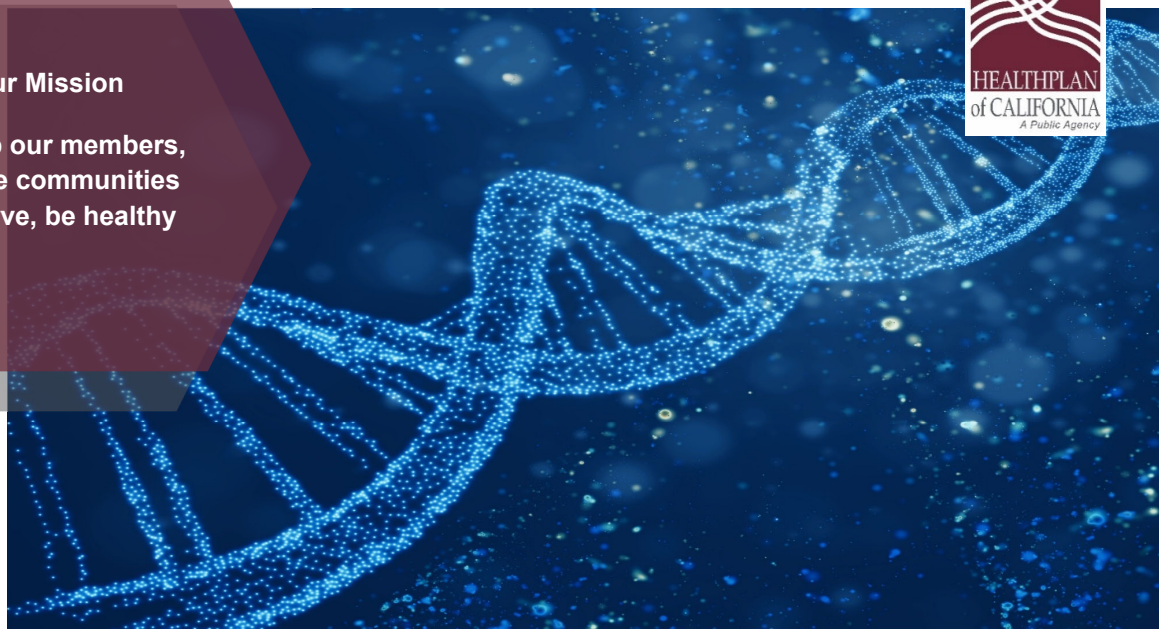
Items on the Consent Calendar have minor or no changes and are recommended by staff for approval.

Some Medi-Cal ("MC") policies are being updated as "MP" to apply to both Medi-Cal and Medicare (Partnership Advantage, eff. ~ Jan. 1, 2028)

GRIEVANCE & APPEALS
Pulse Report

Our Mission

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



G&A PULSE REPORT

INSIDE THIS ISSUE

ISSUE 17 | JUNE 2026

The purpose of this report is to provide objective updates to all stakeholders regarding trends in member experience as expressed through Appeals, Grievances, Exempt Grievances, and State Hearings received in the Grievance & Appeals Department (G&A). The report contains data from the first quarter of 2026.

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

Fluctuations in data can happen. Therefore, statistics included in this report are presented with a 95% confidence level. Membership totals are calculated using monthly snapshot data, averaged across the county by quarter. The scheduling and ride data for Transportation was sourced from the Transportation Dashboard. The Community Supports enrollment information was sourced from the CalAIM Dashboard.

1Q26 HIGHLIGHTS

OVERALL NUMBERS

In 1Q26, G&A investigated 2,521 cases. The chart below shows a breakdown of the cases investigated this quarter. Of the 1,829 cases subject to DHCS-mandated timeframes, 98.9% were closed on time, which is above our goal.

1Q26 TOTAL INVESTIGATED CASES		
	# of Cases	% Total
Grievance	1,537	61.0%
Exempt	621	24.6%
Appeal	292	11.6%
State Hearing	71	2.8%
Grand Total	**2,521**	**100.0%**

KEY POINTS & TRENDS

Lost State Hearings 1Q26. We lost two (2) State Hearings in 1Q26. These cases were for skin removal surgery, and a sleep safe bed. For the skin removal surgery, the member reports limited mobility in their arms following weight loss and was requesting excess skin removal on their arms. The hearing was overturned as the Administrative Law Judge (ALJ) determined the member's procedure should be considered reconstructive, and not cosmetic. The sleep safe bed was for a member with Angelman's Syndrome. The documents received during the hearing showed a medical need for the sleep safe bed, and the denial was overturned by the ALJ due to medical necessity.

The Community Supports benefit continues to be a driver for G&A cases. There were 130 cases closed related to Community Supports in 1Q26, 5.2% of our overall volume for the quarter. These cases were primarily related to the Medically Tailored Meals service. Medically Tailored Meals accounted for 74 of the 130 Community Supports cases this quarter. This makes up 56.9% of the total Community Supports-related concerns. Of those 74 Medically Tailored Meals cases, there were 45 Appeals, 27 Grievances (Standard and Exempt), and two (2) State Hearings. Based on data from the CalAIM Dashboard (last updated on May 17, 2026), the top used benefit in 1Q26 was Housing Transition and Navigation Services, with 7,520 members using the benefit. We closed 17 cases related to this benefit in 1Q26. Additionally, there were 17 cases for Housing Tenancy and Sustaining Services, and nine (9) for Recuperative Care. Medically Tailored Meals, while not the most utilized benefit, is the benefit that contributed the most to our case volume in 1Q26.

We have calculated the cases per 1,000 rates for each of the Community Supports benefits that contributed to our case volume in 1Q26, as well as the total overall below.

1Q26 Community Supports Cases by Benefit			
Benefit	# Cases	Members Served	Cases per 1,000
Medically Tailored Meals	74	4,529	16.34
Housing Tenancy and Sustaining Services	17	1,802	9.43
Housing Transition Navigation Services	15	7,520	1.99
Recuperative Care	9	1,463	6.15
Respite Services	5	304	16.45
Housing Deposits	4	146	27.40
Personal Care & Homemaker	3	716	4.19
Day Habilitation Programs	1	682	1.47
Short-Term Post-Hospitalization Housing	1	1,028	0.97
Sobering Centers	1	90	11.11
Total	130	18,280	7.11

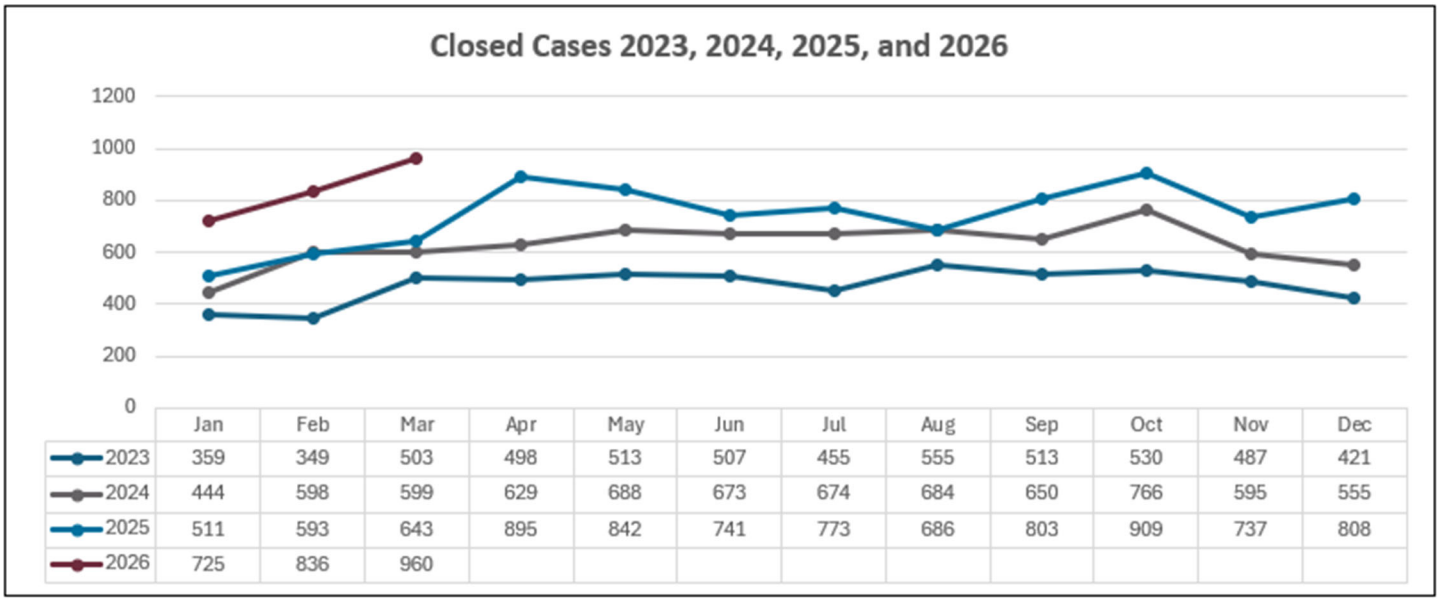
DHCS CATEGORIES

Non-Medical Transportation (NMT) services were the most frequently reported Benefit Type which represented 36.1% of the reported concerns, followed by Outpatient Physical Health, which represented 26.7%. Cases that were Not Benefit Related accounted for 13.6% of the DHCS Benefit Type categories. Cases that fall under the Not Benefit Related category typically consist of reports of poor provider attitude and dissatisfaction with Partnership's customer service.

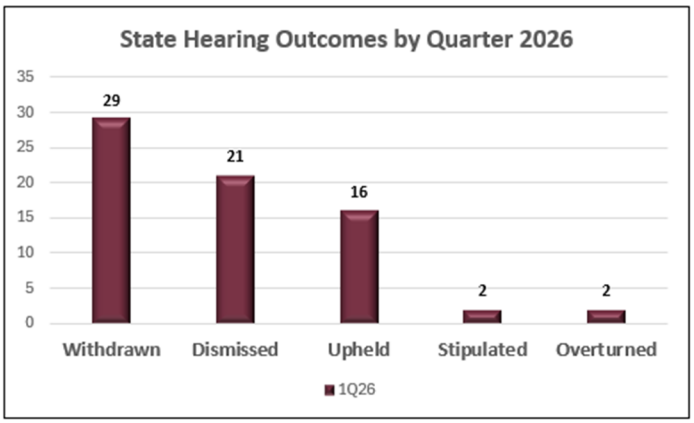
KEY STATISTICS

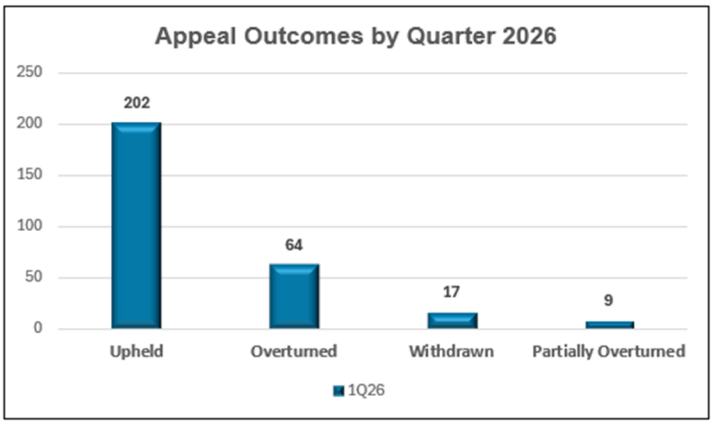
CHARTS OF KEY CASE TRENDS

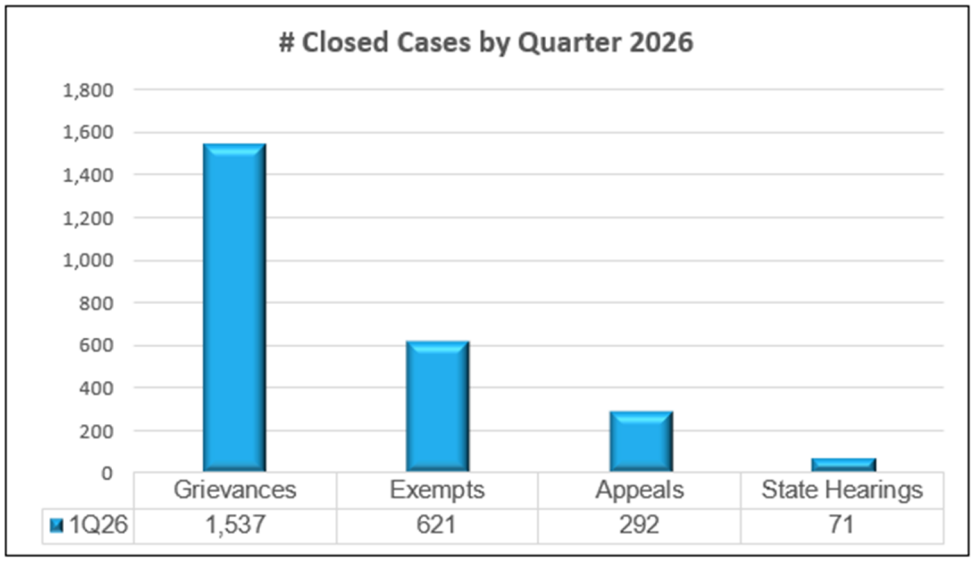
The following charts represent key data metrics used to track and trend Appeals, Grievances, and State Hearings over time.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	359	349	503	498	513	507	455	555	513	530	487	421
2024	444	598	599	629	688	673	674	684	650	766	595	555
2025	511	593	643	895	842	741	773	686	803	909	737	808
2026	725	836	960									







	Grievances	Exempts	Appeals	State Hearings
1Q26	1,537	621	292	71

STATISTICS BY REGION

CHARTS OF CASE STATISTICS BY REGION

The following charts illustrate the distribution of closed cases across each region, providing a breakdown of the total number of cases closed, the average membership, and the number of cases closed per 1,000 members for 1Q26.

1Q26 CASES BY COUNTY			
AUBURN			
County	# of Cases	Avg Membership	Cases p/1,000
Nevada	72	28,447	2.53
Placer	210	60,416	3.48
Plumas	8	5,303	1.51
Sierra	1	818	1.22
Total	291	94,984	3.06

1Q26 CASES BY COUNTY			
CHICO			
County	# of Cases	Avg Membership	Cases p/1,000
Butte	248	83,770	2.96
Colusa	13	9,903	1.31
Glenn	22	13,224	1.66
Sutter	67	43,902	1.53
Yuba	66	36,351	1.82
Total	416	187,150	2.22

1Q26 CASES BY COUNTY			
EUREKA			
County	# of Cases	Avg Membership	Cases p/1,000
Del Norte	41	12,081	3.39
Humboldt	224	55,265	4.05
Lake	113	32,793	3.45
Mendocino	89	39,366	2.26
Total	467	139,505	3.35

1Q26 CASES BY COUNTY			
FAIRFIELD			
County	# of Cases	Avg Membership	Cases p/1,000
Solano	326	97,647	3.34
Napa	35	26,656	1.31
Yolo	142	52,900	2.68
Total	503	177,203	2.84

1Q26 CASES BY COUNTY			
REDDING			
County	# of Cases	Avg Membership	Cases p/1,000
Lassen	39	8,280	4.71
Modoc	14	3,724	3.76
Shasta	317	64,175	4.94
Siskiyou	50	17,601	2.84
Tehama	75	28,967	2.59
Trinity	19	4,975	3.82
Total	514	127,722	4.02

1Q26 CASES BY COUNTY			
SANTA ROSA			
County	# of Cases	Avg Membership	Cases p/1,000
Sonoma	220	105,767	2.08
Marin	110	44,146	2.49
Total	330	149,913	2.20

1Q26 CASES BY COUNTY			
County	# of Cases	Avg Membership	Cases p/1,000
Sonoma	8.7%	12.4%	0.25
Solano	12.9%	11.1%	0.37
Butte	9.8%	9.6%	0.28
Shasta	12.6%	7.3%	0.36
Placer	8.3%	6.9%	0.24
Humboldt	8.9%	6.3%	0.26
Yolo	5.6%	6.0%	0.16
Marin	4.4%	5.0%	0.13
Sutter	2.7%	5.0%	0.08
Mendocino	3.5%	4.5%	0.10
Yuba	2.6%	4.1%	0.08
Lake	4.5%	3.7%	0.13
Tehama	3.0%	3.3%	0.09
Nevada	2.9%	3.2%	0.08
Napa	1.4%	3.0%	0.04
Siskiyou	2.0%	2.0%	0.06
Glenn	0.9%	1.5%	0.03
Del Norte	1.6%	1.4%	0.05
Colusa	0.5%	1.1%	0.01
Lassen	1.5%	0.9%	0.04
Plumas	0.3%	0.6%	0.01
Trinity	0.8%	0.6%	0.02
Modoc	0.6%	0.4%	0.02
Sierra	0.0%	0.1%	0.00
Grand Total	100.0%	100.0%	2.89

DEMOGRAPHICS

CHARACTERISTICS OF FILING MEMBERS

The following charts represent key demographic data of members who filed an Appeal, Grievance, or State Hearing during 1Q26.

1Q26 CASES BY AGE		
Member Age	**% of Cases**	**% of Membership**
Age 0-10	6.3%	18.5%
Age 11-19	3.7%	16.7%
Age 20-44	25.3%	33.7%
Age 45-64	42.6%	19.6%
Age 65+	22.1%	11.5%
Grand Total	**100.0%**	**100.0%**

1Q26 CASES BY ETHNICITY		
Member Ethnicity	**% Cases**	**% Membership**
White	58.3%	38.0%
Other/No Response	15.2%	18.2%
Hispanic	14.9%	34.3%
Black (African American)	6.8%	3.6%
Asian	2.1%	4.0%
Native American	1.9%	1.7%
Hawaiian/Pacific Islander	0.8%	0.2%
Grand Total	**100.0%**	**100.0%**

1Q26 CASES BY LANGUAGE		
Member Language	**% Cases**	**% Membership**
English	93.4%	76.1%
Spanish	5.2%	20.4%
Other	1.0%	2.2%
Russian	0.3%	0.6%
Tagalog	0.1%	0.2%
Punjabi	0.0%	0.5%
Grand Total	**100.0%**	**100.0%**

1Q26 CASES BY GENDER		
MBR Gender	**% Cases**	**% Membership**
Female	63.4%	52.1%
Male	36.6%	47.9%
Grand Total	**100.0%**	**100.0%**

"Deija was extremely responsive and positive, updating me every step of the way, including missed calls, return calls, and a call summary via email. It's clear that Deija takes great pride in her work and truly cares about our members. I feel fortunate to have her on our team."

- Partnership Staff Member

TRANSPORTATION

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Transportation during 1Q26.

1Q26 STATISTICS

Transportation cases in 1Q26 accounted for 1,180 cases of the total 2,521 cases closed. This represented 46.8% of all cases closed in 1Q26. This is a decrease compared to the previous quarter in which 48.7% of the cases were related to transportation services. There were 1,093 Grievances (Exempt and Standard), 72 Appeals, and 15 State Hearings. Transportation cases accounted for 0.3% of the 371,849 completed trips in 1Q26.

TRENDING ISSUES

The top five (5) providers with reported concerns in 1Q26 were North Bay Transit (198), Lyft (170), Redline Transit (81), Budget Friendly (70) and Hey Taxi (67). Members had issues such as missed rides, drivers arriving late, driver behavior and vendor customer service. G&A is partnering with Transportation Services to calculate the percentage of rides with concerns for the top five (5) providers. This is captured in the table below.

1Q26 Transportation Trips with Concerns by Provider			
Provider	# Cases	Trips Completed	Trips with Concerns
North Bay Transit	198	7,379	2.7%
Lyft	170	19,376	0.9%
Redline Transit	81	3,361	2.4%
Budget Friendly	70	2,265	3.1%
Hey Taxi	67	6,132	1.1%

The five (5) counties with the highest reported transportation concerns were: Solano County (272), Shasta County (258), Butte County (242), Humboldt County (232), and Sonoma County (175).

There were 154 Non-Emergency Medical Transportation (NEMT) cases, 608 Non-Medical Transportation (NMT), and 418 cases regarding Partnership's Transportation Department Services in 1Q26.

Fifteen of the cases closed in this quarter were State Hearings. Eleven (11) State Hearings were related to reimbursement for Gas Mileage, Lodging, and/or Meals. The remaining four (4) were related to denied transportation. The outcomes for Transportation-Related State Hearings in 1Q26 were: Upheld (6), Dismissed (4), Withdrawn (4), and Stipulated (1).

The Stipulated State Hearing was for reimbursement of Gas Mileage, Lodging, and Meals. The member had to travel to a follow-up appointment after knee surgery. Documents submitted during the open record period of the hearing process allowed a Partnership Medical Director to approve the request. While it did not meet policy criteria for lodging and meals, it was deemed medically necessary based on the documents received. The Administrative Law Judge (ALJ) determined Partnership overturned correctly based on the new information received and issued the stipulated decision.

G&A identified multiple complaints against the Transportation Services department. The top three (3) complaints against the Transportation department for 1Q26 included Transportation Services Department's customer service, scheduling issues, and reimbursement for Gas Mileage, Lodging, and/or Meals.

PROCESS IMPROVEMENTS

Transportation Services continues to use G&A data to improve provider performance, operational processes, and member satisfaction by working directly with their providers. Transportation Services will continue to provide timely provider education and best practices to ensure members have the best possible experience.

W&R RELATED

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Wellness & Recovery (W&R) during 1Q26. It should be noted that W&R cases are measured based on the number of cases received per quarter, rather than the number of cases closed per quarter. This is due to DHCS' unique reporting of W&R cases.

1Q26 NUMBERS

There were four (4) W&R cases received in 1Q26, representing 0.2% of the total concerns reported this quarter.

TRENDING ISSUES

G&A received four (4) grievances and zero (0) appeals. All the grievances received in 1Q26 were also resolved in the same quarter.

After investigation of the cases, it was determined that the providers were not at-fault in any of the cases.

In one of the case, the member reported concerns that they were labeled as a substance user by their provider. The member also alleged the hotel they were staying in was in poor condition, and the provider wanted him to sign a form stating he would not complain about this provider. When the member refused to sign the paperwork, the member states they were dismissed from the program. Upon investigation, it was determined that the member was abusive toward the staff and other patients, and was asked to sign a behavior contract, but refused. The member then chose to leave; they were not dismissed from the program. The provider also confirmed they did not label the member as a substance user. The provider inspected the member's room when their concerns were brought to their attention and found the room to be in good condition.

Three (3) of the four (4) complaints were regarding dissatisfaction with program requirements. The other case was related to interpersonal relationship issues.

DHCS REPORTING

DHCS requires quarterly reporting of W&R cases. The next two tables provide the specific number of W&R cases and which case category Partnership reported to DHCS. All the cases were closed within the 30-day DHCS regulatory timeframe.

1Q26 DHCS W&R Grievance Outcomes	
# of Grievances Resolved in Favor of Member	0
# of Grievances Resolved in Favor of Partnership	4

1Q26 DHCS Grievance Categories	
Access to Care	0
Quality of Care	0
Program Requirements	3
Interpersonal Relationship Issues	1
Failure to Respect Enrolee's Rights	0
Other	0

WCM RELATED

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Whole Child Model (WCM) during 1Q26.

1Q26 STATISTICS

A total of 20 WCM-related cases were closed in 1Q26, representing 0.8% of the 2,521 cases closed. These cases consist of 12 Appeals and 8 Grievances. There were no State Hearings reported in this quarter related to WCM.

TRENDING ISSUES

The most commonly reported issues were related to transportation, timely access, and private duty nursing. There were three (3) Grievances, and six (6) Appeals related to transportation issues. This makes up 45.0% of the total cases related to WCM. Members reported concerns with driver punctuality and behavior. Members also commonly appealed denials of lodging and meals. There were five (5) upheld and one (1) overturned appeal for lodging and meals in this quarter. There were two (2) Grievances related to timely access. These grievances were both related to delayed or cancelled services.

There were three (3) Appeals related to private duty nursing. Each of these three (3) Appeals were upheld. There were three (3) Appeals for Durable Medical Equipment (DME) this quarter, and two (2) were overturned. The overturned DME appeals were for a Sit to Stand device and safe sleep padding. The upheld DME appeal was for an ultralight manual wheelchair. This appeal was upheld due to their in-home assessment deeming the ultralight manual wheelchair not medically necessary. We also did not receive documents showing the member's current wheelchair was not meeting their needs.

DISCRIMINATION AGAINST CCS MEMBERS

G&A reviews all allegations of discrimination to determine if they fall under civil rights law. There were no discrimination cases reported for a WCM member during 1Q26.

ETHNICITY AND PREFERRED LANGUAGE

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

1Q26 WCM CASES BY ETHNICITY		
Member Ethnicity	**# of Cases**	**% of Cases**
White	7	35.0%
Hispanic	5	25.0%
No Response	5	25.0%
Black (African American)	2	10.0%
Other Asian	1	5.0%
Grand Total	**20**	**100.0%**

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

1Q26 WCM CASES BY LANGUAGE		
Member Language	**# of Cases**	**% of Cases**
English	16	80.0%
Spanish	3	15.0%
American Sign Language (ASL)	1	5.0%
Grand Total	**20**	**100.0%**

DISCRIMINATION

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to discrimination during 1Q26. Because a member may report multiple discrimination allegations in a single Grievance, a case may fall into multiple categories. As a result, the number of concerns may exceed the total number of cases.

1Q26 DISCRIMINATION STATISTICS

G&A changed our process for internal classification of discrimination cases when they do not fall under a protected category in 1Q26. Our reporting has been updated to only include discrimination allegations that fall under a protected category. Discrimination allegations that do not fall under a protected category are still investigated, but as a Standard Grievance.

G&A investigated 83 cases containing 94 discrimination allegations in 1Q26. This represented 3.3% of all cases closed. Each of the 83 discrimination cases fell under a protected category.

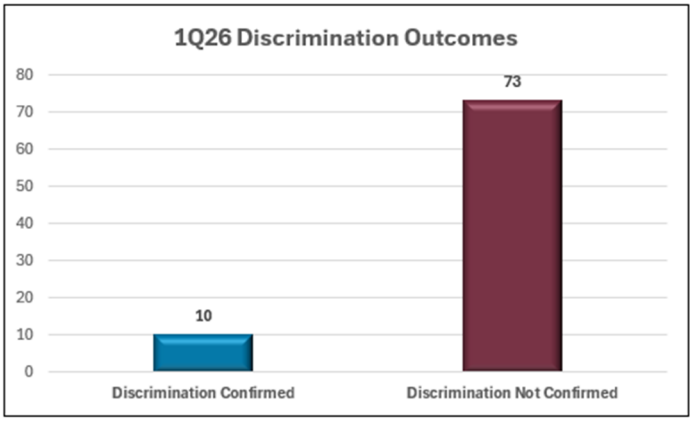
After investigation, it was determined discrimination was likely to have occurred in ten (10) cases.

In four (4) of the cases, there were concerns related to a member's disability. Of those four (4) concerns, three (3) were related to transportation services. Multiple members reported they were denied transportation by Lyft due to their service dogs. In each case, it was confirmed Lyft is required to accommodate service animals. Notes were added to the member's accounts to notify any future drivers that they have service dogs. Their concerns were also escalated to Lyft for additional steps.

Shasta County had the highest number of discrimination cases filed with 22 cases. This accounts for 26.5% of the total discrimination grievance volume. Discrimination was found unlikely to have occurred in all 22 cases filed in Shasta County.

1Q26 DISCRIMINATION TRENDS

Discrimination cases that fell under a protected category increased from 74 in 4Q25 to 83 in 1Q26. This accounts for a 12.2% increase in discrimination cases that fall under a protected category. Our overall caseload increased from 2,454 in 4Q25 to 2,521 in 1Q26. This accounts for a 2.7% increase in overall cases received. This does not account for the increase in discrimination cases. The number of cases where discrimination was deemed likely, however, decreased from 17 in 4Q25 to 11 in 1Q26. This accounts for a 35.3% decrease.



1Q26 CASES BY CATEGORY

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

Discrimination Found Likely	
Civil Rights Category	# of Concerns
Disability	4
Race or Ethnicity	3
Gender	1
Language Assistance Services	1
Limited English Skills	1
Total	10

QUALITY ASSURANCE

INTER-RATER RELIABILITY DEFINED

The quarterly Inter-Rater Reliability (IRR) audit provides physician oversight over clinical decisions made by Partnership's Grievance Registered Nurse team. A list of cases that were not previously reviewed by a Partnership Medical Director is forwarded to Partnership's Chief Medical Officer (CMO) or designated representative, of which a sample size is selected and evaluated. The Compliance Manager and Quality & Training Supervisor complete a subsequent comprehensive review to identify opportunities for operational improvements. Due to the timing of report generation, the data discussed reflects cases closed in 4Q25.

THE RESULTS

A sample size of 37 cases were evaluated for 4Q25 consisting of only Grievances.

The G&A Nurse Specialists categorized all the cases evaluated by the Medical Director as clinical or non-clinical correctly. However, G&A Nurse Specialists did have three (3) findings on this report. The first finding was that the nurse did not thoroughly review the resolution letter's clinical components prior to the letter being sent to the member. The second finding was that the nurse could have requested the member's medical records to determine if the member's concerns were documented in their records. The third finding was that the nurse could have requested or reviewed the related TAR notes to gain clarification on a member's DME-related grievance.

Processing errors by G&A Case Analysts were identified during this reporting period. These issues involved referral errors, such as referrals sent to the incorrect department and asking clinical questions on provider referrals.

TIMELINESS

During 1Q26, a total of 1,829 cases were subject to DHCS Turnaround Time (TAT) requirements. The timeliness target for investigations is 98.6%, with actual performance reaching 99.3%. The timeliness goal for acknowledgment letters is 98.6%, and performance surpassed this benchmark at 99.0%.

G&A staff continued to maintain performance above the threshold despite the steady increase in closed cases from January to March 2026.

1Q26 DHCS Timeliness Performance

Performance Category	Performance Goal	# Late	Performance Result	Status
Investigations	98.6%	19	99.0%	
Ack-Letters	98.6%	17	99.1%	

Partnership is a non-profit community-based health care organization that contracts with the State to administer Medi-Cal benefits through local care providers to ensure Medi-Cal recipients have access to high-quality comprehensive cost-effective health care. Partnership is available to Medi-Cal-qualifying residents in Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, and Yuba.

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HQIP 2027 Measure Proposal

HQIP 2027 Calendar Year Measurement Set (January 1 – December 31, 2027)

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

Key: Change to Measure Design || New / Returning || Removed Measures

2026 Six-Month Bridge Set July 1 – December 31, 2026	2027 Calendar Year Measure Set Recommendations
Risk Adjusted Domain 1. Risk Adjusted Readmissions (RAR) 2. 7-Day Follow-up Clinical Visit (RAR) **Palliative Care Domain** 3. Palliative Care Capacity **Clinical Domain** 4. Elective Delivery Before 39 Weeks 5. Exclusive Breast Milk Feeding Rate 6. Nulliparous, Term, Singleton Vertex (NTSV) Cesarean Rate 7. Vaginal Birth After Cesarean (VBAC) 8. Expanding Delivery Privileges 9. Doula Support 10. Increasing Mammography Capacity 11. Vaccines For Children Enrollment **Patient Safety Domain** 12. Patient Safety Organization Participation 13. Substance Use Disorder Referral, Medication Assisted Treatment (MAT) **Operations / Efficiency Domain** 14. Hospital Quality Improvement Platform	**Risk Adjusted Domain** 1. Risk Adjusted Readmissions (RAR) 2. 7-Day Follow-up Clinical Visit (RAR) **Palliative Care Domain** 3. Palliative Care Capacity **Clinical Domain** 4. Elective Delivery Before 39 Weeks 5. Exclusive Breast Milk Feeding Rate 6. Nulliparous, Term, Singleton Vertex (NTSV) Cesarean Rate 7. Vaginal Birth After Cesarean (VBAC) 8. Expanding Delivery Privileges 9. Doula Support ~~10. Increasing Mammography Capacity~~ ~~11. Vaccines For Children Enrollment~~ 10. Hepatitis B Vaccination 11. ALSO & BLSO Certification Training **Patient Safety Domain** 12. Patient Safety Organization Participation 13. Substance Use Disorder – 7-Day Follow-up After ED Visit (FUA) **Operations / Efficiency Domain** 14. QI Capacity 15. Hospital Quality Improvement Platform **Patient Experience Domain** 16. Cal Hospital Compare-Patient Experience 17. Health Equity

Programmatic Changes:

The proposed measure set on the following pages is the first calendar year program for the HQIP. In general, all the reporting timelines in this set have been adjusted to correlate to the calendar year. Those revisions are not presented here. This proposal includes changes to existing measures, new measures, and measure removals.

A. Removal of Existing Measures for 2027

Increased Mammography Capacity

It is proposed to remove this measure because we cannot continue to ask for increased capacity each year. Capacity at many hospitals increased during the year and a half the measure was in place.

Vaccines For Children (VFC) Enrollment

It is proposed to remove the Vaccines For Children (VFC Enrollment) and replace with the Hepatitis B Vaccination measure. This is consistent with what was planned for the measure as the goal was focused just on enrollment.

B. Revisions to Existing Measures:

Measure 8: Expanding Delivery Privileges

It is proposed that this measure include a partial points option for X-Large size hospitals who are still working on expanding privileges to family physicians and midwives, and it is proposed to change the language from family physicians and midwives to "or" midwives for large and small size hospitals. The change to "or" is in recognition that for some of our smaller hospitals in rural areas, the resources may not exist to have both provider types.

Specifications

The expanding delivery privileges measure includes three phases requiring hospitals to develop policy and procedure, actively recruiting providers, granting delivery privileges, and ultimately demonstrating evidence of family physician and nurse midwife clinical activity.

Measure Requirement Targets

This multi-phase measure began with ***Phase One*** in the 2024-25 measurement year, which asked hospitals to develop by-laws and/or policy and procedure to expand delivery privileges to midwives and family physicians. With ***Phase One*** completed in 2024-25, this measure moved into ***Phase Two*** for the 2025-26 HQIP Measurement Year. Now, in 2027, the measure requirements are delineated by sizes as noted below:

X-Large Hospitals with >100 LGA Beds:

Full Points (5 points):
By December 31, 2027, hospitals must ensure access to family physicians and certified nurse midwives for deliveries by either employing them directly or maintaining active contracts, as demonstrated by granted clinical privileges for these providers. Evidence of deliveries from these providers is required.

Partial Points (2.5 points):
Phase Two Requirement: Hospitals that have developed by-laws and/or policy and procedure allowing midwives and family physicians to hold delivery privileges, must now show evidence that they are actively recruiting and/or share their provider privileges list of midwives and family physicians who have been granted delivery privileges.

NOTE: Hospitals with existing family physicians and midwives privileged to perform deliveries will get full credit so long as these clinicians remain active delivering babies in the hospital.

Small & Large Hospitals with between 25 and 99 LGA Beds:

Full Points (5 points)
Small and Large size hospitals will remain in Phase 2 as follows:

Hospitals that have developed by-laws and/or policy and procedure allowing midwives and/**or** family physicians to hold delivery privileges, must now show evidence that they are actively recruiting these providers and/or share their provider privileges list of midwives and/**or** family physicians who have been granted delivery privileges.

NOTE: Hospitals with existing family physicians and midwives privileged to perform deliveries will get full credit so long as these clinicians remain active delivering babies in the hospital.

Measure 9: Doula Support

This measure began in 2025 with Phase 1. It is proposed to move into Phase 2 of the measure during the 2027 measurement year at which time hospitals will need to demonstrate recruitment or use of doulas in the hospitals as noted below.

Specifications

This measure is being implemented over multiple years, starting with **Phase One in** the 2025-26 measurement year. For 2027, the measure is now in **Phase Two** of implementation requiring hospitals to work toward actively recruiting and/or allowing doulas who accept Partnership HealthPlan to provide support during labor and delivery.

Phase Two Measure Requirements

1. Hospitals will develop policy and/or procedures that allow doulas to support birthing parents in the hospital during labor and delivery, **and**
2. Hospitals will submit evidence of active recruitment of doulas who are credentialed with Partnership.

NOTE: Hospitals with policy and procedure developed before 2027 allowing doulas to provide support during labor and delivery and that are utilizing them will get full points for the measure.

Measure 13 – Substance Use Disorder 7-Day Follow-up After ED Visit (FUA)

It is proposed to align the Substance Use Disorder Referral measure with the HEDIS FUA measure for 7-Day Follow-up After ED Visits. This will move this measure from focusing on prescribing buprenorphine and MAT to a broader range of services to a broader range of members. This measure will also pinpoint a shorter follow-up window moving from the previous 60-day follow-up window to 7 days.

Measure 13 Summary

The Emergency Department (ED) plays a critical role in improving care for patients with substance use disorder (SUD) and preventing overdose deaths, as it is often the entry point for acute stabilization, diagnosis, and connection to follow-up services. Individuals presenting to the ED for substance-related events face a high risk of adverse outcomes—particularly in the year after discharge—making coordinated follow-up care essential, as these patients are especially vulnerable to losing contact with the health care system after high-risk encounters.

Specifications

The percentage of emergency department visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was a follow-up within 7 days of the ED visit (8 days total).

Numerator: Follow-up visit or pharmacotherapy dispensing event on the ED visit date or within 7 days after the ED visit (8 days total).

Denominator: The number of ED visits for members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose* on or between January 1 and December 1 of the measurement period.

Full Points Target (10 pts): ≥ 45.80%
Partial Points Target (5 pts): Between 39.1 – 45.7 %
Hospital's percentages will be rounded to the nearest 10th.

C. New Measures / Returning Measures

Measure 10 - Hepatitis B Vaccination:

It is proposed to remove the VFC Enrollment Measure and replace it with the Hepatitis B Vaccination measure. We have had a similar measure in past years, so it is familiar to our hospitals. Despite changing CDC recommendations, Partnership believes it is important to continue to encourage Hepatitis B vaccination within 24 hours of delivery.

Hepatitis B Vaccination Measure Summary

Hospitals providing maternity services hold the valuable opportunity of optimizing their Hepatitis B birth dose practices. This measure incentivizes birthing hospitals for administering the Hep B vaccine within the first day of life. One of the most important reasons to administer the Hep B vaccination to infants is its ability to prevent chronic infections that can cause liver failure and death. Other important reasons include providing early protection against future exposure to infected blood or bodily fluids, and the high effectiveness against preventing Hep B transition from mothers to infants. The vaccine should be administered in the first 24 hours of life, because the virus can be transmitted form the mother to the child during labor and delivery without the mother knowing her status. The American Academy of Pediatrics specifically recommends universal hepatitis B vaccination for all infants, beginning with the first dose within 24 hours of life. Deferring vaccination to a future well child visit will not achieve this recommendation; it must be available in the hospital.

By State law, all immunizations must be recorded in the California Immunization Registry (CAIR), which makes immunization records easily accessible, ensures accuracy, and improves efficiency.

Specifications

To demonstrate measure compliance, hospitals must enter Hep B vaccine administrations into CAIR. Partnership will use CAIR data uploaded during the Measurement Year to measure performance.

Specification for Hospitals Providing Maternity Services:

Numerator:

Newborn Hepatitis B Vaccine entered in CAIR within first day of life

Denominator:

Newborn births at the hospital between January 1, 2027, and December 31, 2027

Measure 11 – ALSO & BLSO Certification Training:

It is proposed to add this measure to encourage hospitals to build capacity for training staff in Advanced Life Support in Obstetrics and Basic Life Support in Obstetrics. It is particularly important for our Critical Access Hospitals that treat patients in our rural communities to receive training. This measure may go into a second phase in following measurement years where the thresholds of providers are increased to train more staff.

ALSO & BLSO Measure Summary

The American Academy of Family Physicians has developed Advanced Life Support in Obstetrics (ALSO®) and Basic Life Support in Obstetrics (BLSO™) trainings help emergency response personnel and hospital staff to be better prepared to respond and treat obstetric emergencies. ALSO is designed for physicians and midwives who perform deliveries, along with labor & delivery nurses, whereas BLSO is appropriate for first responders, emergency department personnel, nurses, doulas, and students. ALSO training focuses on more advanced and comprehensive management of obstetric emergencies that have are high risk or have a high level of complexity requiring advanced skills and medications, while BLSO focuses on providing initial basic assessment of the patient and management of emergencies that have a moderate level of complexity. Because successful emergency treatment requires a care team to treat the member, both courses take a team-based group approach to learning.

According to the AAFP "Adapted from the Advanced Life Support in Obstetrics (ALSO®) program, BLSO is designed for pre-hospital care providers, emergency department personnel, medical and nursing students and non-delivering physicians. The course format is a blended classroom, which allows learners to work at their own pace to complete the online course portion prior to the live course skills assessment and group testing portion."

Partnership offers some support for holding BLSO or ALSO training within our network area. Hospitals should reach out to the HQIP team to learn more.

Specifications

This measure is designed to encourage hospitals to build capacity for ALSO and BLSO-certified care teams over the next few years. During the first year of this measure hospitals with an OB department shall begin to build capacity for an ALSO certified care team and Critical Access hospitals without OB will build capacity for a BLSO certified care team by training staff throughout the 2027 measurement period in correlation to measure targets.

ALSO & BLSO Measure Target Requirements

Hospitals with Obstetrics:

Full Points Target (5 pts):

30% of Physicians, i.e. MDs & CNM's and 30% of Nurses working regularly in Labor and Delivery are currently certified in ALSO

Partial Points Target (2.5 pts.):

15% of Physicians, i.e. MDs & CNM's and 15% of Nurses working regularly in Labor and Delivery are currently certified in ALSO

Hospitals without Obstetrics:

Full Points Target (5 pts):

30% of ED Clinicians, i.e. MDs & PAs and 30% of Nurses working regularly in the Emergency Department are currently certified in BLSO. Alternative simulation-based trainings in Emergency Obstetrical Care (such as Stanford's GO-MOMS-USA simulation program, done in-person at the hospital) may also be acceptable; they would be reviewed on a case-by-case basis.

Patial Points Target (2.5 pts):

15% of Physicians, i.e. MDs & PA's and 15% of Nurses working regularly in the Emergency Department are currently certified in BLSO.

Measure 14 - Quality Improvement Capacity:

This measure is designed to provide a free full day Hospital Quality Symposium each measurement year for our participating hospitals. At which, hospital quality and executive staff can stay up to date on quality topics at large and at Partnership. We had removed this measure for the 6-month bridge set for logistical reasons and propose to bring the measure back for the 2027 calendar year. There are no changes to the measure from previous measurement years.

Note: If non-OB hospital has staff trained in ALSO, those staff may be counted in the percentage of staff trained in BLSO.

Measure 16 - California Hospital Compare:

This measure is intended to encourage hospitals to provide excellent patient experience and Partnership's scoring of the measure relies upon California Hospital Compare's scores, which are updated annually. This measure was removed for this six-month bridge set as the scores for the 2025-26 measurement year would have just been delivered meaning there would be no new information to score the hospitals. It is proposed to bring this measure back for the 2027 calendar year. The measure will return in the same form as it was during the 2025-26 measurement year.

Measure 17 – Health Equity

This measure is designed to encourage hospitals to work toward reducing health disparities that exist in their area or patient populations. This measure was removed for the 6-month bridge period, and we propose to bring the measure back for the 2027 calendar year. It is proposed that the measure switch from hospitals submitting a CMS Commitment to Health Equity report to submitting a copy of their HCAI Health Equity Report that is required by California Assembly Bill 1204 as noted in the below measure description.

Health Equity Measure Summary

Partnership is actively engaged in Health Equity (HE) initiatives that bring about equitable awareness and result driven change within the 24 counties served and it highly encourages provider organizations to join its efforts. At Partnership, we believe in diversity by accepting, respecting, and valuing individual differences and capitalizing on the diverse backgrounds and experiences of our members, community partners, and staff. Together, we can help move our communities toward equitable access to health care.[29-32]

Partnership recognizes that hospitals are being asked to report health equity work in many ways, which can cause extra administrative burden. To reduce hospitals' reporting burden, Partnership has aligned its HQIP Health Equity measure with Assembly Bill No. 1204 requiring hospitals to share the valuable health equity work they have done without needing to present it in a different format.

Assembly Bill No. 1204 requires the California Department of Health Care Access and Information (HCAI) to establish and oversee the Hospital Equity Measures Reporting Program, which collects and publicly reports hospital performance and patient outcome data by sociodemographic factors such as age, sex, race and ethnicity, payer type, language, disability status, and sexual orientation and gender identity. Under the law, general acute care, children's, and acute psychiatric hospitals, as well as hospital systems, must annually (by September 30th) submit reports to HCAI summarizing key equity measures, identifying their top 10 disparities, and outlining plans to address those disparities. HCAI is responsible for providing public access to these reports and equity plans through its website, and participating hospitals are also required to post the reports on their own websites.

Health Equity Measure Requirements

Hospitals shall submit a copy of their most recently published annual HCAI Health Equity Measures Report to Partnership by December 31, 2027. The submitted report should be the same report hospitals sent to HCAI during the measurement year which was due to HCAI by September 30th.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MCQP1052			**Lead Department: Health Services** Business Unit: Quality Improvement	
Policy/Procedure Title: Physical Accessibility Review Survey – SR Part C			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 02/20/2013		**Next Review Date:** ~~06/11/2026~~08/12/2027 **Last Review Date:** ~~06/11/2025~~08/12/2026		
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~~08/12/2026	

I. RELATED POLICIES:

A. MPQP1022 - Site Review Requirements and Guidelines
B. CMP36 - Delegation Oversight and Monitoring

II. IMPACTED DEPTS:

A. Provider Relations
B. ~~Quality Improvement~~Network Services (Credentialing)

III. DEFINITIONS:

A. The Physical Accessibility Review Survey (PARS) is an on-site review of a provider office site's structural amenities vis-a-vis the potential for an adverse effect on seniors or persons with disabilities.
B. Primary Care Provider (PCP): the PCP is a general practitioner, internist, pediatrician, family physician, obstetrician/gynecologist (OB/GYN), nurse practitioner or physician assistant.
C. High Volume Specialist: a provider in Any Partnership HealthPlan of California's (Partnership's) that has billed at least 500 visits during the prior calendar year and who saw a minimum of 200 unique members during the prior calendar year~~-~~. Specialist types are those recommended by the American Board of Medical Specialties (ABMS). A specialist is defined as: A physician specialist, Board Certified by an ABMS Member Board is a licensed physician who focuses their practice in a particular area of medicine or patient care and may concentrate on certain body systems, specific age groups or complex scientific techniques to diagnose or treat particular medical conditions.
D. High Volume Ancillary Provider: a provider in Partnership's Regions that has billed at least 500 visits during the prior calendar year and who saw a minimum of 200 unique members during the prior calendar Ancillary providers may provide audiology, community based adult services (CBAS), dialysis, occupational/speech/physical therapy, nutritional education, and home infusion or other such services.
E. Excluded Providers: Certain provider types are excluded from the Partnership assessment of accessibility for Seniors and Persons with Disabilities (SPDs). They include licensed and certified facilities, hospitals, dental and vision providers, Long Term Care (LTC) facilities, imaging centers, pharmacies and labs, medical transportation, medical supplies, and Durable Medical Equipment (DME) sites. Non-contracted providers are excluded from Partnership assessment of accessibility for SPDs.

IV. ATTACHMENTS:

A. Physical Accessibility Review Survey Guidelines/Tool
B. Ancillary Services Physical Accessibility Review Survey
~~A.~~C. Community Based Adult Services (CBAS) Physical Accessibility Review Survey
~~B.~~D. PARS Close Letter Template

Policy/Procedure Number: MCQP1052			Lead Department: Health Services Business Unit: Quality Improvement
Policy/Procedure Title: Physical Accessibility Review Survey – SR Part C			☒ **External Policy** ☐ **Internal Policy**
Original Date: 02/20/2013		**Next Review Date:** ~~06/11/202~~08/12/2027~~6~~ **Last Review Date:** ~~06/11/2025~~08/12/2026	
Applies to:	☐**Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

V. PURPOSE:

To define the scope and frequency of performing the Physical Accessibility Review Survey (PARS) for PCPs and ~~High Volume~~High-Volume Ancillary and Specialist Providers (HVASP). The PARS tool was developed by a collaborative coalition made up of staff from the California Department of Health Care Services (DHCS) and Medi-Cal Managed Care Health Plans and meets DHCS standards. The purpose of the PARS is to assess the physical accessibility of provider sites using a set of standards mindful of the needs of seniors or persons with disabilities. Results of the PARS will be made available through the Partnership website and provider directories.

VI. POLICY / PROCEDURE:

Partnership will conduct a PARS at the time of the initial site review for newly credentialed PCPs and at least once every three years thereafter. ~~Providers determined to be HVSAPs will be reviewed every three years following their initial PARS assessment.~~ Partnership will notify DHCS of any changes made to the HVASP methodology by January 31st of each year in accordance with MMCD Policy Letter 12-006 (see references below.) Annually, no later than April 30~~15~~th, Partnership will apply the methodology approved by DHCS to identify any new HVASP that meet the criteria described in Section III. Providers that no longer meet the HVASP definition, will be deleted from the list to survey. Newly identified HVASP providers will receive a PARS assessment within six (6) months of such identification.

A. Requirements
   1. PARS is an on-site review of the office site and covers critical elements across:
      a. Parking
      b. Exterior Building
      c. Interior Building
      d. Restroom
      e. Exam Room
      f. Exam Table/Scale

B. Scheduling - A member of the Quality Improvement department's Quality Inspections team or designee (aka the PARS Reviewer) conducts the PARS. (Refer to Section VI.E. for delegation criteria.)
   1. The Quality Inspections team schedules the physical accessibility reviews and provides information to the provider on preparing for the review in the following situations:
      a. Providers who change site locations subsequent to receiving a PARS assessment must receive a new review. ~~A Provider Relations' Credentialing Specialist~~ Network Services ~~will~~ notifies~~y~~ the Inspections team through the Provider Change Agenda of ~~relocating/~~relocated providers. ~~so that~~ T~~t~~he Inspection team ~~can~~ will ~~schedule~~ complete~~the~~ a review within sixty (60) days of the notification date. ~~or the date the site opened.~~
      ~~a.~~b. PCPs will be assessed at a minimum of every three years.
      ~~b.~~c. Newly identified providers based on the annual HVASP methodology will be assessed within six months of being identified.
      ~~c.~~d. ~~PCPs and~~ E~~e~~xisting HVASPs that continue to meet the ~~High Volume~~High-Volume methodology will be assessed every three years.

C. Review
   1. The PARS Reviewer will conduct the review, using the most recent DHCS PARS tool.
      a. Review Criteria
         1) Criteria are scored as Yes, No, or Not Applicable
         2) Access is identified as Basic or Limited, as well as Medical Equipment Access (if applicable)
         3) There is no Corrective Action Plan (CAP) required when elements of the review do not

meet the standards

2. Results Notification:
   a. Partnership Contracted Provider
      1) The Partnership contracted provider will receive a final close letter within sixty (60) days of the review, which will indicate the level of access and the appropriate accessibility indicator. – See Attachment D~~C~~.
   b. Provider Relations
      1) The results of the PARS will be forwarded to the Partnership Provider Relations department on a ~~quarterly~~ monthly basis. Provider Relations staff will make the information available on the Partnership website and in the provider directories in accordance with MMCD Policy Letter 12-006.

D. Physical Access Designation
   1. Access designations are documented in the Partnership HealthPlan Provider Directory as required by MMCD 12-006.
      a. Basic Access:~~-~~ Demonstrates access for SPDs meet the Basic Access requirements, for all Critical Elements (CE) in the following areas: parking, building, elevator, doctor's office, exam room and restroom.
      b. Limited Access: ~~-~~Demonstrates access for SPDs where one or more of the Critical Elements (CE) are missing or incomplete in the following areas: parking, building, elevator, doctor's office, exam room, and restroom.
      c. Medical Equipment Access: Demonstrates the PCP site has a height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patient). This is noted in addition to the level of basic or limited access as appropriate.
      d. Provider Directory Indicators noted:
         In addition to identifying the locations' accessibility level, the following should be identified (where applicable) such;
         P = Parking EB = Exterior Building IB = Interior Building
         R = Restroom E = Exam Room T = Exam Table/Scale

E. Delegation of PARS functions

F. Organizations or groups who have one or more DHCS Certified Site Reviewers or appropriately trained personnel may be determined eligible, at Partnership discretion, to perform PARS functions. An organization or group will perform these functions under a formal delegation agreement.

G. A formal delegation agreement is inclusive of a detailed grid outlining key functions and responsibilities of both Partnership and the delegated entity.

H. Delegated entities will perform PARS functions for all PCP sites no less than once every three years.

I. Delegated organizations and/or groups will provide timely copies of all PARS reviews conducted at the site level, within Partnership's service area, when requested.

J. Partnership's Quality Inspections team will track all PARS conducted by the delegated entities.

K. For organizations and groups that are more than one year past due for PARS at the site level or otherwise missing a PARS, the Inspections team will refer to Partnership's Delegation Oversight Reporting Sub-Committee (DORS), which is managed by Partnership's Compliance unit within the Administration department, for action.

L. As part of the oversight process, Partnership may perform one or more repeat PARS on sites that have had the PARS performed by a delegated entity.

VII. REFERENCES:

A. MMCD Policy Letter 12-006 Revised Facility Site Review Tool (Aug. 12, 2012)

B. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-017 Primary Care Provider Site Review: Facility Site Review and Medical Record Review (Sept. 22, 2022 supersedes APL 20-006)

C. DHCS APL 15-023 Facility Site Review Tools for Ancillary Services and Community-based Adult Service Providers (Oct. 28, 2015)

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES: Medi-Cal: 02/19/14; 02/18/15; 02/17/16, 02/15/17; *03/14/18; 03/11/20; 3/10/21; 05/12/21; 06/08/22; 06/14/23; 06/12/24; 06/11/25; 08/12/26

*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:

Physical Accessibility Review Survey

California Department of Health Care Services
Medi-Cal Managed Care Division

Provider Name: ☐ PCP ☐ Specialist ☐ Ancillary	Date of Review: Name of Reviewer:
Address: City:	Health Plan Name:
Phone: FAX:	Contact Person Name:

	Level of Access:
Basic Access: Demonstrates facility site access for the members with disabilities to parking, building, elevator, doctor's office, exam room and restroom. To meet Basic Access requirements, all (29) Critical Elements (CE) must be met.	☐ Basic Access
Limited Access: Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, doctor's office, exam room, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.	☐ Limited Access
Medical Equipment Access: PCP site has height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patient). This is noted in addition to level of Basic or Limited Access as appropriate.	☐ Medical Equipment is available

Below are the symbols that will be used in the provider directories to indicate areas of accessibility at a provider office/site. These should also be used in online directories. In order for a provider office to receive a symbol, the appropriate criteria must be met.

These symbols are in addition to identifying whether the provider office has Basic Access or Limited Access. A provider who has Basic Access will automatically meet the critical elements for the first six symbols (P, EB, IB, R, and E). And a provider who has Medical Equipment Access will meet the medical equipment elements for the last symbol (T).

Accessibility Indicator	Must Satisfy these Criteria	Yes	No	N/A	Comments
P = PARKING	Critical Elements (CE): 3, 7, 8, 11				
EB - EXTERIOR BUILDING	(CE): 14, 20, 22, 23 25, 27, 28, 31				
IB = INTERIOR BUILDING	(CE): 31, 34, 37 If lift include: 40 If elevators include: 53, 54, 55, 56, 57, 58				
R=RESTROOM	(CE): 65, 67, 68, 71, 75, 77				
E=EXAM ROOM	(CE): 80, 85				
T = EXAM TABLE/SCALE	Medical Equipment Elements (ME): 81, 82, 86				

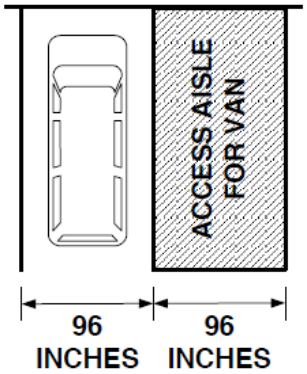
I certify that there have been no changes since the last physical accessibility review:

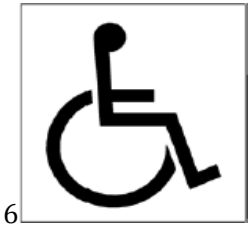
Name: _____ Signature: _____ Date: _____

I certify that there have been no changes since the last physical accessibility review:

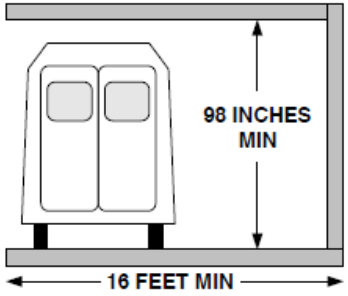
Name: _____ Signature: _____ Date: _____

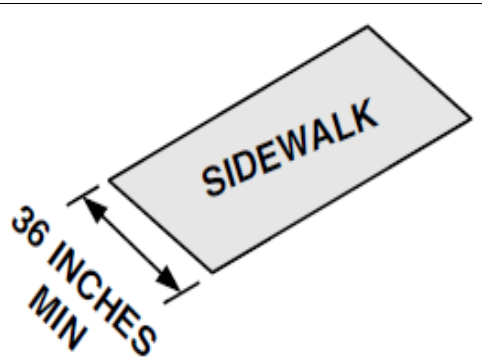
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
PARKING						
1	Is off-street public parking available?	Self explanatory.				
2	Are accessible parking spaces provided in off-street parking?	Self explanatory.				
3 (CE)	**Are the correct number of accessible parking spaces provided?** **1 to 25 total spaces – 1 required** **26 to 50 – 2 required** **51 to 75 – 3 required** **76 to 100 – 4 required** **101 to 150 – 5 required** **151 to 200 – 6 required** **201 to 300 – 7 required** **301 to 400 – 8 required**	If there are 25 total parking spaces or less, at least one accessible space is required. If there are between 26 and 50 total spaces, at least two accessible spaces are required, etc.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
4	Is the accessible parking space(s) closest to the main entrance?	The accessible parking space (s) should afford the shortest route of travel from adjacent parking to the accessible entrance.				
5	Is there an access aisle next to the accessible space(s)?	The access aisle is the space next to the accessible parking space where a person using the accessible space can load and unload from the vehicle. 				
6	Is the parking space(s) and access aisle(s) free of curb ramps that extend into the space and other obstructions?	If a curb ramp extends into the parking space(s) or access aisle, a person using that space and aisle would not have adequate level space to unload and load from the vehicle.				

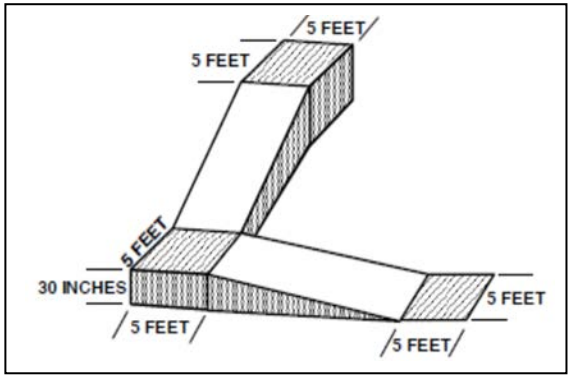
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
7 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the parking locations?**	Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street or behind parked cars where drivers cannot see them.				
8 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the drop off locations?**	See above Question # 7.				
9	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility.  6				

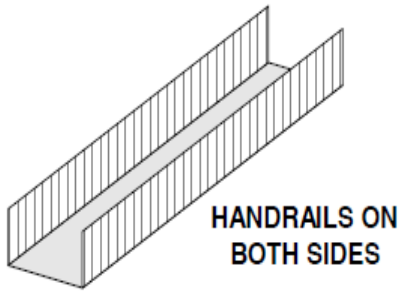
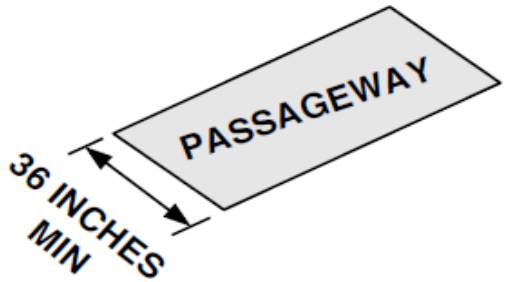
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
10	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle?	Signs must be located so a vehicle parked in the space does not obscure them. (Van accessible spaces must be indicated with an additional sign)				
11 (CE)	**Is VAN accessible parking provided?**	1 van space for every 6 standard accessible spaces must be provided, but never less than one. For example, if there are 23 total spaces, at least one accessible space is required and it must be large enough (See Question # 5 for dimensions) to accommodate a van. If there are 201 total parking spaces, at least seven accessible spaces would be required and two of those would have to accommodate vans.				
12	Is VAN accessible parking signage provided?	Signs must be mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
13	If van accessible parking is provided in a parking garage, is there at least 8 feet 2 inches (98 inches total) vertical clearance available for full-sized, lift equipped vans?	If there is no parking garage, check NA. If designated accessible parking is located in a garage, the vertical clearance should be at a minimum 8 feet 2 inches (98 inches). Vertical clearance should be posted.  				
EXTERIOR ROUTE (FROM ACCESSIBLE PARKING, PUBLIC TRANSPORTATION, AND PUBLIC SIDEWALK TO THE ENTRANCE)						
14 (CE)	**For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)**	Self explanatory.				
	a. Parking?					
	b. Public transportation?					

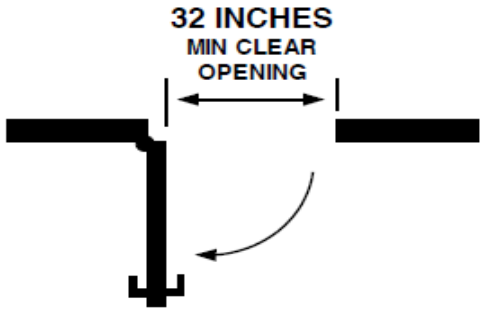
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	c. Public sidewalk?					
15	Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following: (Please mark NA for those that do not apply.)					
	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
16	Is the accessible route to the building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.)	An example of a stable surface is a floor or ground surface without loose elements like gravel or wood chips. Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface. Avoid glossy or slick surfaces such as ceramic tile.				
	a. Parking?					

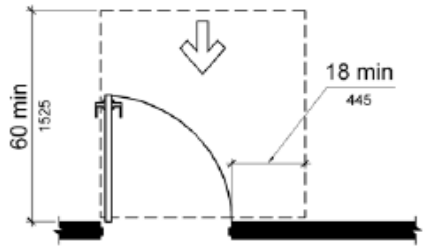
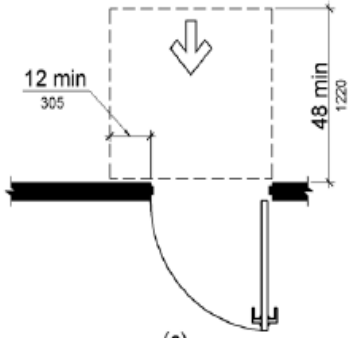
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	b. Public transportation?					
	c. Public sidewalk?					
17	Is there an accessible route that does not include stairs or steps?	Self explanatory.				
18	Is the route to the entrance from the accessible parking spaces, including transitions at curb ramps, free of grates, gaps, and openings that are both greater than ½ inch wide and over ¼ inch deep?	Self explanatory.				
RAMPS:						
19	Is an access ramp present?	If there is more than one ramp, select the one that appears to be the primary access ramp.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
20 (CE)	**Is each run (leg) of the ramp no longer than 30 feet between landings?**	**Each "run," shown in the white sections in the diagram below, must be no longer than 30 feet.** 				
21	Are 60 inches (5 feet) long, level landings provided at the top and bottom of each ramp run?	See Question 20 diagram above.				

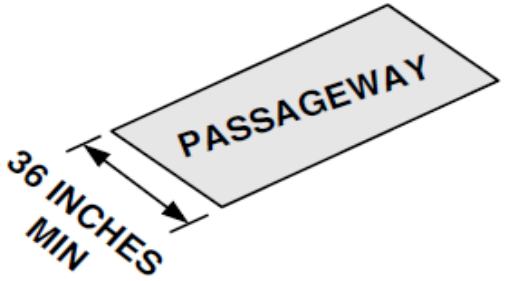
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
22 (CE)	**Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?**	If the ramp is not longer than 6 feet, check NA.  				
23 (CE)	**Are all ramps at least 36 inches wide?**	 				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
BUILDING ENTRANCE						
24	Is the main entrance accessible?	Self explanatory.				
25 (CE)	**If a main entrance is not accessible, is there another accessible entrance?**	Self explanatory.				
26	If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance?					

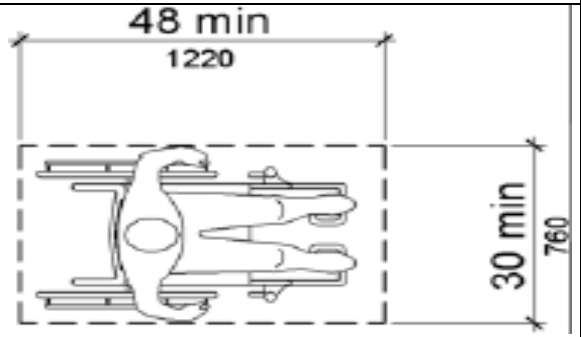
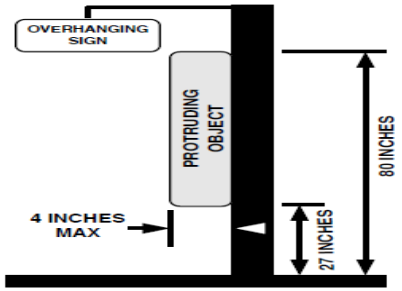
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
27 (CE)	**Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°?**	When measuring double doors, measure the opening with one door open to 90°.  				
28 (CE)	**Is space available for a wheelchair user to approach, maneuver, and open the door?**	Appropriate space perpendicular and parallel to a doorway permits a wheelchair user, people using walkers and other mobility devices to open the door safely and independently. Following are two common examples of required minimum maneuvering clearances: 1. Approaching the door and pulling it toward you to open requires 60 inches of clear space perpendicular to the doorway and 18 inches parallel to the doorway. 2. Approaching the door and pushing it away from you to open requires 48 inches of clear space perpendicular to the doorway.				

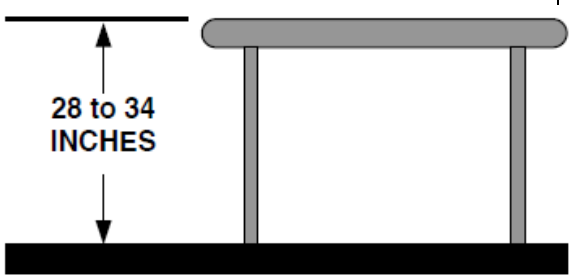
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
		 (a) front approach, pull side  (c) front approach, push side, door provided with both closer and latch				
29	Is the space required to open the door level and clear of movable objects (chairs, trash cans, etc.)?	If there are nonpermanent items such as trash cans, merchandise, etc., located in these areas, they must be removed or relocated.				

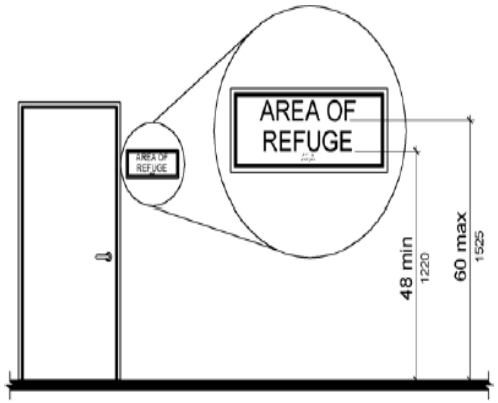
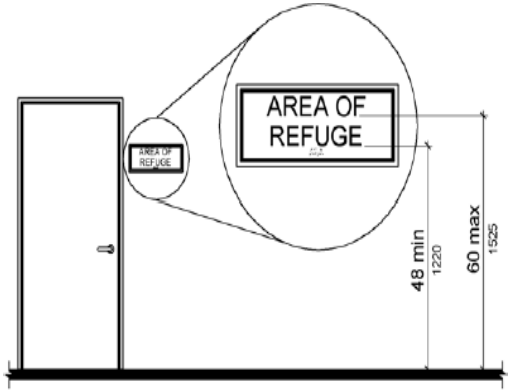
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
30	Are there automatic doors?	Self explanatory.				
31 (CE)	**Do entrance doors have handles that can be opened without grasping, pinching, or twisting of the wrist?**	Can the door be opened by someone with a closed fist or fully open hand? Door knobs, for example, cannot be used in this manner.				
INTERIOR ROUTE (FROM THE BUILDING ENTRANCE TO THE CLINIC/OFFICE ENTRANCE, TO THE REGISTRATION COUNTER/WINDOW, AND THROUGH THE CLINIC/OFFICE TO AREAS THAT PATIENTS COULD GO)						
32	Is there an interior route to the medical office?	Some medical offices are accessed directly from the street or parking lot rather than being located within a larger office building or complex, therefore they do not have interior routes.				

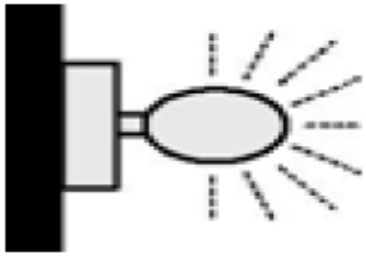
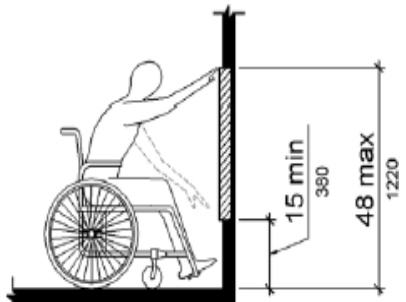
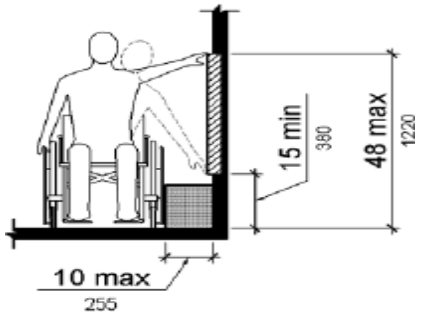
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
33	Is there an interior accessible route to the medical office that does not include stairs or steps?	Floors of a given story are level throughout the building, or connected by ramps, passenger elevators or access lifts.				
34 (CE)	**Are <u>ALL</u> interior paths of travel at least 36 inches wide?**					
35	Is the interior accessible route stable, firm, and slip resistant?	Avoid unsecured carpeting or other loose elements. It is easier for people using walkers, wheelchairs and other aids to walk or push on surfaces that have low pile carpeting without a pad underneath. Glossy or slick surfaces such as ceramic tile or marble can be slippery.				
36	Is the interior accessible route well lighted?	A brightly lit corridor will help avoid falls.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
37 (CE)	**If there are stairs on the accessible route, are there handrails on each side?**	If there are no stairs, check NA.				
38	If there are stairs, are all stairs risers closed that are on the accessible route?					
39	If there are stairs, are all stair treads marked by a stripe providing a clear visual contrast to assist people with visual impairments?	Contrast striping must be provided on the upper approach and lower tread for interior stairs and on the upper approach and all treads for exterior stairs. Stripes must be 2" to 4" wide placed parallel to and no more than 1" from the nose of the step or upper approach. The stripe must extend the full width of the step or upper approach and should be made of material that is at least as slip resistant as the other stair treads (a painted stripe is acceptable).				
40 (CE)	**If a platform lift is used, can it be used without assistance?**	If there is no platform lift, check NA. Lifts sometimes require a key for operation, thus preventing independent use.				

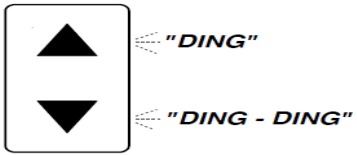
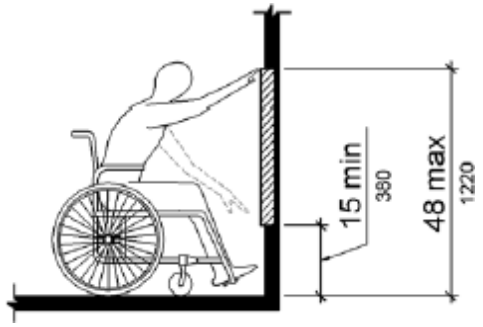
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
41	Does the interior door to the medical office require less than 5 pounds of pressure to open?	If interior door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
42	Is there a clear space 30 inches wide by 48 inches long in the waiting area(s) for a wheelchair or scooter user to park that is not in the path of travel?					
43	Is the path through the medical office free of any objects that stick out into the circulation path that a blind person might not detect with a cane?	If an object protrudes more than 4 inches and is located between 27 inches above the walking surface and below 80 inches, a blind person walking with a cane will not detect it. 				

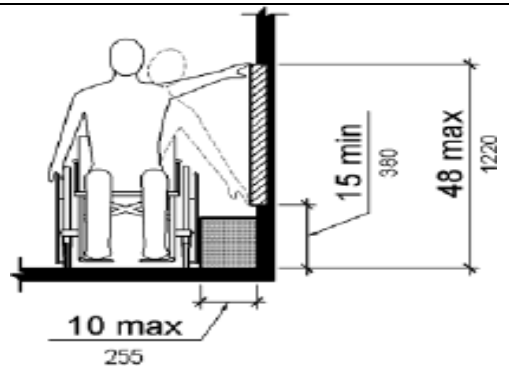
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
44	If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up?	If floor mats are not in use, check NA. Floor mats that are not secured to the floor can roll up or bunch up under walkers or wheelchair casters and cause a tripping hazard.				
45	Is a section of the sign-in/registration counter no more than 34 inches high and at least 36 inches wide and free of stored items.					
46	Does the office have a method, other than a lowered counter, by which people can sign in/register? (If yes, please note this method in comments.)	A medical office may use reasonable alternative methods to meet this need such as a clip board.				

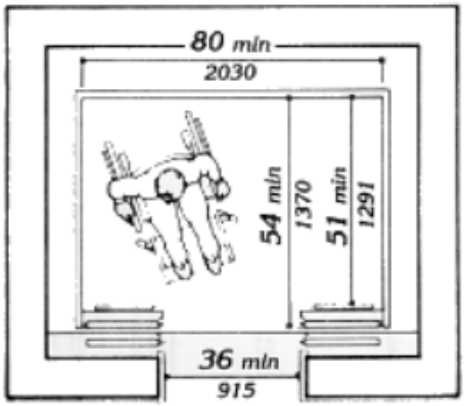
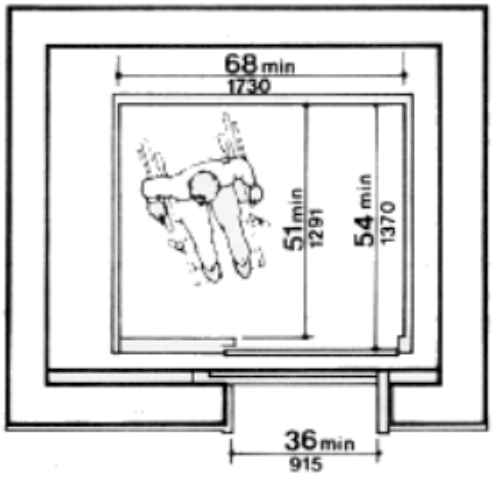
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
47	Do signs identifying permanent rooms and spaces include raised letters and Braille?					
48	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted between 48 inches and 60 inches from the floor.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
49	If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and each room where patients are seen?	If the building does not have a fire alarm system, check NA. 				
50	Are all patient-operated controls (call buttons, self-service literature, brochures, hand sanitizers, etc.) mounted or presented between 15 inches and 48 inches from the floor?	 				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
51	Are all patient operated controls (e.g., call buttons, hand sanitizers) operable with one hand without grasping, pinching, or twisting to operate?	For example, a pump hand sanitizer that must be operated using two hands is inaccessible.				
ELEVATORS						
52	Is there an elevator?					
53 (CE)	**If needed, is the elevator available for public/patient use during business hours?**	Self explanatory.				

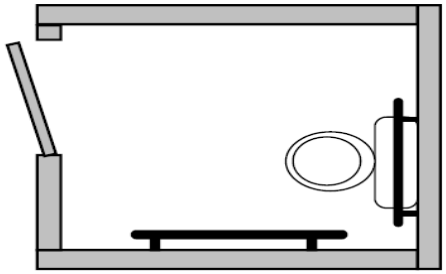
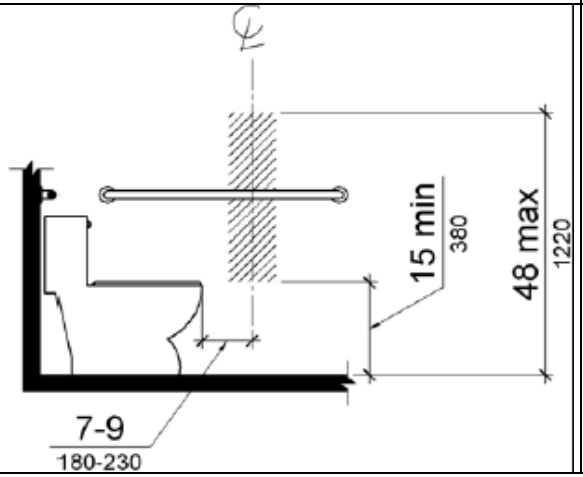
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
54 (CE)	**Is the elevator equipped with both visible and audible door opening/closing and floor indicators?**	A visible and audible signal is required at each elevator entrance to indicate which car is answering a call. An audible signal would be a "ding" or a verbal announcement. 				
55 (CE)	**Is there a raised letter and Braille sign on each side of each elevator jamb?**	These signs allow everyone to know which floor they are on before entering or exiting the elevator.				
56 (CE)	**Are the hall call buttons for the elevator no higher than 48 inches from the floor?**					

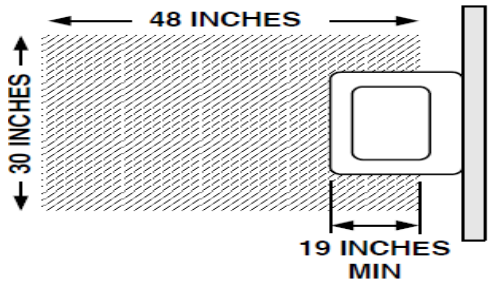
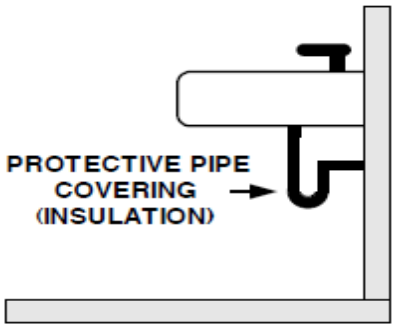
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
						

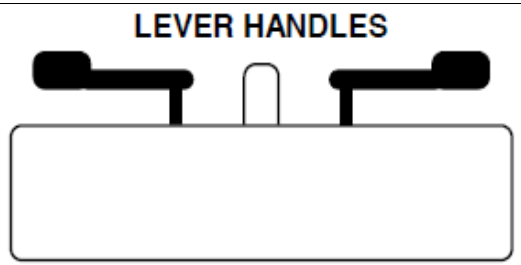
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
57 (CE)	**Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?**	The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where the door is located.  (a)  				

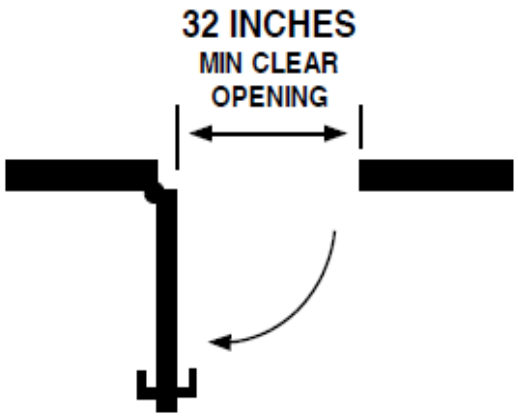
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
58 (CE)	**Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons?**	Self explanatory.				
59	Is there an emergency communication system in the elevator?	Self explanatory.				
60	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people with hearing or speech impairments could be jeopardized. Visible signal requirement could be satisfied with something as simple as a button that lights when the message is answered, indicating that help is on the way.				

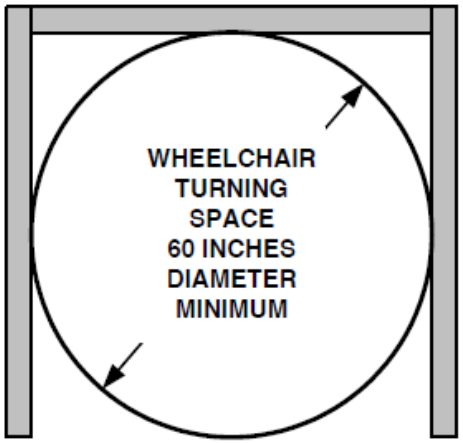
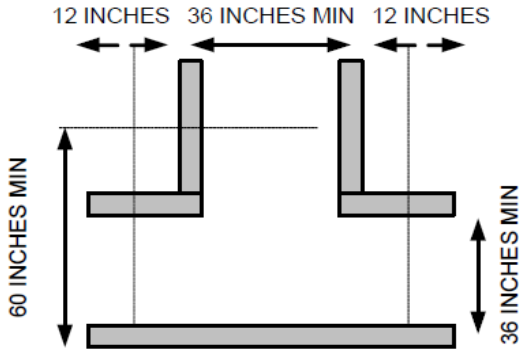
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
61	Do raised letters and Braille identify the emergency intercom in the elevator?	Self explanatory.				
TOILET ROOMS (INCLUDING THOSE USED FOR SPECIMEN COLLECTION)						
ALL TOILET ROOMS:						
62	Is there an accessible toilet room?	Self explanatory.				
63	If there is an inaccessible toilet room, is there directional signage to an accessible toilet room?	Mark NA if there are no inaccessible toilet rooms. Self explanatory.				
64	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the				

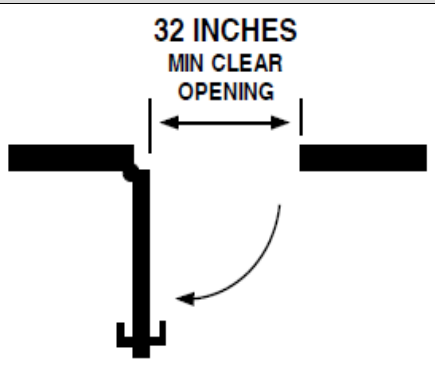
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
		weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
65 (CE)	**For all toilet rooms with and without stalls:** **Are grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?**	Grab bars should be installed in a horizontal position between 33 and 36 inches above the floor measured to the top of the gripping surface. 				
66	Are all objects mounted at least 12 inches above and 1½ inches below the grab bars?	This includes seat cover dispensers, toilet paper dispensers, sanitizers, trash containers, etc.				
67 (CE)	**Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?**					

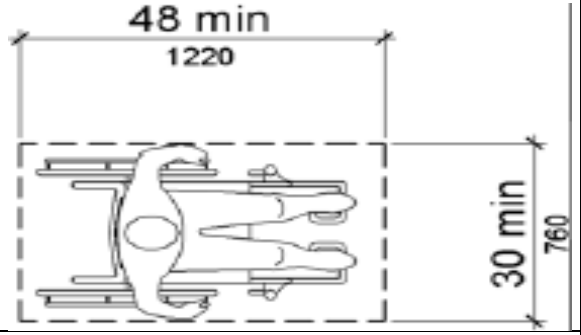
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
68 (CE)	**Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?**	This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath. 				
69	Is the space in front of the sink free of trash cans and other movable items?	Self explanatory.				
70	Are the pipes and water supply lines under the sink wrapped with a protective cover?					
71 (CE)	**Are faucet handles operable with one hand and without grasping, pinching, or twisting? (Check Yes if faucets are automatic.)**	A knob handle would not be accessible.				

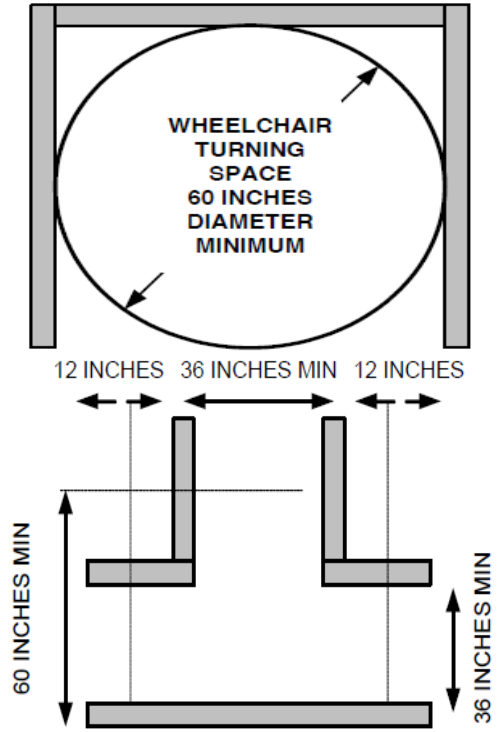
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
						
72	Are all dispensers mounted no higher than 40 inches from the floor?	Included are soap dispensers, paper towel dispensers, seat cover dispensers, hand dryers, etc.				
73	Are all dispensers (soap, paper towel, etc.) operable with one hand and without grasping, pinching, or twisting?	Self explanatory.				
74	If there is a pass-through door for specimen collection, is there a 30 inches by 48 inches space for a wheelchair or scooter user to park in front of it?	If there is no such door, check NA.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	TOILET ROOM WITHOUT STALLS					
75 (CE)	***Toilet room without stalls:*** **Do toilet room doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**	If there is no toilet room without stalls, check NA. 				
76	Is the space inside the toilet room without stalls clear, without trash cans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	TOILET ROOM WITH STALLS					
77 (CE)	***Toilet Room with stalls:*** **Is there a 60-inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space inside the toilet room with stalls to allow a turn around for wheelchair and scooter users?**	If there is no toilet room with stalls, check NA.  				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
78	Is the space inside the accessible stall clear, without trash cans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				
79	Can the hardware on the stall door be operated without grasping, pinching, or twisting of the wrist?	Handles, pulls, latches, locks, and other operating devices on accessible doors shall have a shape that is easy to grasp with one hand and does not require tight grasping, tight pinching, or twisting of the wrist to operate.				
EXAM/TREATMENT ROOMS/MEDICAL EQUIPMENT						
80 (CE)	**Do exam room doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**					

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
81 (ME)	**Is there a height adjustable exam table that lowers to between 17 inches and 19 inches from the floor to the top of the cushion?**	Self explanatory				
82 (ME)	**Is there space next to the height adjustable exam table for a wheelchair or scooter user to approach, park, and transfer or be assisted to transfer onto the table?**	9 				
83	Does the exam table provide elements to assist during a transfer (such as rails) and support a person while on the table? (If yes, please list in comments.)	Items that could help support a patient while on the table would be armrests, side rails, padded straps, cushions, wedges, etc.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
84	Is a lift available to assist staff with transfers (portable, overhead, or ceiling mounted)?	Self explanatory.				
85 (CE)	**Is there a 60 inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space so that a wheelchair or scooter user can make a 180° turn?**					

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
86 (ME)	**Is a weight scale available within the medical office with a platform to accommodate a wheelchair or scooter and the patient?**	Accessible scales are usable by all people including: wheelchair users, people with activity limitations, and larger people who may exceed a standard weight scale limit. This includes people with conditions that interfere with mobility, walking, climbing, using steps (joint pain, short stature, pregnancy, fatigue, respiratory and cardiac conditions, post surgical conditions, orthopedic injuries); and/or who use mobility devices (e.g. canes, crutches, walkers).				

References

2010 ADA Standards for Accessible Design
U.S Department of Justice
http://www.ada.gov/2010ADAstandards_index.htm

The revised regulations for Titles II and III of the Americans with Disabilities Act of 1990 (ADA) were published in the Federal Register on September 15, 2010. They provide the scoping and technical requirements for new construction and alterations resulting from the adoption of revised 2010 Standards in the final rules for Title II (28 CFR part 35) and Title III (28 CFR part 36). The 2010 ADA Standards go into effect March 15, 2012, but can be used now instead of the 1991 standards. The FSR Attachment C draws upon access requirements found in both the 1991 Americans with Disabilities Act Accessibility Guidelines and the 2010 ADA Standards. Some diagrams that appear in the FSR Attachment C are reproduced from these sources.

Two questions in the FSR Attachment C were drawn from Title 24, Part 2 of the California Building Standards Code. These are

1133B.4.4 – Striping for the visually impaired (Rev.1-1-2009), and 1115B-1 – Bathing and Toilet Facilities, placement of toilet paper dispensers. These standards can be found in:
2009 California Building Standards Code with California Errata and Amendments
State of California
Department of General Services
Division of the State Architect
Updated April 27, 2010
http://www.documents.dgs.ca.gov/dsa/pubs/access_manual_rev_04-27-10.pdf

Some diagrams are reprinted with permission from the Kentucky Department of Vocational Rehabilitation. These illustrations can also be found in:
"Health Care Usability Profile V3"

Oregon Health & Science University RRTC: Health & Wellness
Authors: Drum, C.E., Davis, C.E., Berardinelli, M., Cline, A., Laing, R., Horner-Johnson, W., & Krahn, G.
Oregon Institute on Disability and Development
Portland, OR 97239
rrtc@ohsu.edu
healthwellness.org

Ancillary Services Physical Accessibility Review Survey

California Department of Health Care Services
Managed Care Quality and Monitoring Division

For purposes of this tool, Ancillary Services refers to Diagnostic and Therapeutic services such as, but not limited to: Radiology, Imaging, Cardiac Testing, Kidney dialysis, Physical Therapy , Occupational therapy , Speech therapy ,Cardiac rehabilitation, Pulmonary testing.

Provider Name: _____ ☐ Radiology ☐ Infusion ☐ Physical Therapy ☐ Other _____	Date of Review: Name of Reviewer:
Address: City:	Health Plan Name:
Phone: FAX:	Contact Person Name:

	Level of Access:
Basic Access: Demonstrates ancillary facility site access for the members with disabilities to parking, building, elevator, restroom, diagnostic and treatment use. To meet Basic Access requirements, all (34) Critical Elements (CE) must be met.	☐ Basic Access
Limited Access: Demonstrates ancillary facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, restroom, diagnostic and treatment use. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.	☐ Limited Access
Medical Equipment: Diagnostic and treatment equipment meet accessibility features for use as indicated the "accessibility indicators". (assistance is available for the equipment used).	☐ Medical Equipment is available ☐ List of Equipment

Below are the symbols that will be used in the provider directories to indicate areas of accessibility at the ancillary site. These should also be used in online directories. In order for an ancillary site to receive a symbol, the appropriate criteria must be met.

These symbols are in addition to identifying whether the provider office has Basic Access or Limited Access. A provider who has Basic Access will automatically meet the critical elements for the first 5 symbols (P, EB, IB, R, PD).

Accessibility Indicator	Must Satisfy these Criteria	Yes	No	N/A	Comments
P = PARKING	**Critical Elements (CE): 3,7,8,11**				
EB = EXTERIOR BUILDING	**(CE): 14,20,21,22,25**				
IB = INTERIOR BUILDING	**(CE): 28,31,42,43,44,45,46,47**				
R =RESTROOM	**(CE): 53, 55,56,59,62,64**				
PD = PATIENT DIAGNOSTIC AND TREATMENT USE	**(CE): 66,67,70,76,78**				
T = MEDICAL EQUIPMENT	**(T): 72,73,74,77,80,81**				

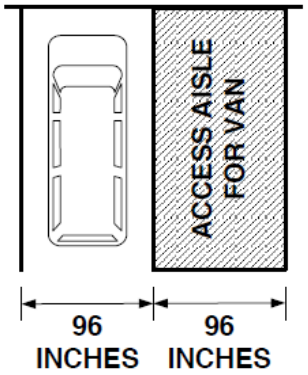
2nd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

Name: _____ Signature: _____ Date: _____

3rd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

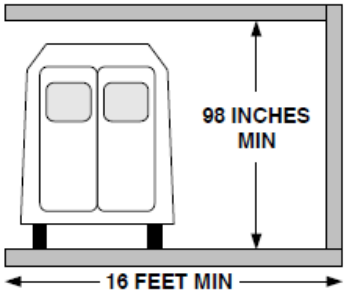
Name: _____ Signature: _____ Date: _____

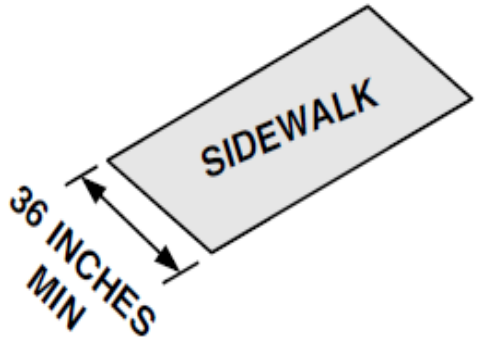
PARKING						
1	Is off-street public parking available?	Self explanatory.				
2	Are accessible parking spaces provided in off-street parking?	Self explanatory.				
3 (CE)	**Are the correct number of accessible parking spaces provided?** **1 to 25 total spaces – 1 required** **26 to 50 – 2 required** **51 to 75 – 3 required** **76 to 100 – 4 required** **101 to 150 – 5 required** **151 to 200 – 6 required** **201 to 300 – 7 required** **301 to 400 – 8 required**	**If there are 25 total parking spaces or less, at least one accessible space is required. If there are between 26 and 50 total spaces, at least two accessible spaces are required, etc.**				
4	Is the accessible parking space(s) closest to the main entrance?	The accessible parking space (s) should afford the shortest route of travel from adjacent parking to the accessible entrance.				

5	Is there an access aisle next to the accessible space(s)?	The access aisle is the space next to the accessible parking space where a person using the accessible space can load and unload from the vehicle.  				
6	Is the parking space(s) and access aisle(s) free of curb ramps that extend into the space and other obstructions?	If a curb ramp extends into the parking space(s) or access aisle, a person using that space and aisle would not have adequate level space to unload and load from the vehicle.				

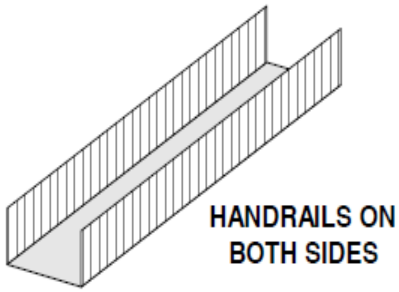
7 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the parking locations?**	**Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street or behind parked cars where drivers cannot see them.**				
8 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the drop off locations?**	**See above Question # 7.**				

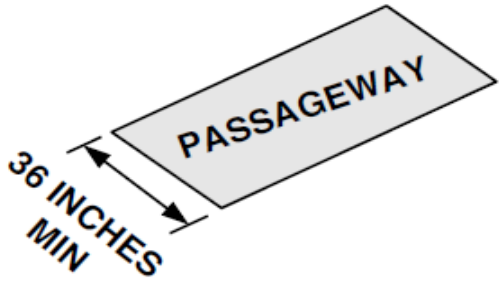
9	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility. 				
10	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle?	Signs must be located so a vehicle parked in the space does not obscure them. (Van accessible spaces must be indicated with an additional sign)				
	Is VAN accessible parking provided?	**1 van space for every 6 standard accessible spaces must be provided, but never less than one. For example, if there are 23 total spaces, at least one accessible space is required and it must be large enough (See Question # 5 for dimensions) to accommodate a van. If there are 201 total parking spaces, at least seven accessible spaces would be required and two of those would have to accommodate vans.**				
12	Is VAN accessible parking signage provided?	Signs must be mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle.				

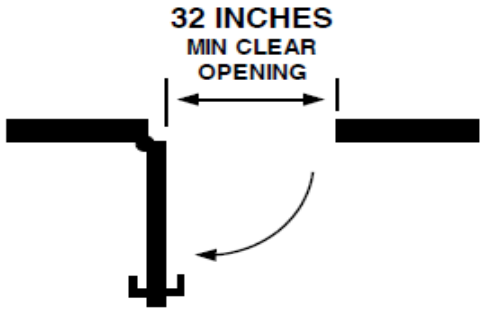
13	If van accessible parking is provided in a parking garage, is there at least 8 feet 2 inches (98 inches total) vertical clearance available for full-sized, lift equipped vans?	If there is no parking garage, check NA. If designated accessible parking is located in a garage, the vertical clearance should be at a minimum 8 feet 2 inches (98 inches). Vertical clearance should be posted.  				

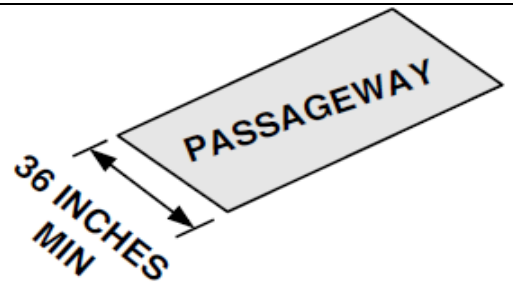
EXTERIOR ROUTE (FROM ACCESSIBLE PARKING, PUBLIC TRANSPORTATION, AND PUBLIC SIDEWALK TO THE ENTRANCE)						
14 (CE)	**For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)**	**Self explanatory.**				
	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
15	Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following:(Please mark NA for those that do not apply.)					

	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
16	Is the accessible route to the building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.)	An example of a stable surface is a floor or ground surface without loose elements like gravel or wood chips. Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface. Avoid glossy or slick surfaces such as ceramic tile.				
	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
17	Is there an accessible route that does not include stairs or steps?	Self explanatory.				

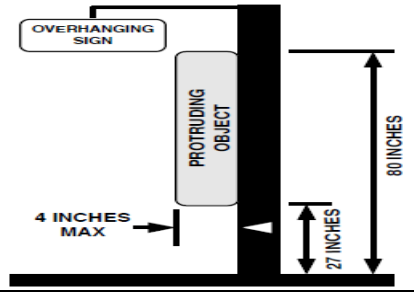
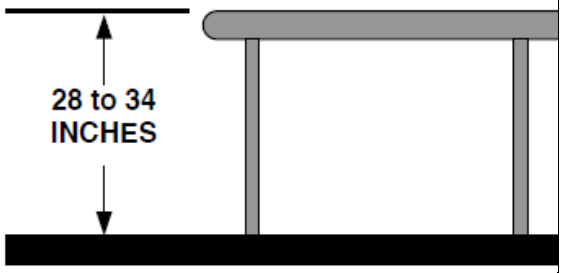
18	Is the route to the entrance from the accessible parking spaces, including transitions at curb ramps, free of grates, gaps, and openings that are both greater than ½ inch wide and over ¼ inch deep?	Self explanatory.				
RAMPS:						
19	Is an access ramp present?	If there is more than one ramp, select the one that appears to be the primary access ramp.				
20 (CE)	**Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?**	**If the ramp is not longer than 6 feet, check NA.**  				

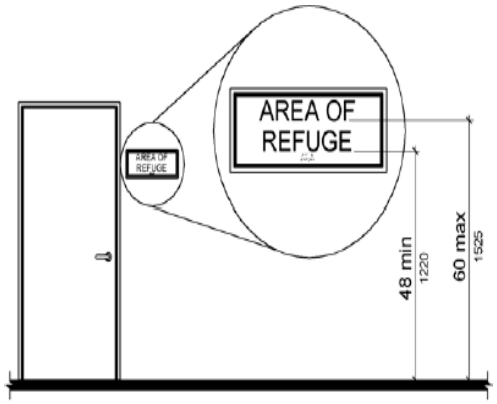
21 (CE)	**Are all ramps at least 36 inches wide?**					

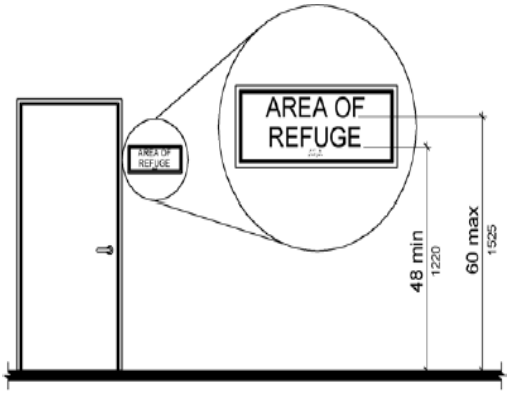
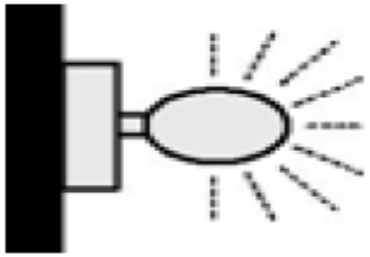
BUILDING ENTRANCE						
22 CE	**Is the main entrance accessible?**	**Self explanatory.**				
23	If a main entrance is not accessible, is there another accessible entrance?	Self explanatory.				
24	If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance?					
25 (CE)	**Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°?**	**When measuring double doors, measure the opening with one door open to 90°.** 				

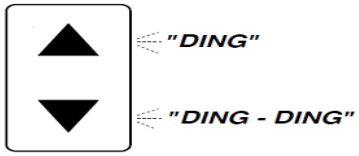
26	Are there automatic doors?	Self explanatory.				
INTERIOR ROUTE (FROM THE BUILDING ENTRANCE, TO THE REGISTRATION COUNTER/WINDOW, AND THROUGH TO THE PARTICIPANT AREAS						
27	Is there an interior route to the patient area?	Some patient areas are accessed directly from the street or drop off rather than being located within a larger building or complex, therefore they do not have interior routes.				
	Are <u>ALL</u> interior paths of travel at least 36 inches wide?					
29	Is the interior accessible route stable, firm, and slip resistant?	Avoid unsecured carpeting or other loose elements. It is easier for people using walkers, wheelchairs and other aids to walk or push on surfaces that have low pile carpeting without a pad underneath. Glossy or slick surfaces such as ceramic tile or marble can be slippery.				

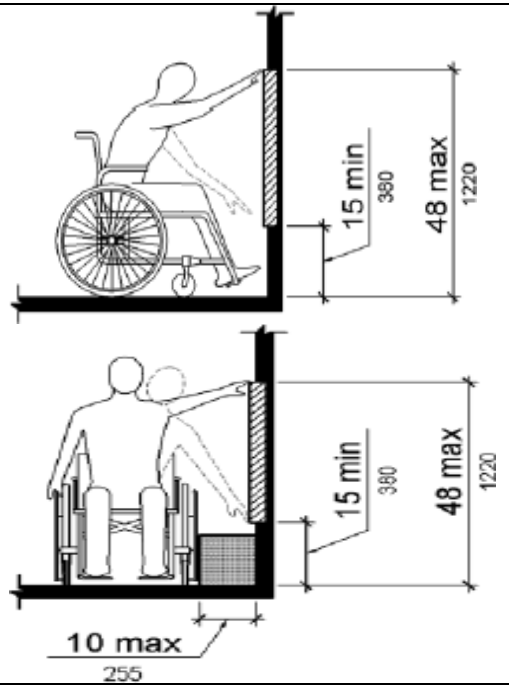
30	Is the interior accessible route well lighted?	A brightly lit corridor will help avoid falls.				
31 (CE)	**If there are stairs on the accessible route, are there handrails on each side?**	**If there are no stairs, check NA.**				
32	If there are stairs, are all stair risers closed that are on the accessible route?					
33	If there are stairs, are all stair treads marked by a stripe providing a clear visual contrast to assist people with visual impairments?	Contrast striping must be provided on the upper approach and lower tread for interior stairs and on the upper approach and all treads for exterior stairs. Stripes must be 2" to 4" wide placed parallel to and no more than 1" from the nose of the step or upper approach. The stripe must extend the full width of the step or upper approach and should be made of material that is at least as slip resistant as the other stair treads (a painted stripe is acceptable).				

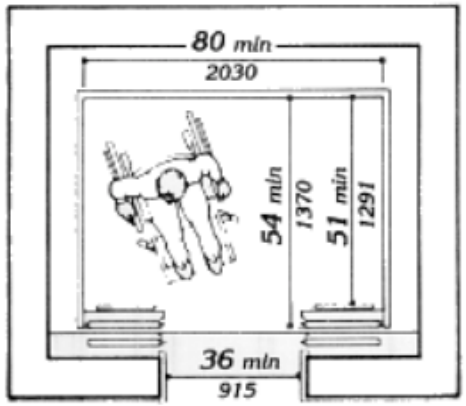
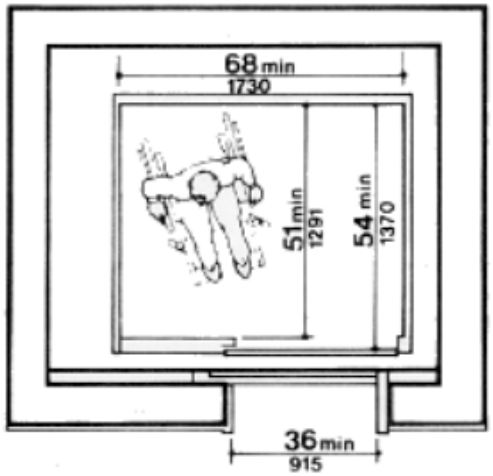
34	Is the path through the facility free of any objects that stick out into the circulation path that a blind person might not detect with a cane?	If an object protrudes more than 4 inches and is located between 27 inches above the walking surface and below 80 inches, a blind person walking with a cane will not detect it.  				
35	If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up?	If floor mats are not in use, check NA. Floor mats that are not secured to the floor can roll up or bunch up under walkers or wheelchair casters and cause a tripping hazard.				
36	Is a section of the sign-in/registration counter no more than 34 inches high and at least 36 inches wide and free of stored items?	 				

37	Does the office have a method, other than a lowered counter, by which people can sign in/register? (If yes, please note this method in comments.)	A medical office may use reasonable alternative methods to meet this need such as a clip board.				
38	Do signs identifying permanent rooms and spaces include raised letters and Braille?					

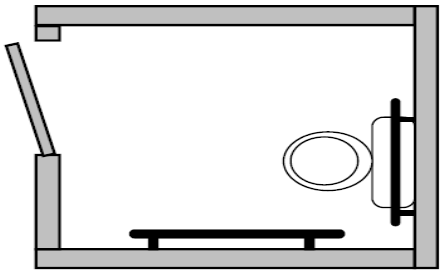
39	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted between 48 inches and 60 inches from the floor.				
40	If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and Participant Areas?	If the building does not have a fire alarm system, check NA. 				

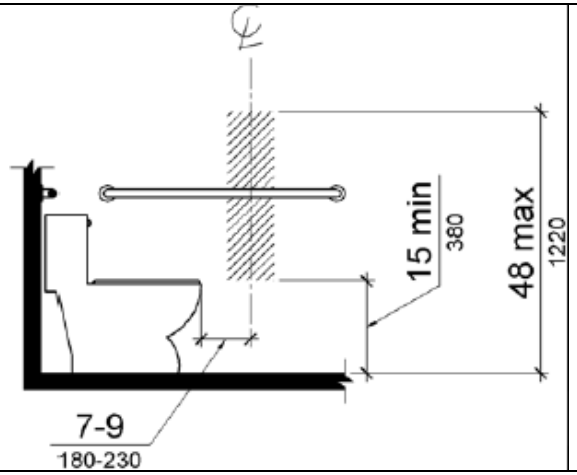
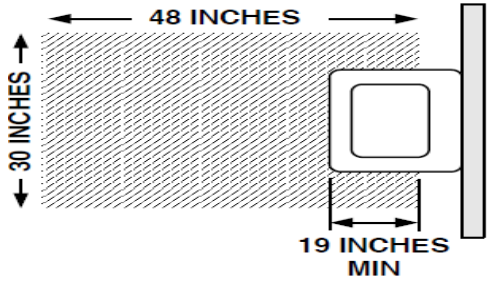
ELEVATORS						
41	Is there an elevator?	Self explanatory.				
42 (CE)	**If needed, is the elevator available for public/patient use during business hours?**	**Self explanatory.**				
43 (CE)	**Is the elevator equipped with both visible and audible door opening/closing and floor indicators?**	**A visible and audible signal is required at each elevator entrance to indicate which car is answering a call. An audible signal would be a "ding" or a verbal announcement.** 				
44 (CE)	**Is there a raised letter and Braille sign on each side of each elevator jamb?**	**These signs allow everyone to know which floor they are on before entering or exiting the elevator.**				

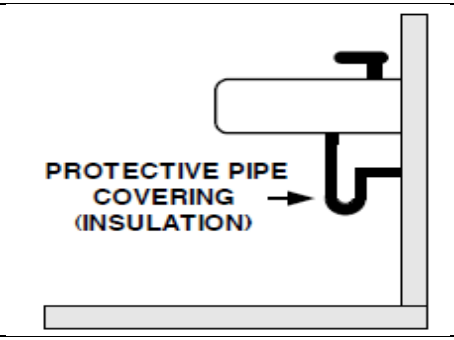
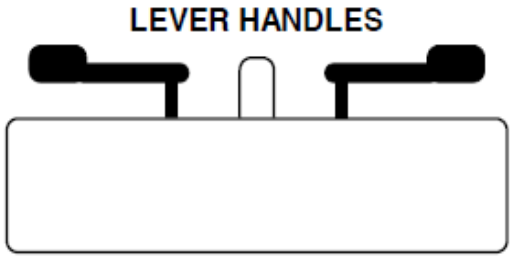
45 (CE)	**Are the hall call buttons for the elevator no higher than 48 inches from the floor?**					

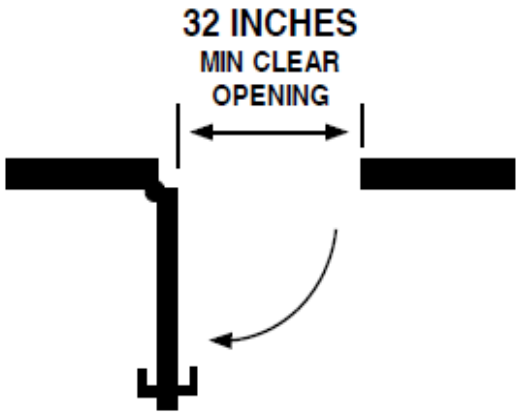
46 (CE)	**Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?**	**The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where the door is located.**  (a)  				
	Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons?	**Self explanatory.**				

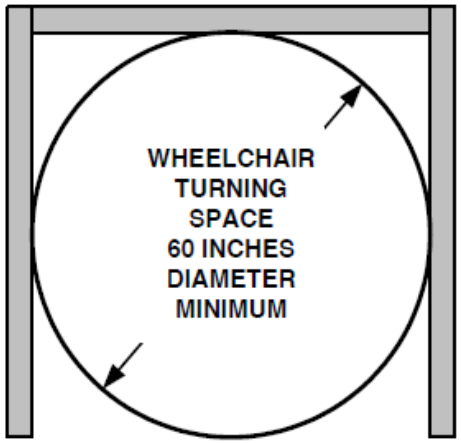
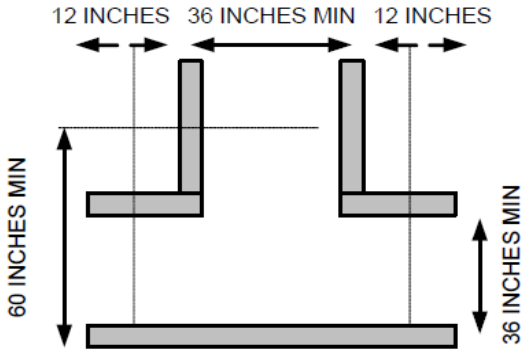
48	Is there an emergency communication system in the elevator?	Self explanatory.				
49	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people with hearing or speech impairments could be jeopardized. Visible signal requirement could be satisfied with something as simple as a button that lights when the message is answered, indicating that help is on the way.				
50	Do raised letters and Braille identify the emergency intercom in the elevator?	Self explanatory.				

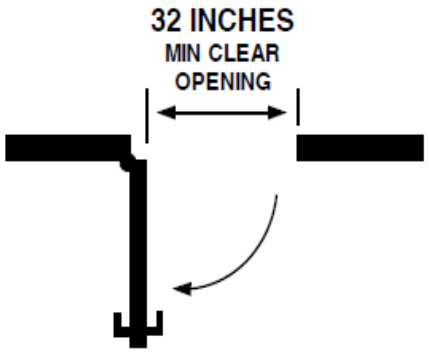
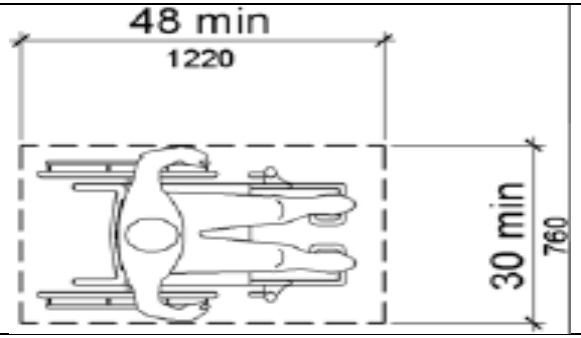
ALL RESTROOMS/TOILET ROOMS (WITH AND WITHOUT STALLS):						
51	Is there an accessible restroom/toilet room?	Self explanatory.				
52	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
53 (CE)	**Are grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?**	**Grab bars should be installed in a horizontal position between 33 and 36 inches above the floor measured to the top of the gripping surface.** 				
54	Are all objects mounted at least 12 inches above and 1½ inches below the grab bars?	This includes seat cover dispensers, toilet paper dispensers, sanitizers, trash containers, etc.				

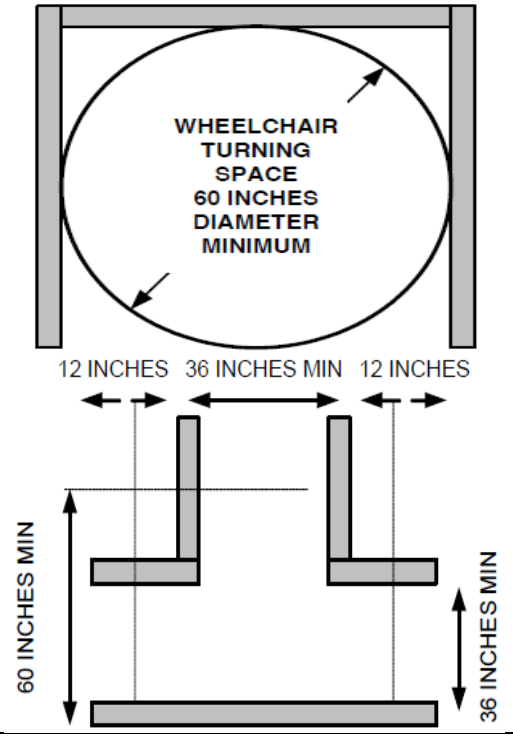
55 (CE)	**Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?**					
56 (CE)	**Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?**	**This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath.** 				
57	Is the space in front of the sink free of trashcans and other movable items?	Self explanatory.				

58	Are the pipes and water supply lines under the sink wrapped with a protective cover?					
59 (CE)	**Are faucet handles operable with one hand and without grasping, pinching, or twisting? (Check Yes if faucets are automatic.)**	**A knob handle would not be accessible.** 				
60	Are all dispensers mounted no higher than 40 inches from the floor?	Included are soap dispensers, paper towel dispensers, seat cover dispensers, hand dryers, etc.				
61	Are all dispensers (soap, paper towel, etc.) operable with one hand and without grasping, pinching, or twisting?	Self explanatory.				

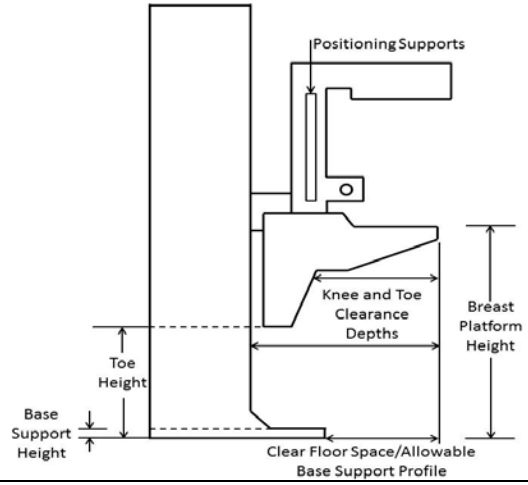
62 (CE)	**Do restroom doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**					
63	Is the space inside the restroom clear, without trashcans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				

64 (CE)	**Is there a 60-inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space inside the restroom to allow a turn around for wheelchair and scooter users?**	 				
65	Can the hardware on the stall door be operated without grasping, pinching, or twisting of the wrist?	Handles, pulls, latches, locks, and other operating devices on accessible doors shall have a shape that is easy to grasp with one hand and does not require tight grasping, tight pinching, or twisting of the wrist to operate.				

PATIENT AREAS (DIAGNOSTIC & TREATMENT, ROOMS)						
	Do doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?					
	Is there space next to the equipment for a wheelchair or scooter user to approach, park, and transfer or be assisted to transfer onto following?					
	a. Equipment (such as PT)?					
	b. Diagnostic apparatus?					
	c. Patient activity areas (such as OT, dining)?					
	d. Infusion (chairs, beds for chemo, dialysis)?					

68	Patient Dressing Rooms are accessible (all bullet points need to be present) • Doorways are at least 32 inches • Turning Radius is 60x60 inches • Seating 17-19 inches from the floor • Grab bars	If there are reasonable alternative for dressing room accommodations, this measure is met.				
69	In the diagnostic/treatment area, is there a 60 inch diameter turning circle or a 60 inch x 60 inch "T" shaped space so that a wheelchair or scooter user can make a 180° turn?					
70 (CE)	**If any diagnostic equipment or treatment tables/chairs are used, is there a patient pre-assessment process (i.e. phone, prior to appointment) to verify that the necessary services can be provided?**	Self explanatory.				

71	Does the Diagnostic Table have a weight limit?	Document weight limit : □ MRI _____ □ CT _____ □ Fluoroscopy_____ □ PET _____ □ Bone Density/Dexascan _____ □ Ultrasound _____ □ Nuclear Medicine_____ □ Xray_____ □ _____ □ _____				
72 (T)	**Is there height adjustable equipment (chairs and tables) that lowers between 17 inches and 19 inches from the floor to the top of the cushion?**	Score each appropriate equipment that do or do not lower 17 to 19 inches from the floor to the top of the cushion:				
	a. MRI					
	b. CT					
	c. Fluoroscopy					
	d. PET					
	e. Bone Density/Dexascan					
	f. Ultrasound					
	g. Nuclear Medicine					
	h. Xray					
	i. Physical Therapy Table					
	j. Dialysis Chair					
	k. Other					
	l. Other					
73 (T)	**Mammography machine can accommodate wheelchair users with knee and foot clearance under the breast plate allowing technologist to take quality**	The top of breast platform needs to go to 26 inches above the floor to accommodate an individual seated in a wheelchair.				

	images.					
74 (T)	**A Mammography chair is available for patients who must be seated.** ***Example:*** *persons with balance difficulties, or cannot stand for any length of time.*	The chair's footrests must accommodate and ride over the base support.				
75	Are transfer and positioning supports available?	Examples include: • Positioning supports while on the equipment as pillows, wedges, strapping, transfer supports Please list elements in comments.				
76 (CE)	**Does staff provide patient transfer assistance on and off of equipment (this includes use of lift equipment when needed).**	**Self Explanatory**				

77 (T)	**Is lift equipment available to assist staff with transfers (portable, overhead, or ceiling mounted)?**	**Self Explanatory**				
78 (CE)	**Is staff trained yearly on safe transfer techniques?**	**Self explanatory**				

WEIGHT MEASUREMENT						
79	Are patients normally weighed at this provider site?	Self explanatory				
80 (T)	**Is a weight scale available that can be used by a wheelchair or scooter user, obese patients whose weight exceeds the weight limits for standard scales, and for patients that cannot step onto a standard scale?**	**Accessible scale platform dimensions-should be a minimum of 32x 36 inches**				
81 (T)	**If there is no accessible scale, are other methods to weigh the patient in place?**	**Examples of other methods to weigh the patient are: weight scales integrated into examination tables, chairs, stretchers, and lifts, or an accessible scale located in a nearby office, within the same building.**				

Community Based Adult Services (CBAS) Physical Accessibility Review Survey

California Department of Health Care Services
Managed Care Quality and Monitoring Division

Provider Name: ☒ CBAS ☐ Other	Date of Review: Name of Reviewer:
Address: City:	Health Plan Name: Partnership HealthPlan of CA
Phone: FAX: (	Contact Person Name:
	Level of Access:
Basic Access: Demonstrates facility site access for the members with disabilities to parking, building, elevator, Participant Areas, and restroom. To meet Basic Access requirements, all (24) Critical Elements (CE) must be met.	☐ Basic Access
Limited Access: Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, participant areas, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.	☐ Limited Access

Below are the symbols that will be used in the provider directories to indicate areas of accessibility at a provider office/site. These should also be used in online directories. In order for a provider office to receive a symbol, the appropriate criteria must be met.

These symbols are in addition to identifying whether the provider office has Basic Access or Limited Access. A provider who has Basic Access will automatically meet the critical elements for the first six symbols (P, EB, IB, R, PA,). And a provider who has Medical Equipment Access will meet the medical equipment elements for the last symbol (T).

Accessibility Indicator	Must Satisfy these Criteria	Yes	No	N/A	Comments
P = PARKING	Critical Elements (CE): 6,7,8				
EB = EXTERIOR BUILDING	(CE): 9,15,16,17,20				
IB = INTERIOR BUILDING	(CE): 23,26,36,37,38,39,40,41				
R=RESTROOM	(CE): 47,49,50,53,56,58				
PA= PARTICIPANT AREAS	(CE): 60,61				

2nd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

Name: _____ Signature: _____ Date: _____

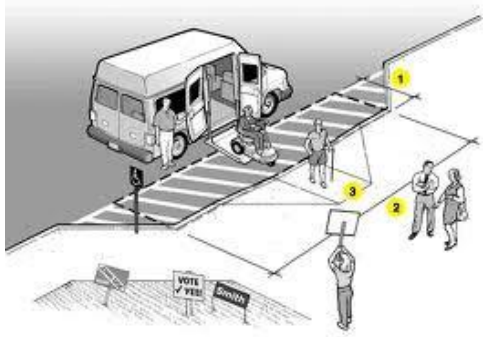
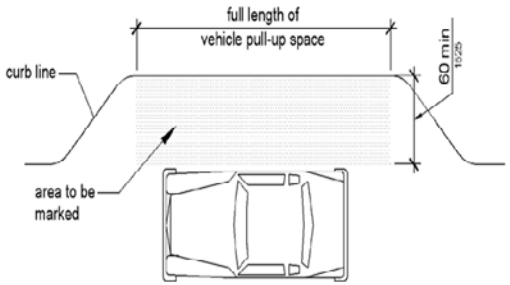
3rd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

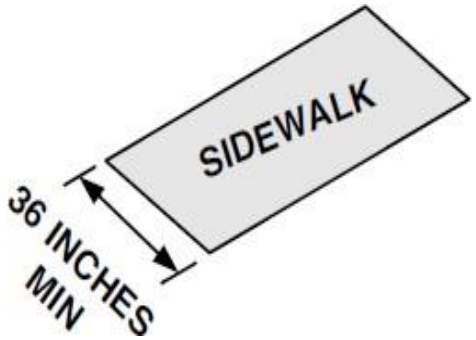
Name: _____ Signature: _____ Date: _____

PARKING						
1	Are accessible parking spaces provided in the designated parking area?	Self explanatory.				
2	Are the correct number of accessible parking spaces provided? 1 to 25 total spaces – 1 required 26 to 50 – 2 required 51 to 75 – 3 required 76 to 100 – 4 required 101 to 150 – 5 required 151 to 200 – 6 required 201 to 300 – 7 required 301 to 400 – 8 required	If there are 25 total parking spaces or less, at least one accessible space is required. If there are between 26 and 50 total spaces, at least two accessible spaces are required, etc.				
3	Is the accessible parking space(s) closest to the main entrance?	The accessible parking space (s) should afford the shortest route of travel from adjacent parking to the accessible entrance.				

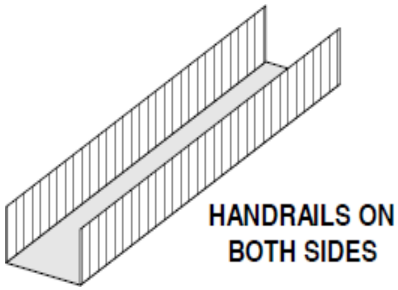
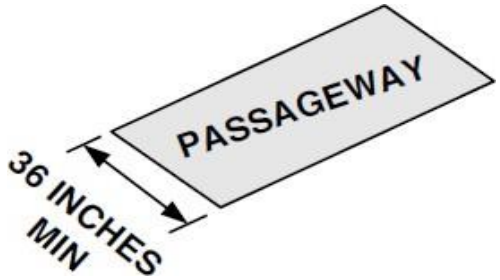
4	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility. 				
5	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle?	Signs must be located so a vehicle parked in the space does not obscure them. (Van accessible spaces must be indicated with an additional sign)				

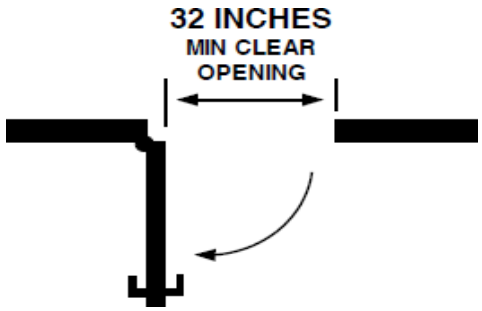
6 (CE)	**Is a passenger loading zone provided with a vehicular pull-up space.**	The vehicular pull-up space dimension is a minimum of 96 inches wide and 20 feet long				

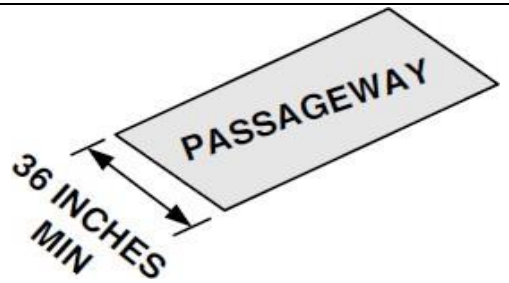
7 (CE)	**Is there an access aisle that adjoins an accessible route and does not overlap the Vehicular way /driveway?**	**Access aisles serving vehicle pull-up *spaces* shall be a minimum of 60 inches wide.**  				
8 (CE)	**Do curbs on the route have curb ramps at the drop off locations?**	**Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street or behind parked cars where drivers cannot see them.**				

EXTERIOR ROUTE (FROM DROP OFF AND PICK UP LOCATIONS TO THE ENTRANCE)						
9 (CE)	**For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)**	**Self explanatory.**				
	a. Public Transportation					
	b. Public sidewalk?					
	c. Drop off?					
10	Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following: (Please mark NA for those that do not apply.)					
	a. Public Transportation					
	b. Public sidewalk?					
	c. Drop off?					
11	Is the accessible route to the	An example of a stable surface is a floor or				

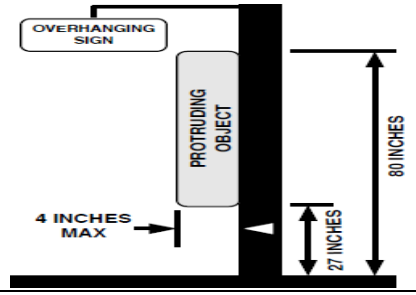
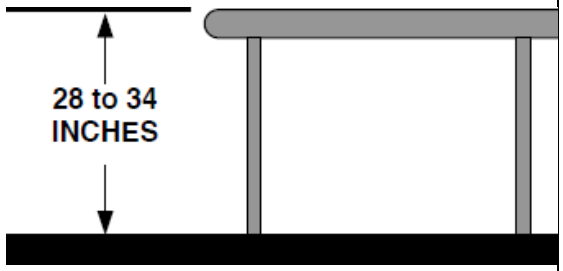
11	building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.)	ground surface without loose elements like gravel or wood chips. Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface. Avoid glossy or slick surfaces such as ceramic tile.				
	a. Public Transportation					
	b. Public sidewalk?					
	c. Drop off?					
12	Is there an accessible route that does not include stairs or steps?	Self explanatory.				
13	Is the route to the entrance from drop off, free of grates, gaps, and openings that are both greater than ½ inch wide and over ¼ inch deep?	Self explanatory.				

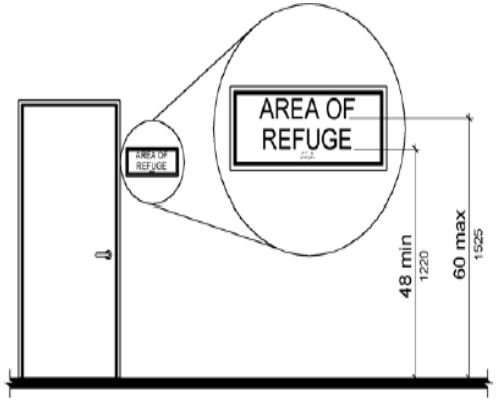
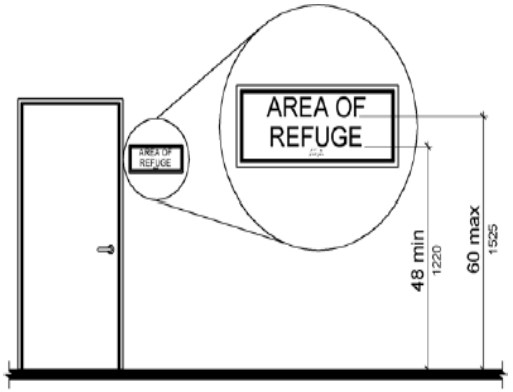
RAMPS:						
14	Is an access ramp present?	If there is more than one ramp, select the one that appears to be the primary access ramp.				
15 (CE)	**Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?**	**If the ramp is not longer than 6 feet, check N/A.**  				
16 (CE)	**Are all ramps at least 36 inches wide?**	 				

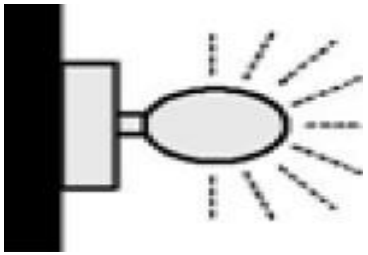
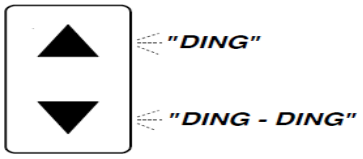
BUILDING ENTRANCE						
17 (CE)	**Is the main entrance accessible?**	**Self explanatory.**				
18	If a main entrance is not accessible, is there another accessible entrance?	Self explanatory.				
19	If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance?					
20 (CE)	**Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°?**	**When measuring double doors, measure the opening with one door open to 90°.** 				

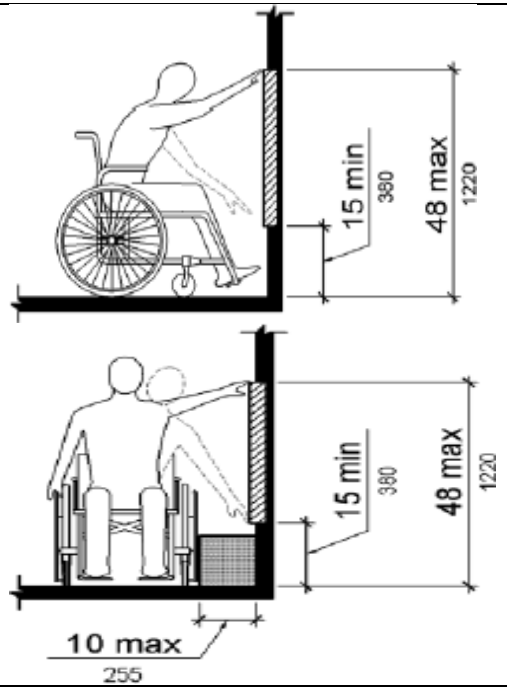
21	Are there automatic doors?	Self explanatory.				
INTERIOR ROUTE (FROM THE BUILDING ENTRANCE, TO THE REGISTRATION COUNTER/WINDOW, AND THROUGH TO THE PARTICIPANT AREAS						
22	Is there an interior route to the participant area?	Some participant areas are accessed directly from the street or drop off rather than being located within a larger building or complex, therefore they do not have interior routes.				
23 (CE)	**Are <u>ALL</u> interior paths of travel at least 36 inches wide?**					
24	Is the interior accessible route stable, firm, and slip resistant?	Avoid unsecured carpeting or other loose elements. It is easier for people using walkers, wheelchairs and other aids to walk or push on surfaces that have low pile carpeting without a pad underneath. Glossy or slick surfaces such as ceramic tile or marble can be slippery.				

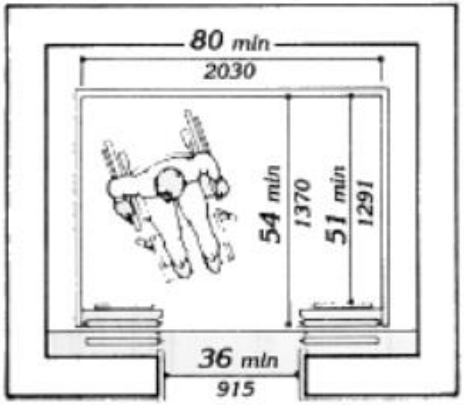
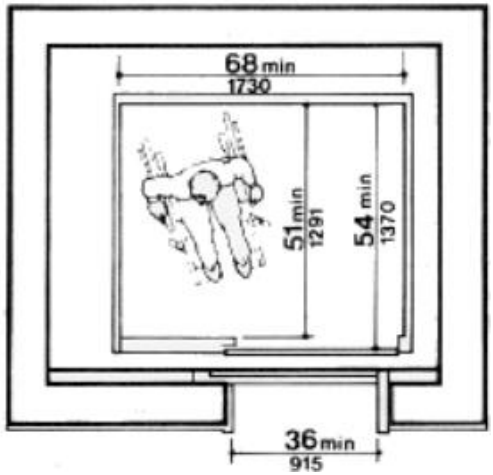
25	Is the interior accessible route well lighted?	A brightly lit corridor will help avoid falls.				
26 (CE)	**If there are stairs on the accessible route, are there handrails on each side?**	**If there are no stairs, check N/A.**				
27	If there are stairs, are all stair risers closed that are on the accessible route?					
28	If there are stairs, are all stair treads marked by a stripe providing a clear visual contrast to assist people with visual impairments?	Contrast striping must be provided on the upper approach and lower tread for interior stairs and on the upper approach and all treads for exterior stairs. Stripes must be 2" to 4" wide placed parallel to and no more than 1" from the nose of the step or upper approach. The stripe must extend the full width of the step or upper approach and should be made of material that is at least as slip resistant as the other stair treads (a painted stripe is acceptable).				

29	Is the path through the facility free of any objects that stick out into the circulation path that a blind person might not detect with a cane?	If an object protrudes more than 4 inches and is located between 27 inches above the walking surface and below 80 inches, a blind person walking with a cane will not detect it.  				
30	If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up?	If floor mats are not in use, check NA. Floor mats that are not secured to the floor can roll up or bunch up under walkers or wheelchair casters and cause a tripping hazard.				
31	Is a section of the sign-in/registration counter no more than 34 inches high and at least 36 inches wide and free of stored items.	 				

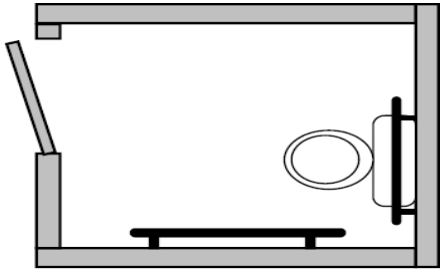
32	Do signs identifying permanent rooms and spaces include raised letters and Braille?					
33	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted between 48 inches and 60 inches from the floor.				

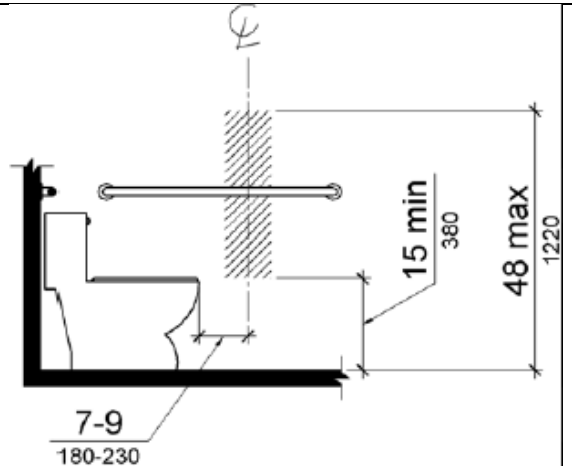
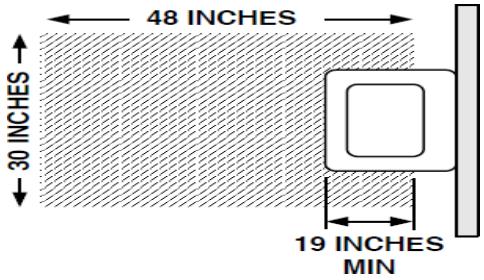
34	If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and Participant Areas?	If the building does not have a fire alarm system, check NA. 				
ELEVATORS						
35	Is there an elevator?					
36 (CE)	**If needed, is the elevator available for public/patient use during business hours?**	**Self explanatory.**				
37 (CE)	**Is the elevator equipped with both visible and audible door opening/closing and floor indicators?**	**A visible and audible signal is required at each elevator entrance to indicate which car is answering a call. An audible signal would be a "ding" or a verbal announcement.** 				

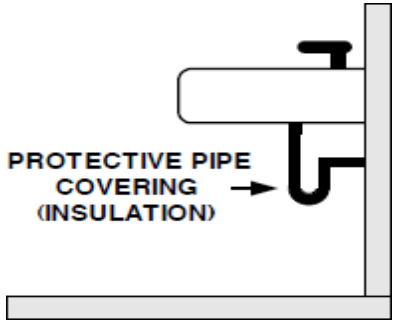
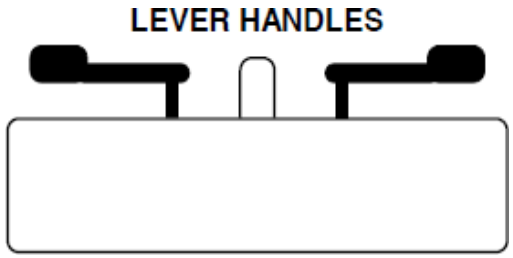
38 (CE)	**Are there raised letter and Braille sign on each side of each elevator jamb?**	**These signs allow everyone to know which floor they are on before entering or exiting the elevator.**				
39 (CE)	**Are the hall call buttons for the elevator no higher than 48 inches from the floor?**					

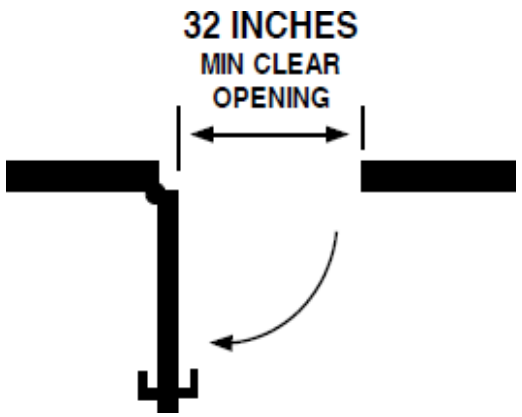
40 (CE)	**Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?**	**The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where the door is located.**  (a)  				
41 (CE)	**Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons?**	**Self explanatory.**				

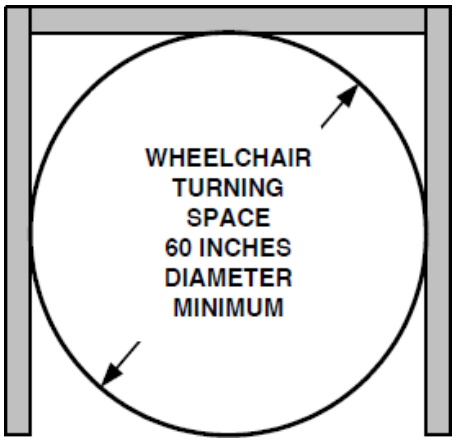
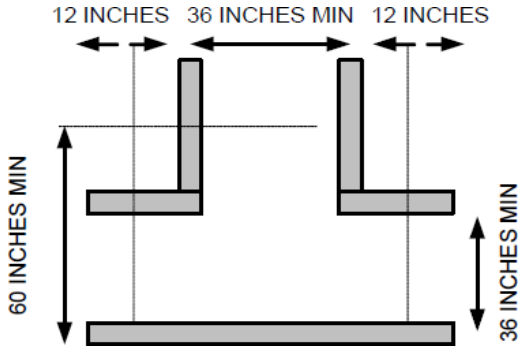
42	Is there an emergency communication system in the elevator?	Self explanatory.				
43	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people with hearing or speech impairments could be jeopardized. Visible signal requirement could be satisfied with something as simple as a button that lights when the message is answered, indicating that help is on the way.				
44	Do raised letters and Braille identify the emergency intercom in the elevator?	Self explanatory.				

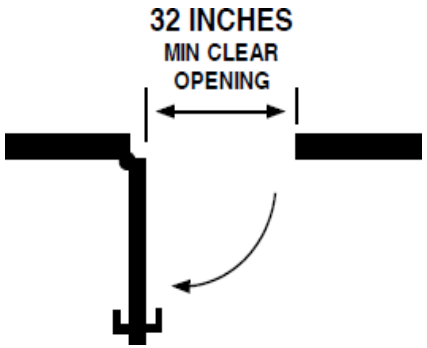
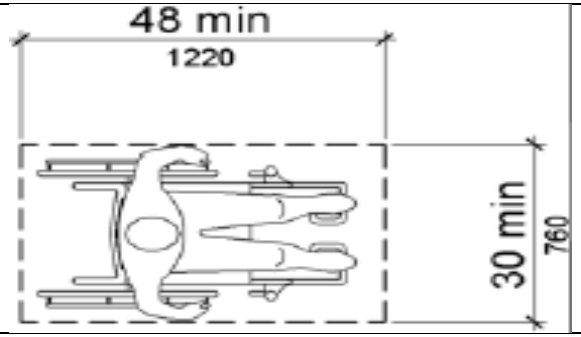
ALL RESTROOMS/TOILET ROOMS (WITH AND WITHOUT STALLS):						
45	Is there an accessible restroom/toilet room?	Self explanatory.				
46	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
47 (CE)	**Are grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?**	**Grab bars should be installed in a horizontal position between 33 and 36 inches above the floor measured to the top of the gripping surface.** 				
48	Are all objects mounted at least 12 inches above and/or 1½ inches below the grab bars?	This includes seat cover dispensers, toilet paper dispensers, sanitizers, trash containers, etc.				

49 (CE)	**Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?**					
50 (CE)	**Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?**	**This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath.** 				
51	Is the space in front of the sink free of trashcans and other movable items?	Self explanatory.				

52	Are the pipes and water supply lines under the sink wrapped with a protective cover?					
53 (CE)	**Are faucet handles operable with one hand and without grasping, pinching, or twisting? (Check Yes if faucets are automatic.)**	**A knob handle would not be accessible.** 				
54	Are all dispensers mounted no higher than 40 inches from the floor?	Included are soap dispensers, paper towel dispensers, seat cover dispensers, hand dryers, etc.				
55	Are all dispensers (soap, paper towel, etc.) operable with one hand and without grasping, pinching, or twisting?	Self explanatory.				

56 (CE)	**Do restroom doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**					
57	Is the space inside the restroom clear, without trashcans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				

58 (CE)	**Is there a 60-inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space inside the restroom to allow a turn around for wheelchair and scooter users?**	 				
59	Can the hardware on the stall door be operated without grasping, pinching, or twisting of the wrist?	Handles, pulls, latches, locks, and other operating devices on accessible doors shall have a shape that is easy to grasp with one hand and does not require tight grasping, tight pinching, or twisting of the wrist to operate.				
PARTICIPANT AREAS (QUIET ROOM/THERAPY ROOM S-PT/OT, ACTIVITY AREA)						

60 (CE)	**Do doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**					
61 (CE)	**There is space in the following areas for a wheelchair or scooter user to approach and park for participation in activities or use of exercise equipment:**					
	a. Quiet room?					
	b. Physical Therapy Room {PT}?					
	c. Occupational Therapy {OT}?					
	d. Activity Area					

62	Is there a bed that is between 17 inches and 19 inches from the floor to the top of the cushion?	Self explanatory				

PARTNERSHIP HEALTHPLAN of CALIFORNIA A Public Agency

2525 Airpark Drive, Redding, California 96002

Date

Site Name
Attn: Contact name, Title
Address
City, State, Zip

RE: Physical Accessibility Review Survey (PARS) FSR Part C

Dear Ms. / Mr. last name of contact,

In compliance with the Department of Health Care Services (DHCS), Medi-Cal Managed Care Division Policy Letter 12-006, Partnership HealthPlan of California (Partnership) has been conducting assessments of our network providers' offices to determine the level of physical accessibility of provider sites, including primary care physician, and specialist and ancillary service providers, that serve a high volume of Seniors and Persons with Disabilities (SPDs).

The information gathered will allow PHC to provide information to assist Partnership members in choosing provider sites that will be able to meet their needs.

The access level below will be denoted in the Partnership Provider Directory and on the Partnership website, as well as the Accessibility Indicators next to your individual information.

Accessibility Levels:

☐ Basic Access	Demonstrates facility site access for the members with disabilities to parking, building, elevator, doctor's office, exam room and restroom. To meet Basic Access requirements, all (29) Critical Elements (CE) must be met.
☐ Limited Access	Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, doctor's office, exam room, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.
☐ Medical Equipment Access	The site has height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patient). This is noted in addition to level of Basic or Limited Access as appropriate.

Accessibility categories: (checked boxes indicate what will be identified in the directory):

- ☐ **P**-Parking and pedestrian walkways
- ☐ **EB-**Exterior entrance to medical office buildings or office complexes
- ☐ **IB**-Interior entrance to medical office buildings or office complexes
- ☐ **R**- Restroom accessibility
- ☐ **E**- Maneuverability and access to waiting rooms and exam/treatment rooms
- ☐ **T***- Adjustable exam table and a weight scale that can accommodate a wheelchair or scooter.

*Please note that this is in addition to the other Accessibility Indicators and will not affect the level of basic accessibility.

A copy of the survey tool was provided to you at the time the site visit was scheduled. Please let us know if you need another copy.

Deficiencies for each category are:

- **P (Parking)**: The guidelines state:
  - There must be at least 1 ADA parking space for every 25 regular spaces.
  - Curbs on the route from off-street public parking must have curb ramps at the parking locations.
  - Curbs on the route from off-street public parking must have curb ramps at the drop off locations
  - There must be at least 1 VAN accessible parking space provided. To qualify, the parking space and access aisle must be at least 92" each or at least a total of 192" overall.
- **EB (Exterior Building):** The guidelines state:
  - If accessible route crosses a curb, there must be a curb ramp provided to the building entrance from: Parking, Public Transpiration, and Public Sidewalk.
  - If ramp is present, each run (leg) of the ramp should be no longer than 30' between landings.
  - If ramp is over 6' long, handrails must be provided on both sides of the ramp and be mounted between 34" and 38" above the ramp surface.
  - Handrails must be at least 36" wide.
  - If the main entrance is not accessible, there must be another accessible entrance.
  - The entrance doors must have a minimum opening of at least 32" when opened at 90 degrees.
  - There must be space available for a wheelchair user to approach, maneuver, and open the door (Pull doors requires a clear space of 60" perpendicular X 18" parallel to the doorway; Push doors require 48" perpendicular to the doorway).
  - Entrance doors must have handles that can be opened without grasping, pinching or twisting the wrist.
- **IB (Interior Building):** The guidelines state:
  - All interior paths of travel must be at least 36" wide.
  - If there are stairs on the accessible route, handrails must be on each side.
  - If a platform lift is used, it must be available without assistance.
  - If there is an elevator, is available for public/patient use during business hours?
  - The elevator equipped with both visible and audible door opening/closing and floor indicators.
  - The elevator must have raised letter and Braille signs on each site of each elevator jamb.
  - The elevator hall call buttons must be no higher than 48" from the floor.
  - The elevator car must be large enough for a wheelchair or scooter user to enter, turn to reach the controls, & exit (Must be 36" wide doorway with: centered doorway-51" long X 80" wide care, side doorway-54" long X 68" wide.

- The buttons on the control panel inside the elevator must have Braille and raised characters/symbols.

- **R (Restroom)**: The guidelines state:
  - Grab bars must be provided, one on the wall behind the toilet and one on the wall next to the toilet (must be mounted in a horizontal position between 33" and 36" above the floor).
  - The toilet paper dispenser must be mounted below the side grab bar with the centerline of dispenser between 7" and 9" in front of the toilet, and at least 15" high.
  - There must be space which is at least 30" wide and 48" deep to allow wheelchair user to park in front of the sink (space must extend at least 17" under the sink from the front edge, although it can extend up to 19" underneath).
  - Faucet handles must be operable with one hand and without grasping, pinching, or twisting.
  - Doorways must have a minimum opening of 32" with the door open at 90 degree.
  - For toilet rooms with stalls, there must be a 60" diameter turning circle or 60" x 60" "t"-shaped space inside the stall to allow a turnaround for wheelchair and scooter users.
- **E (Exam room):**
  - The exam room doorways must have a minimum clear opening of 32" with the door open at 90 degrees.
  - There must be a 60" diameter or a 60" x 60" "t"-shaped space for 180 degree turns.
- **T (Exam Table/Scale):**
  - There must be a height adjustable exam table that lowers to between 17" and 19" from the floor to the top of the cushion.
  - There must be space next to height adjustable exam table for a wheelchair or scooter user to approach, park, and transfer or be assisted to transfer onto the table (30" wide x 48" long).
  - There must be a weight scale available within the medical office with a platform to accommodate a wheelchair or scooter and the patient.

Although these are considered a critical element, corrective action is not required as the assessment is for informational purposes only at this time.

Please contact me if you have any questions.

Thank you for your assistance with the review.

Sincerely,

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Title: MPUG3010 (previously MCUG3010, UG100310)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Chiropractic Services</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 02/21/1995</td><td colspan="4">Next Review Date: ~~08/13/2026~~08/12/2027
Last Review Date: ~~08/13/2025~~08/12/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: ~~08/13/2025~~08/12/2026</td></tr>
</table>

I. RELATED POLICIES:

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

II. IMPACTED DEPTS:

A. Health Services
B. Member Services
C. Claims

III. DEFINITIONS:

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

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. Coverage criteria apply on implementation of D-SNP, effective January 1, 2028 and subject to CMS and DHCS approval.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

This guideline describes the conditions under which chiropractic services are a covered benefit.

VI. GUIDELINE / PROCEDURE:

A. Chiropractic services are a Partnership HealthPlan of California benefit for members who meet medical

necessity guidelines.

1. For Partnership Medi-Cal Members: Refer to the Medi-Cal Provider Manual/ Guidelines section on Chiropractic Services (*chiro*).
2. For Partnership Advantage Enrollees~~Members~~: Refer to the Medicare Benefit Policy Manual 100-02 Chapter 15, Section 30.5 and Section 240.

B. Authorizations

1. Members age 21 and over who are capitated or assigned to a primary care provider (PCP) require a referral authorization form (RAF) from their PCP for chiropractic services.
   a. No Treatment Authorization Request (TAR) is required for up to 2 visits per month. Additional monthly visits require prior authorization with justification of medical necessity.
   b. For Partnership Advantage Members, procedures, or Current Procedural Terminology (CPT) codes submitted by a licensed Chiropractor which relate to manual manipulation of the spine to correct a spinal subluxation, will be reimbursed at the Medicare rate. Other CPT billing codes submitted by a Chiropractor listed in the Medi-Cal Provider Manual/ Guidelines section on Chiropractic Services, will be reimbursed at the Medi-Cal rate.
2. Members under age 21 require prior authorization with justification of medical necessity for chiropractic services. A TAR must be submitted and EPSDT criteria will be considered when evaluating the request.
3. Except as noted in VI.B.4. below, only Partnership-credentialed and Partnership-contracted chiropractors will be paid for chiropractic services.
4. Chiropractic services provided by Indian Health Services (IHS) providers to American Indian/Alaskan native members, irrespective of contracting or in-network status, are reimbursable consistent with the Department of Health Care Services (DHCS) fee-for-service provider manual.
5. Initial assessments without spinal manipulation may be billed using CPT code 99202. Chiropractic service CPT codes 98940 through 98942 may be used for chiropractic services as noted:
   a. 98940: Chiropractic Manipulative Treatment (CMT); spinal, one or two regions
   b. 98941: Spinal, three to four regions
   c. 98942: Spinal, five regions
6. Therapeutic modalities (such as massage, ice/cold packs, education, ultrasound) performed with chiropractic manipulation are not billable separately; the chiropractic service codes are considered bundled payments that include all associated adjunctive therapies performed by the chiropractor.
7. Note that code 98943: CMT, extraspinal, one or more regions, is not covered by Medi-Cal, Medicare or Partnership.

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines: Chiropractic Services *(chiro)*
B. Title 22 California Code of Regulations (CCR) Sections 51304a, 51308
C. Title 42 US Code Section 1396(a)(43) and 1396d(r)
D. DHCS FFS Provider Manual – Chiropractic Services
E. DHCS FFS Provider Manual – Tribal Federally Qualified Health Centers (Tribal FQHCs)
F. Welfare and Institutions (W&I) Code Section 14131.10(b)(1)(C)
G. Medicare Benefit Policy Manual 100-02 Chapter 15, Section 30.5 and Section 240.

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

Guideline/Procedure Number: MPUG3010 (previously MCUG3010, UG100310)			**Lead Department: Health Services** **Business Unit: Utilization Management**
Guideline/Procedure Title: Chiropractic Services			☒ **External Policy** ☐ **Internal Policy**
Original Date: 02/21/1995		**Next Review Date:** ~~08/13/2026~~08/12/2027 **Last Review Date:** ~~08/13/2025~~08/12/2026	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

X. **REVISION DATES:** 3/28/95, 4/28/00; 9/19/01; 10/16/02; 9/15/04; 9/21/05; 10/17/07; 10/15/08; 1/18/12; 5/21/14; 9/17/14; 02/18/15; 05/20/15; 05/18/16; 06/21/17; *08/08/18; 08/14/19; 02/12/20; 11/11/20; 10/13/21; 05/11/22; 04/12/23; 04/10/24; 09/11/24; (MPUG3010) 08/13/25; 08/12/26

*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

Policy/Procedure Number: MPUP3111 (Previously MCUP3111)				**Lead Department: Health Services** **Business Unit:** Utilization Management	
Policy/Procedure Title: Pulmonary Rehabilitation				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 10/20/2010 **Effective Date:** 01/01/2011			**Next Review Date:** ~~08/13/2026~~08/12/2027 **Last Review Date:** ~~08/13/2025~~08/12/2026		
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:** ~~08/13/2025~~08/12/2026	

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3104 – Transplant Authorization Process
C. MCUP3113 – Telehealth Services

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. 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. Coverage criteria apply on implementation of D-SNP, effective January 1, 2028 and subject to CMS and DHCS approval.

B. Pulmonary Rehabilitation: a multi-disciplinary program of care for patients with chronic respiratory impairment that is individually tailored and designed to optimize physical and social performance and autonomy and an evidence-based, multidisciplinary, and comprehensive intervention for patients with chronic respiratory diseases who are symptomatic and often have decreased daily life activities.

IV. ATTACHMENTS:

A. Pulmonary Rehabilitation Questionnaire

V. PURPOSE:

To define covered services and medical necessity criteria for pulmonary rehabilitation.

VI. POLICY / PROCEDURE:

A. This policy addresses indications for the use of pulmonary rehabilitation and its conditions, as well as the process for coverage for Partnership Medi-Cal Members and Partnership Advantage ~~Members~~enrollees.

~~A. Medicare National Coverage Determinations apply only to Partnership Advantage enrollees and do not determine Medi-Cal coverage.~~

B. All requests for pulmonary rehabilitation require prior authorization. The provider must submit a treatment authorization request (TAR) for consideration.

C. The following codes may be used when applicable for TAR and claim submissions for pulmonary rehabilitation delivered to a Partnership Medi-Cal Member in an outpatient or virtual setting, or to a Partnership Advantage Member in a physician's office or a hospital outpatient setting:
   1. G0237 – Pulmonary Therapeutic Procedure to Build Strength and Endurance
   2. G0238 – Pulmonary Rehab 1:1
   3. G0239 – Pulmonary Rehab Group Training
   4. 93041 – ECG Monitoring
   5. 94625 – Physician or other qualified health care professional* services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring [session]
      a. The modifier -95 is added for telehealth provided services.
   6. 94626 - Physician or other qualified health care professional* services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring [per session]
      ~~b.~~a. The modifier -95 is added for telehealth provided services.

      ~~**Telehealth services must comply with applicable DHCS Medi-Cal or CMS telehealth coverage and billing requirements.**~~

      **Provider types who can bill for these services include physicians (doctor of medicine and doctor of osteopathic medicine), physician assistants, nurse practitioners and physical therapists. The ICD-10-CM diagnosis code on the claim must be one of the following: J41.0 thru J41.8, J43.0 thru J43.9, J44.9, U07.1, Z76.82 or Z94.2. Telehealth services must comply with applicable DHCS Medi-Cal or CMS telehealth coverage and billing requirements.*

D. Partnership Advantage Criteria (Effective January 1, 2028):
   1. Partnership Advantage covers pulmonary rehabilitation for ~~Members~~ enrollees with:
      a. Moderate to very severe COPD (defined as GOLD classification II, III and IV), when referred by the physician treating the chronic respiratory disease;
      b. Confirmed or suspected COVID-19 and experiencing persistent symptoms that include respiratory dysfunction for at least four weeks.~~;~~
   2. D-SNP Medicare ~~National Coverage Determinations~~regulations ~~apply only~~applicable to the Partnership Advantage program are applied only to Partnership Advantage enrollees and do not determine Medi-Cal coverage.
   3. For pulmonary rehabilitation to be covered for Partnership Advantage ~~Members~~enrollees, the program must include the following components:
      a. Physician-prescribed exercise during each pulmonary rehabilitation session
      b. Education or training that is closely and clearly related to the individual's care and treatment which is tailored to the individual's needs and assists in achievement of goals toward independence in activities of daily living, adaptation to limitations and improved quality of life.
         1) Education must include information on respiratory problem management and, if appropriate, brief smoking cessation counseling.
      c. A psychosocial assessment.
      d. An outcomes assessment.
      e. An individualized treatment plan detailing how components are utilized for each patient. The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.
      f. A physician or nonphysician practitioner immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under the program. This provision is satisfied if the physician or nonphysician practitioner meets the requirements for direct supervision for physician office services, which may include virtual presence through audio/video real-time communications.

g. The necessary cardio-pulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary (for example, oxygen, cardiopulmonary resuscitation equipment, and defibrillator) to treat chronic respiratory disease.

E. Medi-Cal Coverage Criteria:

1. Partnership Medi-Cal covers pulmonary rehabilitation for Members who have a diagnosis listed in E.1.a. or E.1.b.~~2~~ below or who meet the criteria listed in E.1~~3~~.c. A completed Pulmonary Rehabilitation Questionnaire (Attachment A) must be submitted with the TAR.
   a. Chronic pulmonary conditions eligible for pulmonary rehabilitation include the following:
      1) Chronic Obstructive Pulmonary Disease (COPD) – chronic bronchitis or emphysema
      2) Interstitial lung disease or idiopathic pulmonary fibrosis
      3) Alpha-1-antitrypsin deficiency
      4) Asbestosis
      5) Asthma
      6) Bronchiectasis
      7) Chronic airflow obstruction
      8) Cystic fibrosis
      9) Fibrosing alveolitis
      10) Lung Reduction Surgery
      11) Pneumoconiosis
      12) Pulmonary alveolar proteinosis
      13) Pulmonary hemosiderosis
      14) Radiation pneumonitis
   b. Other chronic conditions affecting pulmonary function which may be eligible for pulmonary rehabilitation include:
      1) Ankylosing spondylitis
      2) Bronchopulmonary dysplasia
      3) Guillain-Barre syndrome or other infective polyneuritis
      4) Lung cancer
      5) Muscular dystrophy
      6) Myasthenia gravis
      7) Pulmonary Arterial Hypertension (PAH)
      8) Paralysis of the diaphragm
      9) Sarcoidosis
      10) Scoliosis
   c. A Member will also qualify for pulmonary rehabilitation if they meet the criteria detailed in Attachment A and have at least moderate functional pulmonary disability, with appropriate medical management, as demonstrated by one of the following within 12 months prior to the TAR ~~-~~(unless there are special considerations as noted in Section VI.F):
      1) Obstructive disorders: Moderate to very severe COPD (defined as GOLD classification II, III, IV)
      ~~1)~~2)Restrictive/fibrotic disorders FEV1, FVC, TLC, or DLCO less than 60% of predicted
      ~~2)~~3)Either: A maximal pulmonary exercise stress test under optimal bronchodilatory treatment, as indicated, that demonstrates limitation to exercise with a maximal oxygen uptake (VO2max) equal to or less than 20ml/kg/min, or about 5 metabolic equivalents (METS)
2. Special Considerations: The following conditions may also be considered for pulmonary rehabilitation although the patient will not necessarily meet the same criteria stated above in VI.~~D.~~ E.1.

a. Members eligible for lung transplantation are eligible for pulmonary rehabilitation without demonstration of chronic lung disorders or dysfunction beginning at the time the Member is approved for a transplant by Partnership and continuing for six weeks after transplantation. For further transplant information, please review policy MCUP3104 Transplant Authorization Process.

b. Members with post-COVID-19 pulmonary sequelae may also be eligible for pulmonary rehabilitation without demonstration of chronic lung disorders or dysfunction.

F. Limits on Coverage:

1. Partnership Medi-Cal Members and Partnership Advantage ~~Members~~ enrollees who meet the criteria will initially be approved up to a maximum of 36 one--hour sessions. Additional visits can be requested with evidence of compliance with therapy, combined with improvement of function during pulmonary rehabilitation.
   a. Medi-Cal generally limits pulmonary rehabilitation to up to 72 lifetime sessions when medically necessary. ~~has a lifetime limit of 72 sessions of pulmonary rehabilitation, if medically necessary.~~

VII. REFERENCES:

A. American Thoracic Society Documents: Pulmonary Rehabilitation for Adults with Chronic Respiratory Disease. AJRCCM, Vol 208, No.4, Apr 15, 2023 https://doi.org/10.1164/rccm.202306-1066ST

B. Medi-Cal Provider Manual/ Guidelines: Respiratory Care (*respir*)

C. American Lung Association Public Policy Position on Lung Health: https://www.lung.org/policy-advocacy/public-policy-positions/public-policy-position-lung-health

D. Rehabilitation Interventions for Post-Acute COVID-19 Syndrome: A Systematic Review Int J Environ Res Public Health. 2022 Apr 24;19(9):5185. DOI: 10.3390/ijerph19095185

E. Lin JS, Webber EM, Thomas RG. Screening for Chronic Obstructive Pulmonary Disease: A Targeted Evidence Update for the U.S. Preventive Services Task Force [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2022 May. (Evidence Synthesis, No. 215.) Table 1, Classification of COPD as Defined by Global Initiative for Chronic Obstructive Lung Disease (GOLD) Available from: https://www.ncbi.nlm.nih.gov/books/NBK580644/table/ch1.tab1/

~~E.~~F. Global Initiative for Chronic Obstructive Lung Disease 2026 Report

~~F.~~G. Medicare National Coverage Determinations (NCD) Manual 100-03: Chapter 1, Part 4, Section 240.8 Pulmonary Rehabilitation Services. Implementation date 01/07/2008 or any subsequent updates published by CMS.

~~G.~~H. Title 42 Code of Federal Regulations (CFR) Section § 410.26 Services and supplies incident to a physician's professional services: Conditions.

~~H.~~I. 42 CFR § 410.47 Pulmonary rehabilitation program: Conditions for coverage.

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~~7~~)
08/13/25; 08/12/26

Medi-Cal
Partnership Enhanced Benefit approved by Board Resolution number 10.5, dated January 26, 2011.
DHCS added Pulmonary Rehabilitation as a benefit in 2018.

03/21/12; 02/18/15; 02/17/16; 02/15/17; *03/14/18; 11/13/19; 10/14/20; 10/13/21; 08/10/22; 09/13/23; 09/11/24; 08/13/25; 08/12/26

*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:
PartnershipAdvantage:
MPUP3111 - 10/20/2010 to 01/01/2015

****

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

Pulmonary Rehabilitation Questionnaire

Patient's Name: _____ Date: _____

M or F Weight: _____ Height: _____ Age: _____ DOB: _____

Pulmonary Function Testing (PFT) results must be submitted with TAR.

Note: Members with special considerations for pulmonary rehabilitation (patients eligible for lung transplant or those with Post-COVID-19 sequelae) are not required to submit PFT results (4.a. – c. below) but must otherwise complete and submit this form with the TAR.

MEMBER'S DIAGNOSIS:

Member must meet ALL of the following criteria:

	YES	NO
1. Reduction in exercise tolerance that restricts the ability to perform activities of daily living	☐	☐
2. Symptoms that persist despite appropriate medical management	☐	☐
3. No longer smoking or vaping any products (including marijuana) or at least actively quitting by evidence of use of a cessation protocol	☐	☐
4. Have at least moderate functional pulmonary disability, with appropriate medical management, as demonstrated by one of the following:		
a. Obstructive disorders: Pulmonary function tests showing FEV1/FVC less than 70%	☐	☐
b. Restrictive/fibrotic disorders FEV1, FVC, TLC, or DLCO less than 60% of predicted	☐	☐
c. Either: A maximal pulmonary exercise stress test under optimal bronchodilatory treatment, as indicated, that demonstrates limitation to exercise with a maximal oxygen uptake (VO2max) equal to or less than 20ml/kg/min, or about 5 metabolic equivalents (METS)	☐	☐
9. The member is physically able, motivated and willing to participate and is a candidate for self-care post-program.	☐	☐
10. The member does not have any concomitant medical conditions that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g. symptomatic coronary artery disease, CHF, recent (6 months) myocardial infarction, dysrhythmia, active joint disease, claudication, malignancy).	☐	☐
11. Member has had no pulmonary exacerbation within the past four weeks.	☐	☐

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPUP3139 (previously MCUP3139)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Criteria and Guidelines for Utilization Management</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 08/12/2020</td><td colspan="4">Next Review Date: ~~08/13/2026~~08/12/2027
Last Review Date: ~~08/13/2025~~08/12/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td colspan="3">☒ Medi-Cal</td><td>☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="3">☐ P & T</td><td>☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~08/13/2025~~08/12/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MPQP1002 – Quality/ Utilization Advisory Committee
B. MPRP4001 – Pharmacy & Therapeutics (P&T) Committee

II. IMPACTED DEPTS:

A. Health Services
B. Compliance
C. Provider Relations

III. DEFINITIONS:

A. 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. Coverage criteria apply on implementation of D-SNP, effective January 1, 2028 and subject to CMS and DHCS approval.
B. Standard of Care: The level and type of care that a reasonably competent and skilled health care professional, with a similar background and in the same medical community, would provide under the same circumstance.

IV. ATTACHMENTS:

A. Table of Approved Criteria and Guidelines Referenced for Utilization Management

V. PURPOSE:

To establish an approved list of Utilization Management criteria and guidelines for reviewing Treatment Authorization Requests (TARs) and hospitalizations. (Note: The process for review and approval of criteria for pharmacy services can be found in policy MPRP4001 Pharmacy & Therapeutics [P&T] Committee.)

VI. POLICY / PROCEDURE:

A. Partnership HealthPlan of California ~~(Partnership)~~ is responsible for reviewing requests for services submitted by network providers. A key element of these reviews is the use of specific criteria and guidelines to assist in determining the medical necessity and clinical appropriateness of services

requiring approval. When making decisions to approve, modify or deny service authorization requests, Partnership uses . ~~It is important that the~~ criteria and guidelines ~~used in this process be~~ that are known, ~~and~~ accessible and reflective of well-accepted standards of care. This policy will establish the process of Criteria and Guideline review and approval for use by the Partnership network of providers. All decisions are made in accordance with federal or state medical necessity requirements

B. Process of Review and Approval:
   1. On an annual basis, the Quality/ Utilization Advisory Committee (Q/UAC) will review a list of criteria and guidelines to be used by Partnership Utilization Management staff and Partnership medical directors in performing reviews of treatment authorization requests (TARs).
      a. This list will be evaluated during the Chief Medical Officer (CMO)/Medical Director (MD) meeting the month prior to presentation to Q/UAC.
      b. To be included in this list, a criteria set or guideline must be developed by a nationally recognized entity or a Partnership policy that has been approved through the standard committee process.
      c. These guidelines and criteria sets should be utilized by managed care organizations throughout the country or region. (This would mean that the criteria and guidelines reflect the generally accepted standard of care.)
      d. Guidelines and criteria sets should be supported by clinical literature and peer review.
      e. A specific guideline or criteria can be submitted for potential inclusion in the approved list by any provider within the Partnership network or by Partnership staff.
         1) This recommendation will be submitted to the Office of the CMO.
         2) The CMO will assign the suggested criteria or guideline to a specific medical director for evaluation. This medical director will present the review at the next CMO/MD meeting.
         3) After the medical directors have completed their evaluation of the guideline or criteria set, they will decide to either forward the document to Q/UAC with a recommendation for approval, or decide that the guideline or criteria should not be used by Partnership for performing reviews.
   2. Hierarchy of Guidelines and Criteria Sets:
      a. The guidelines and criteria can be grouped into the following groups:
         1) Required standards as set forth by the State of California (Department of Health Care Services [DHCS] or other agencies) where Partnership is contractually and legally obligated to follow the guidelines.
         2) Required Medicare standards as set forth by the Centers for Medicare & Medicaid Services (CMS) when applicable.
            a) For Partnership Advantage Members: TARs are reviewed according to Section 40 of the CMS Medicare guidance for Part C & D Organization/ Coverage Determinations. The hierarchy of guidelines and criteria sets is as follows:
               i. Medicare National Coverage Determination (NCD) policy
                  a. NCDs are applicable nationwide in the US to specify the Medicare coverage of certain services.
               ii. Medicare Local Coverage Determination (LCD) policy
                  a. In the absence of an NCD policy, an item or service may be covered based on an LCD. An LCD is a determination by a region-specific Medicare Administrative Contractor (MAC) whether to cover a particular service on a MAC-wide basis. (*When both NCD and LCD guidance exist, an LCD should never contradict NCD guidance but may be used for supplemental information.*)
               iii. Partnership internal coverage criteria and evidence-based medical literature as described in this policy where no NCD or LCD is available.

3) Industry accepted guidelines that are used by a variety of other managed care organizations (e.g. InterQual® and National Comprehensive Cancer Network [NCCN]).
4) Guidelines developed through government agencies (e.g. Center for Disease Control [CDC] or Agency for Healthcare Research and Quality [AHRQ]).
5) Policies developed by Partnership.

b. There should be few circumstances where these groups of guidelines conflict. ~~In situations where there is a conflict~~If they do, Partnership shall follow the guidelines required by the highest applicable legal or regulatory authority, and, when consistent with requirements, the use of the guidelines ~~should favor~~will prioritize ~~the~~ ~~patient~~Member's health and safety. ~~first.~~

c. The guidelines that are required by statute or contract ~~should~~ shall be followed at all times, as long as the patient's safety is not compromised.

d. Partnership policies should be followed as long as there is no conflict with legally required or contractually required services.

C. See Attachment A for Table of Approved Criteria and Guidelines Referenced for Utilization Management.

VII. REFERENCES:

A. National Committee for Quality Assurance (NCQA) Guidelines ~~(Effective July 1, 2025)~~ UM 2 Clinical Criteria for UM Decisions Elements A
B. Contractual obligations with the Department of Health Care Services (DHCS)
C. Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Section 40 Coverage Determinations, Organization Determinations (Initial Determinations) and At-Risk Determinations (11/18/2024)

VIII. DISTRIBUTION:

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 202~~87~~)
08/13/2025; 08/12/26

Medi-Cal
08/11/21; 08/10/22; 08/09/23; 08/14/24; 08/13/25; 08/12/26

PREVIOUSLY APPLIED TO:
MCUP3139 (08/12/2020 – 08/12/2025)

APPROVED CRITERIA AND GUIDELINES REFERENCED FOR UTILIZATION MANAGEMENT

Criteria/ Guideline	Citation Style for Policy Reference	Abbreviation
Medi-Cal Provider Manual / Guidelines	Medi-Cal Guidelines then subsection used and abbreviation *Example:* Medi-Cal Guidelines Pathology: Molecular Pathology (*path molec*)	_ _
Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance	As applicable for Partnership Advantage Members: Medicare Manual title, subsection used (Date) *with hyperlink* *Medicare Manual Example:* Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Section 40 Coverage Determinations, Organization Determinations (Initial Determinations) and At-Risk Determinations (11/18/2024) *NCD Example*: Medicare National Coverage Determinations (NCD) Manual 100-03: Chapter 1, Part 4, Section 280.14 Infusion Pumps. Implementation date 02/18/2005 or any subsequent updates published by CMS. *LCD Example:* Medicare Local Coverage Determination (LCD) L33794 External Infusion Pumps Revision Effective Date 10/01/2024 or any subsequent updates published by CMS.	CMS NCD LCD
InterQual® Criteria	InterQual® Criteria including version year and then subset used *Example*: InterQual® 2024 DME Criteria – Insulin Pump, Ambulatory	IQ
All Plan Letters from DHCS	Department of Health Care Services (DHCS) All Plan Letter (APL) (2 digit year)-(number) Title (Date) *with hyperlink* *Example:* Department of Health Care Services (DHCS) All Plan Letter (APL) 22-005 No Wrong Door for Mental Health Services Policy (03/30/2022)	APL (xx)-(xxx)
CCS Numbered Letters	California Children's Services (CCS) Numbered Letter (NL) (2 digit year)-(number) Title (Date) *with hyperlink* *Example:* California Children's Services (CCS) Numbered Letter (NL) 09-0514 Powered Mobility Devices (PMD) (05/29/2014)	CCS NL (xx)-(xxxx)
Agency for Healthcare Research and Quality	Agency for Healthcare Research and Quality: then guideline used *with hyperlink*	AHRQ
Centers for Disease Control and Prevention	Centers for Disease Control and Prevention (CDC): then guideline or article used *with hyperlink* *Example:* Centers for Disease Control and Prevention (CDC): Epigenetics, Health, and Disease	CDC
National Comprehensive Cancer Network	National Comprehensive Cancer Network (NCCN): then guideline used *with hyperlink* *Example*: National Comprehensive Cancer Network (NCCN): NCCN Guidelines for Treatment of Cancer by Site	NCCN

Criteria/ Guideline	Citation Style for Policy Reference	Abbreviation
United States Preventive Services Taskforce	United States Preventive Services Taskforce (USPSTF) guidelines: then guideline used *with hyperlink* *Example*: United States Preventive Services Taskforce (USPSTF): Cervical Cancer: Screening	USPSTF
Up-To-Date	UpToDate: Author(s), Article Title, publishing date *with hyperlink* or UpToDate: Search Term or Title of Article *Example:* UpToDate: D. Kline, Lewis R. MD et al. Clinical Presentation and Diagnosis of OSA in Adults; published online 9 August 2019. or UpToDate: Obstructive Sleep Apnea	UTD
Cochrane Reviews	Cite specific journal article located through Cochrane Reviews: Author(s), Article Title *with hyperlink*, Cochrane Database of Systematic Reviews, publishing date, DOI, Date Accessed. or Cochrane Reviews: Search Term or Title of Article *Example:* Reis S, Metzendorf M-I, Kuehn R, Popp M, Gagyor I, Kranke P, Meybohm P, Skoetz N, Weibel S. Nirmatrelvir combined with ritonavir for preventing and treating COVID-19. Cochrane Database of Systematic Reviews 2023, Issue 11. Art. No.: CD015395. DOI: 10.1002/14651858.CD015395.pub3. Accessed 15 May 2026. or Cochrane Reviews: Cochrane COVID-19 publications	CR
OpenEvidence	Cite specific journal article located through OpenEvidence	
Other government or specialty society guidelines as noted in Partnership policies	Varies	– –

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Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the June 17, 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: Population Health – *Presenter: Christine Smith, Community Health Needs Liaison, Pop Health*			
MPNP9007 – Lactation Policy and Guidelines *(formerly Breastfeeding Guidelines)*	197 – 205	**I. Related Policies**: Updated policy code ("MC to MP") for relevant policies, updated reference to MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program. **III.D Definitions:** Updated Partnership Advantage (D-SNP) effective date to 1/1/2028; Updated Partnership Advantage "members" to "enrollees." Also added that coverage criteria apply upon implementation, subject to CMS and DHCS approval. **V.A Purpose**: Added language clarifying lactation services and supplies covered preventive services provided without cost sharing **VI.E Policy/Procedure:** Added requirement for culturally and linguistically appropriate delivery of lactation services, aligned with California Advancing and Innovating Medi-Cal (CalAIM) and DHCS health equity standards; included reference to MPND9002 **VI.I.1B Policy/Procedure:** Clarified Electronic Visit Verification (EVV) applies only to home-based lactation services; excluded facility/office settings **VI.I. Policy/Procedure:** Added language recognizing doulas as Medi-Cal providers for lactation support; referenced MPNP9006 and MPCR15 **VI.C.1 Timing of Lactation Support Services:** Clarified eligibility for lactation support services during pregnancy and up to one year post-partum. **VI.C.2 Providers of Lactation Support Services:** Clarified provision of lactation education and support across prenatal, delivery, and postpartum periods; added reference to APL 26-005. **VI.C.2D Providers of Lactation Support Services:** Added telehealth guidance for lactation services; ensured access to in-person care is maintained **VI.C.5A-B Lactation Support Services:** Clarified lactation services as a covered preventive benefit without cost sharing per APL 26-005; defined preventive services versus medically necessary services requiring authorization **VI.C.6B3 Breast Pumps:** Replace CPSP with PHPS health education codes for reimbursement of breast pump education. **VI.C.6C Breast Pumps:** Clarified breast pump coverage without a Treatment Authorization Request; added three-year limit, and defined TAR requirement for early replacement **VII. References:** **Added APL 25-013** - Medi-Cal Rx Pharmacy Benefits, And Cell and Gene Therapy Coverage (09/18/2025) – supersedes (APL) 22-012	Member Services Pharmacy Utilization Management Quality Improvement Care Coordination

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)
		Added APL 26-005 Maternity Services for Pregnant and Postpartum Medi-Cal Members (03/25/2026) **IX. Position Responsible for Implementing Procedure:** Updated to Chief Medical Officer.	
MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program	297 – 210	**I. Related Policies**: Updated policy code ("MC to MP") for MPNP9006 – Doula Services Benefit. **III. Definitions:** Updated terminology to reflect "nutritious food packages" and removed reference to prescriptive checks; Updated Partnership Advantage (D-SNP) effective date to Jan. 1, 2028 and updated Partnership Advantage "members" to "enrollees." Also added that coverage criteria apply upon implementation, subject to CMS and DHCS approval. **VI.A.1 Coverage Guidelines:** Clarified Partnership responsibility to identify, refer, and follow up with eligible members to support access to WIC services **VI.B.1 Identification and Referral:** Added provider requirement to assess nutritional risk and food insecurity for WIC eligibility **VI.B.5 Identification and Referral:** Added requirement to follow up on WIC referrals and document member access to services in the medical record **VI.B.6 Identification and Referral:** Clarified documentation of WIC referrals and outcomes; added reference to MPNP9007 **VI.C.1 Follow-up** : Clarified provider training requirements for WIC referrals, follow-up, and documentation **VI.C.3 Follow-up:** Added QI monitoring of WIC referral and follow-up practices **VI.D.1 MOU Requirements:** Reverted to original WIC MOU execution language, removing the "good faith effort" standard. **VII.F References:** Added APL 26-005 - Maternity Services for Pregnant and Postpartum Medi-Cal Members (03/25/2026) **IX. Position Responsible for Implementing Procedure:** Updated to Chief Medical Officer.	Member Services Pharmacy Utilization Management Quality Improvement Care Coordination
Policy Owner: Utilization Management *Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations*			
MCUP3041 – Treatment Authorization Request (TAR) Review Process	211 – 229	**Section I. B. and L.:** Policy MPUP3014 Emergency Services was added as a Related Policy and policy MCUP3064 Communication Services was removed, because that policy has been archived and the information is included in policy MPU3001 UM Program Description, which is already listed. **VI. A.2.b.**: Clarification was added to say that Partnership's Online Services (OLS) portal is available "24 hours per day, 7 days per week." **VI.B.1.a. – c.**: Clarification was added to specify that Partnership requires TARs for certain procedures in three categories: Non-behavioral (medical) healthcare, Behavioral healthcare, and Pharmacy.	Provider Relations Providers

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)
		VI.B.2.: Additional language was added in paragraph regarding exhaustion of Medicare coverage to say "This requirement applies only when Medicare coverage is primary and applicable to the requested service." **VI.C.2.b.:** Redundant sentence regarding the assignment of a specified number of days for an inpatient TAR was deleted because the same information was stated below at VI.C.2.b.1). **VI.C.3.a.:** Language regarding long term care facility was removed because Partnership does not typically see emergency or obstetrical admissions to an LTC facility. **VI.C.4.b.:** CCR Title 22 section 50777 was added as a regulation requiring that Medi-Cal beneficiaries apply for any available health care coverage when no cost is involved. **VI.C.4.d.:** Language was updated to clarify that Partnership assigns Members with ESRD to a Direct Member status (rather than issuing a lifetime TAR) to ensure that dialysis services are approved in an efficient manner. **VI.C.5.:** Hospice Services section was updated to include language from recent APL 25-008. **VI.C.6.:** Terminology was updated from Long Term Care to Extended Care nursing services. **VI.D.6.a.3):** Language was changed to say "as soon as possible" rather than "within 24 hours" for Partnerships attempts to obtain any missing necessary information for urgent concurrent care. **VI.D.6.a.4):** Language was clarified to describe how Partnership will inform the hospital Utilization Review department staff of denial decisions for urgent concurrent reviews. **VI.D.6.c.1):** Time frame for rendering a decision for a non-urgent pre-service review was changed from 5 business days to 7 calendar day as per CMS-0057-F. **VI.D.6.c.4):** Language describing a second pend time frame up to 28 days was removed as this is no longer applicable according to CMS-0057-F. **VI.D.6.c.5)a):** Time frame for rendering a decision for a non-urgent pre-service review was changed from 5 business days to 7 calendar days as per CMS-0057-F and option to extend a pend up to 28 days was removed. **VI.E.4.:** Policy language was updated to include description of IRR audits for pharmacist reviewers and lead pharmacy technicians, in addition to the IRR audits already described for physician and nurse reviewers. **VII.A.:** Reference to DHCS Contract was updated. **VII.B.:** Date of APL 21-011 was updated for revision. **VII.C.:** Reference for APL 22-012 was updated to reflect current APL 25-013. **VII.E.:** Reference to Title 42 CFR 438.114 was updated to include description **VII.F.:** Reference was added for Title 22 CCR 50763 and 50777 **VII.G.:** Reference to Title 28 CCR 1300.71.4 was updated to include description **VII.H.:** Reference to CMS Final Rule CMS-0057-F was updated **Attachment A:**	

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)
		• Various policy numbers and names were updated throughout. • Updated the Diagnostic Studies section H. on page 1 of policy Attachment to define and clarify three acronyms we were using at A.B. and C. as follows; A. Magnetic Resonance Angiography (MRA) B. Mass Spectrometry Imaging (MSI) C. Magnetoencephalography (MEG) and also added a Note to specify that "No TAR is required for CT scans for MRIs." • References to APL 22-012 were updated to reflect APL 25-013 for Medi-Cal Rx	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPNP9007 (previously MCCP2020; MCUP3009; MPUG3009; UG100309)			**Lead Department: Health Services** Business Unit: Population Health	
Policy/Procedure Title: Lactation Policy and Guidelines (formerly Breastfeeding Guidelines)			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/19/2000		**Next Review Date:** ~~08/13/2026~~08/12/2027 **Last Review Date:** ~~08/13/2025~~08/12/2026		
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:** ~~08/13/2025~~08/12/2026	

I. RELATED POLICIES:

A. MPXG5009 – Lactation Clinical Practice Guideline
B. MPCR16 – Lactation Consultant Credentialing Policy
C. MCUG3118 – Prenatal and Perinatal Care
D. MCUP3041 – Treatment Authorization Request (TAR) Review Process
~~E. MCCP2021 – Women, Infants and Children (WIC) Supplemental Food Program~~
E. MCUP3113 – Telehealth Services
F. MCUP3013 – Durable Medical Equipment (DME) Authorization
G. MP~~C~~UG3011 – Criteria for Home Health Services
H. MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program
~~H.~~I. MP~~C~~NP9006 – Doula Services Benefit
~~I.~~J. MPCR15 – Doula Credentialing and Re-Credentialing Criteria

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Electronic Visit Verification (EVV): A federally mandated telephone and computer-based application program that electronically verifies in-home service visits for Medicaid-funded personal care services and home health care services for in-home visits by a provider. In California, this is known as CalEVV.
B. Essential Health Benefits: – A set of health care service categories that must be covered by certain plans - Categories include, among others, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, and mental health and substance use disorder services.
~~C.~~ WIC - Women, Infants and Children Supplemental Nutrition Program: – The Special Supplemental Nutrition Program for Women, Infants, and Children, – a~~A~~ 100% federally funded program providing nutritious food (via prescriptive checks), individual counseling and nutrition education, breastfeeding promotion and support, and referrals to other needed services to at-risk, low- to moderate-income (up to 185% of the federal poverty level) pregnant, postpartum, and breastfeeding members, children up to the age of five; and parents/guardians and other family members in households with a child under age five.
C.
~~B.~~D. Partnership Advantage (PA): Effective January 1, 202~~8~~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~~ Enrollee Handbook. Coverage criteria apply on implementation of D-SNP, subject to CMS and DHCS approval.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

A. To support optimal nutrition in the healthy infant by appropriately supporting the parent's efforts to initiate and sustain breastfeeding exclusively for about 6 months and with complementary foods (not formula) for at least 12 months per American Academy of Pediatrics (AAP) recommendations. Lactation services and supplies are covered preventive services and are provided without cost sharing to the member.

B. To give the policy framework around provisions of the Affordable Care Act (ACA), Section 4106a, Women's Health Preventive Services. It is the goal of Partnership HealthPlan of California (Partnership) to be fully compliant with this portion of the ACA. This section states that pregnant and postpartum members are eligible to receive the following as preventive services:
   1. Comprehensive lactation services including counseling by a trained health care provider or allied health professional during pregnancy and/or the postpartum period.
   2. To have access to breast pumps and breastfeeding equipment and supplies, as indicated to support lactation.

VI. POLICY / PROCEDURE:

A. General Breastfeeding Guidelines
   1. Introduction: Human breast milk is uniquely specific to the needs of the human infant. Breastfeeding is acknowledged as the preferred method of infant feeding by Partnership and the AAP. Research has demonstrated numerous health benefits of breastfeeding. Additional to health benefits breastfeeding also provides social, economic and environmental benefits for both parent and infant.

B. Promotion and Support of Breastfeeding
   1. Lactation Education and Support Services: Each county served by Partnership has a local Women Infants and Children (WIC) Nutrition Program that includes lactation education, support and provision of breast pumps, for low-income individuals, including Partnership members. All pregnant members should be referred to WIC. Lactation support for Partnership members is a shared goal and responsibility of WIC and the health delivery system provided through Partnership, by the following providers and support services:
      a. Primary care providers (PCPs) are encouraged to provide opportunities for members to learn about the advantages of breastfeeding through educational materials. Referrals for all pregnant members to prenatal breastfeeding classes will ensure they have current evidence-based information about breastfeeding.
      b. Prenatal care providers should specifically assess a pregnant member's knowledge and interest in breastfeeding at the first prenatal visit. Obstetrical care includes documentation of a complete breast exam and anticipatory guidance for any condition that could affect breastfeeding. Education regarding the advantages of breastfeeding should be ongoing. Pregnant members and their families should be referred to a breastfeeding class and have access to one-on-one breastfeeding education prenatally and postnatally. This is especially important for members

who are first-time parents or have not breastfed in the past.

c. The Comprehensive Perinatal Services Program (CPSP) has divided authority between the California Department of Health Services (DHCS) and the California Department of Public Health (CDPH). It is an enhanced program of perinatal services to be offered through the Medi-Cal program and reimbursed (by DHCS) at higher rates than traditional obstetrical services. The CPSP provider certification process is administered and approved by the CDPH. *Note:* Partnership HealthPlan of California (Partnership) encourages, but does not require, providers to be CPSP certified in order to provide obstetrical and perinatal services, however, obstetrics providers need to provide CPSP-like services or refer to another CPSP provider for non-obstetric CPSP or CPSP-like services. (*See also the Partnership HealthPlan Perinatal Services (PHPS) definition below*)

d. Partnership Population Health: Through specific programs and general case management support, Partnership Population Health supports breastfeeding in accordance with current guidelines and evidence-based practices. Members who are planning to breastfeed and need specific resources are encouraged to call for assistance with breastfeeding when wanted.

e. Partnership HealthPlan Perinatal Services (PHPS): CPSP-like services that are equivalent to, or substantially similar to, the services defined by the CDPH-defined CPSP program. *(See also the Comprehensive Perinatal Services Program (CPSP) definition above).*

~~e.~~ Health Equity and Cultural Responsiveness: Lactation services must be delivered in a culturally and linguistically appropriate manner, consistent with CalAIM and DHCS health equity expectations and in accordance with MPND9002 Cultural & Linguistic Program Description. ~~Description and MCNP9003 Cultural and Linguistic Services.~~

~~f.~~

~~f.~~g. Postpartum follow-up: Calls are made to Partnership members and Partnership Advantage enrollees within the first month after delivery, when possible, to encourage a timely postpartum visit. If needed, referrals are made for lactation assistance, support, education and information.

~~g.~~h. Hospitals providing obstetrical care play a key role in supporting successful initiation of breastfeeding. Standards of care for hospitals in this area are fully outlined in the UNICEF/WHO Baby Friendly Hospital Initiative) (https://www.unicef.org/documents/baby-friendly-hospital-initiative) and will also include:

1) The hospital should receive information on the member's prenatal record stating the infant feeding plan. That plan should be confirmed when a member is admitted for delivery.
2) Family centered childbirth practices allowing for early parent-infant contact and breastfeeding within one half-hour of birth as well as rooming in. Hospitals are encouraged to view initiation of breastfeeding as a process accomplished over several days and offer support, assistance, and education accordingly.
3) Newborns should be nursed whenever they show signs of hunger/interest approximately 8-12 times every 24 hours after the first 24 hours. Parents can be encouraged to hold their infants even when not feeding to better assist them as they begin the process of learning and understanding their infant's feeding cues.
4) Members need access to qualified nursing staff and/or International Board Certified Lactation Consultant (IBCLC) to assist with initiation of breastfeeding, evaluate breastfeeding progress and to give ongoing information during the hospital stay.
5) Supplements such as formula should not be given to breastfeeding newborns unless there is an order from the Health Care Provider.
6) Discharge planning includes the assessment of the need for follow-up with WIC, a peer counselor, the infant care office, an IBCLC, home health, or public health nurse visit specifically to assist the parent with breastfeeding. Whenever possible this should occur within 1-2 days of discharge.

7) The lactating parent leaves the hospital with a list of resources for support and assistance with breastfeeding, information on how to tell if the baby is getting enough milk, and referral to a breastfeeding support group.

~~h.~~i. Infant Care providers should encourage exclusive breastfeeding for about six months and breastfeeding with complementary foods (not formula) for at least 12 months per AAP recommendations. Infant Care providers should consider a referral to a qualified lactation consultant, Home Health Nurse or Public Health Nurse for evaluation before suggesting supplementation with formula or cessation of lactation. Providers need to consider the parent's health and well-being when giving recommendations. If a baby needs to stop feeding at the breast, the parent is to be provided with a breast pump and instructions on how to use it to maintain the milk supply.

~~i.~~j. Home Health Nurse or Public Health Nurse Visit: All members are eligible to receive Home Health Nurse visits or Public Health Nurse visits after discharge from the hospital for assistance with breastfeeding. It is strongly recommended that home visiting nurses have specific training in lactation/breastfeeding support. The first parent-baby home health visit by a Home Health Nurse does not require prior authorization and subsequent visits are easily available through the authorization process. Public Health Nurse visits do not require authorization and can be ordered in a variety of ways including by notation on the postpartum discharge orders at time of discharge or by contacting the local county Public Health Department.

1) Electronic Visit Verification (EVV) Requirements:
   a) Effective January 1, 2023, as per APL 22-014, EVV requirements must be implemented for all Medi-Cal personal care services and home health care services that are delivered during in-home visits by a provider, which includes visits that begin in the community and end in the home, or vice versa.
   ~~a)~~b) EVV requirements apply only to lactation services delivered as part of covered home health or personal care services. Facility-based and office-based lactation services are not subject to EVV.
   ~~b)~~c) Please refer to policy MCUG3011 Home Health Services for further information on EVV requirements.

i. Doulas are recognized Medi-Cal providers who may offer various types of support, including lactation support, education, and care coordination. For more details, refer to Partnership policy MP~~C~~NP9006 Doula Services Benefit and MPCR15 Doula Credentialing and Re-credentialing Criteria.

C. Partnership HealthPlan of California Breastfeeding Services

1. Timing of Lactation Support Services: Partnership members are eligible to receive lactation support during and after pregnancy and for up to 1 year after delivery. Lactation Education and Support is different in the prenatal, immediate postpartum (in the hospital), early postpartum (from hospital discharge to 84 days after delivery), and late post-partum periods (from 84 days to 365 days post-delivery). From a Partnership standpoint, care during the postpartum period includes two specifically defined postpartum visits, one occurring prior to 21 days after delivery and the second between 21 to 84 days after delivery. This postpartum review and examination includes obtaining a history, performing a physical exam and evaluation of infant feeding. Additionally, earlier post discharge follow-up lactation visits should be encouraged, preferably in the first few days after discharge home. Some parents also need lactation education and support after 84 days post-delivery. Lactation visits independent of the standard postpartum visits are covered by Partnership. See billing and codes section for specific requirements.
2. Providers of Lactation S~~s~~upport S~~s~~ervices:
   a. Perinatal clinical providers and facilities provide education and lactation support during pregnancy, at the time of delivery and after delivery to ensure individuals have information

needed to support shared decision making and a successful initiation of breast feeding when that is chosen by the member. See DHCS APL 26-~~—~~005.

~~a.~~b. Basic lactation support services may be provided in a provider office by a medical professional as follows: Physician, Nurse Practitioner (NP), Physician Assistant (PA), Certified Nurse Midwife (CNM), or Licensed Midwife (LM).

1) Providers offering lactation support services will ensure that the services are provided by an individual who has the appropriate education and knowledge.
2) Registered Nurse (RN), Registered Dietician (RD), International Board Certified Lactation Consultants (IBCLC), Lactation Educators and other lactation support staff without additional health professional licensure may provide basic lactation support services under the supervision of a Partnership contracted Physician.

~~b.~~c. IBCLCs with an underlying health professional licensure (RN, RD, Doctor of Medicine [MD], Doctor of Osteopathic Medicine [DO], CNM, NP, PA) may become contracted/credentialed to provide lactation support services through Partnership.

1) Contracted/credentialed IBCLC will ensure that any services provided by an individual within their employment has appropriate education and knowledge.
2) Lactation Educators and other lactation support staff without additional health professional licensure may provide basic lactation support services under the supervision of a Partnership contracted /credentialed IBCLC.
3) IBCLCs must be credentialed by the credentials committee, as described under policy MPCR~~#~~16 Lactation Consultant Credentialing Policy.

~~b.~~d. Lactation services may be delivered via telehealth when clinically appropriate, consistent with DHCS telehealth policy. Telehealth shall not be used to reduce access to in-person care when requested or clinically necessary. Refer to Partnership MCUP3113 Telehealth Services policy.

3. Other Health Professionals who are Certified Lactation Consultants or trained Lactation Educators, under the supervision of a Partnership contracted/credential IBCLC or provider office, may perform lactation consultation services outside of the hospital setting.
4. Lactation Educators: A Lactation Educator may provide basic lactation education services. The Lactation Educator must always work under the supervision of a Partnership contracted/credentialed IBCLC or provider office, who is ultimately responsible for the patients seen by lactation educators.
   a. If an IBCLC is supervising lactation educators, the following documentation must be maintained in the lactation educator's personnel file:
      1) Documentation of successful completion of a basic lactation education program.
      2) A letter from their supervising IBCLC describing the training and experience of the Lactation Educator, and the manner in which they are supervised.
   b. The IBCLC must maintain written protocols for the Lactation Educator, listing:
      1) Documentation standards
      2) Topics that the Lactation Educator may address
      3) Indications for referral to the IBCLC, with standards for timeliness of referrals.
5. Lactation Support Services:
   a. Per APL 26-005, lactation services are a covered preventative benefit and must be provided without member cost-sharing and without unreasonable administrative barriers.
   b. Lactation Service Types:
      1) Preventative services: lactation services including routine lactation education, counseling and support that do not require prior authorization.
      2) Medically necessary services are ~~: Additional or specialized lactation support that~~covered without an approved referral authorization or TAR.~~: may require authorization.~~ ~~based on Medi-Cal guidelines.~~ Additional or specialized lactation support may require authorization based on Medi-Cal guidelines.

~~No Referral Authorization is required for up to 60 calendar days of services; however, a Treatment Authorization Request (TAR) is required for visits after 60 calendar days, with a written treatment plan and specific request for additional visits. These TARs will be reviewed for medical necessity, according to the usual TAR process.~~

~~a. Prior authorization requirements shall not be applied to routine preventative lactation services. Authorization shall be required for extended or medically necessary services beyond standard preventative care, consistent with DHCS guidance.~~

~~b.~~c. Services provided in a contracted hospital outpatient service~~s~~, physician office, IBCLC private office, via telehealth or member's home may be billed to Partnership using the S9445 HCPCS code, billed in 15 minute increments, up to a maximum of 4 units per day. ~~In addition, lactation services provided by a Comprehensive Perinatal Service Program (CPSP) after the post-partum member's eligibility for CPSP has expired, may also use the S9445 HCPCS Code.~~

6. Breast Pumps: When breastfeeding is interrupted or discontinued the use of Breast Pumps and alternative feeding fluids may be necessary. If lactating parent is unable to feed the baby at the breast due to a medically based separation or a physical problem of varying duration, and until resolution of any of these problems are achieved, providing a breast pump in a timely fashion is appropriate and a covered benefit.
   a. Electric breast pumps may be recommended for infants with feeding problems where a lactating parent must be separated from or is unable to nurse the baby. Partnership strongly recommends the use of an electric breast pump for adequate maintenance of milk supply when a baby is not able to breastfeed.
   b. In partnership with local WIC agencies, multi-user electric breast pumps and the breast pump equipment (Kits) are provided through each county's WIC program, when available. They provide the pump, equipment and education to support appropriate use.

   Single-user personal double electric breast pumps are also available for Partnership members, or for lactating parents whose infant is a Partnership member (who is 12 months old or younger). These pumps are available by prescription from a number of Partnership contracted durable medical equipment (DME) providers. No TAR is required. The Partnership breast pump benefit has a frequency limit of 1 pump for every 3 years. Replacement pumps needed prior to 3 years will require submitting a TAR showing the medical need for replacement.
   c. ~~Partnership breast pump benefit is limited to one pump every three years.~~
      1) Providers will utilize DME order form with prescription to submit request for pump no sooner than 30 calendar days prior to the Estimated Due Date (EDD), up to 12 months after delivery.
      2) Providers will provide supportive pump education on how to successfully use the selected pump at a health education visit prior to the EDD.
      3) Providers will be reimbursed up to 1 hour for breast pump education utilizing ~~CPSP~~ PHPS health education codes, or billing code S9445. Office visit codes may also be used ~~,~~ for appropriate providers.
   d. When infants are born at less than 36 weeks gestation and remain hospitalized, arrangements will be made on an individual case by case basis to use a multi-phase hospital grade electric pump for the initiation and maintenance of the lactating parent's milk supply while the infant is hospitalized. Specific instruction and support for the use of this pump will be provided by the hospital staff.
7. Alternate Feeding Fluids:
   a. Banked Human Milk is available in limited supplies for infants with specific conditions and for whom their lactating parent's milk is temporarily not available.
      1) Banked Human Milk for newborns whose lactating parents are unable to breastfeed due to medical reasons is a covered benefit under Partnership. Prior Authorization is required.

2) Donor/processed banked breast milk requires a prescription from a physician. The prescription must specify *Processed human milk __# of ounces per day for __# of weeks* as well as the infant's name and Client Identification Number (CIN) along with the parent/guardian's name and phone number and a diagnosis. The prescription can be faxed or scanned and emailed to the milk bank.
3) If the infant requires an increase in supply, a new prescription is needed.
4) For outpatient infants, the first shipment is usually for one week of milk. The parent/guardian can request up to a 2 week supply on subsequent orders.
5) When a hospital orders the milk, a purchase order number is required, along with the parent's address, attending physician, and whether the order is for premature milk or mature milk. The hospital can provide a verbal order and then fax a written doctor's order to the milk bank. Partnership does not pay for Banked Human Milk in hospitalized recipients as the bank will bill the hospital directly in those instances.
6) For some newborn intensive care units (NICUs) in California, the physician may want to have a supply of processed donor milk stored in the freezer at all times. Other hospitals order donor milk when a patient needs it. The processed milk has a six-month expiration period.

b. Special infant formulas for specific medical conditions must be prescribed by an approved Medi-Cal prescriber and dispensed to the member by a Medi-Cal Rx pharmacy provider (when approved through the State Medi-Cal Pharmacy TAR process).
1) The pharmacy (prescription) benefit is carved-out to State Medi-Cal as of January 1, 2022. For State Medi-Cal authorization requirements, please refer to the State Medi-Cal Enteral Nutrition policy https://medi-calrx.dhcs.ca.gov/home/enteral-nutrition-products/
2) WIC may be able to provide specialty infant formulas when authorization for a pharmacy TAR is pending with State Medi-Cal. Providers should check with the local WIC office for availability of interim product in urgent cases.

VII. REFERENCES:

A. American Academy of Pediatrics, Clinical Practice Guidelines: https://publications.aap.org/pediatrics/collection/523/Clinical-Practice-Guidelines
B. Affordable Care Act, Section 4106a, Women's Health Preventive Services
C. Hale, Thomas Wright, Krutsch, Kaytlin. *Hale's Medications & Mothers' Milk 2023: A Manual of Lactational Pharmacology*. 20th ed., New York, NY: Springer Publishing Company, 2022.
D. Kimberlin, David W., editor. *Red Book: 2021-2024 Report of the Committee on Infectious Diseases*. 32nd ed., Itasca, IL: American Academy of Pediatrics, 2021.
E. Infant Risk Center: https://infantrisk.com/breastfeeding Call 806-352-2519
F. CA WIC Association: Ramping up for Reform-Quality Breastfeeding Support in Preventive Care. https://thewichub.org/ramping-up-for-reform-quality-breastfeeding-support-in-preventive-care/
G. Department of Health and Human Services/Center for Medicaid and CHIP Services
H. Medicaid Coverage of Lactation Services. CMS Bulletin
I. DHCS All Plan Letter (APL) ~~22-012 Revised~~25-013 ~~– Governor's Executive Order N-01-19 Regarding Transitioning~~ Medi-Cal Pharmacy Benefits, and Cell and Gene Therapy Coverage~~ From Managed Care to Medi-Cal Rx~~ (~~12/30/2022~~09/18/2025)
J. DHCS APL 22-014 Electronic Visit Verification Implementation Requirements (07/21/2022)
K. Partnership Website: Pregnancy & Breastfeeding - Breastfeeding Booklet https://www.partnershiphp.org/Members/Medi-Cal/Pages/Health%20Education/Pregnancy--Breastfeeding.aspx
L. 42 CFR § 422.107, Requirements for dual eligible special needs plans

~~L.~~M. DHCS APL 26-~~-~~005 Maternity Services for Pregnant and Postpartum Medi-Cal Members (03/25/2026)

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

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

X. REVISION DATES:
Medi-Cal (MPNP9007)
~~MPNP9007 (Effective~~ 08/13/25~~)~~; 08/12/26
~~N/A~~

Partnership Advantage (Program effective January 1, 202~~87~~)
08/13/25; 08/12/26~~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:
MCCP2020 (02/15/17 to 08/1~~23~~/25)
*03/14/18; 06/12/19; 06/10/20; 08/11/21; 03/09/22; 03/08/23; 03/13/24; 03/12/25

Medi-Cal (UG100309; MPUG3009; MCUP3009: -04/19/2000 to 02/15/2017)
05/16/01; 05/15/02; 10/20/04; 10/19/05; 08/20/08; 04/21/10; 09/15/10; 10/01/10; 06/20/12; 11/20/13; 08/20/14; 04/15/15; 01/20/16; 10/19/16 to 02/15/17

Healthy Families:
MPUG3009 - 10/01/2010 to 03/01/2013

*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.

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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.

Policy/Procedure Number: MPNP9007 (previously MCCP2020; MCUP3009; MPUG3009; UG100309)			**Lead Department: Health Services** Business Unit: Population Health
Policy/Procedure Title: Lactation Policy and Guidelines (formerly Breastfeeding Guidelines)			☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/19/2000			**Next Review Date: 08/13/202608/12/2027** **Last Review Date: 08/13/202508/12/2026**
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

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: MPNP9008 (previously MCCP2021; MCUP3100)			**Lead Department: Health Services** Business Unit: Population Health	
Policy/Procedure Title: Women, Infants and Children (WIC) Supplemental Food Program			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/21/2010		**Next Review Date:** ~~08/13/2026~~08/12/2027 **Last Review Date:** ~~08/13/2025~~08/12/2026		
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:** ~~08/13/2025~~08/12/2026	

I. RELATED POLICIES:

A. MCUG3118 – Prenatal & Perinatal Care
B. MCQG1015 ~~–~~ Pediatric Preventive Health Guidelines
C. MP~~C~~NP9006 – Doula Services Benefit
D. MCCP2036 ~~–~~ Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Members Services

III. DEFINITIONS:

A. WIC ~~–~~ Women, Infants and Children Supplemental Nutrition Program~~:~~ ~~–~~ The Special Supplemental Nutrition Program for Women, Infants, and Children - A 100% federally funded program providing nutritious food packages~~,~~ ~~(via prescriptive checks),~~ individual counseling and nutrition education, breastfeeding promotion and support, and referrals to other needed services to at-risk, low- to moderate-income (up to 185% of the federal poverty level) pregnant, postpartum, and breastfeeding members, children up to the age of five; and parents/guardians and other family members in households with a child under age five.
B. Partnership Advantage (PA): 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~~ Enrollee Handbook. ~~-~~Coverage criteria apply on implementation of D-SNP, subject to CMS and DHCS approval.

IV. ATTACHMENTS:

N/A

V. PURPOSE:

To define the responsibilities of Partnership HealthPlan of California (Partnership) and the respective

Women, Infants and Children (WIC) Providers in the counties Partnership serves.

VI. POLICY / PROCEDURE:

A. Coverage Guidelines:

1. WIC services are not covered by Partnership. However, Partnership shall identify eligible members, make referrals, and follow-up as appropriate to support access to WIC services. Partnership members and Partnership Advantage enrollees who are eligible for WIC supplemental food services will be referred to their respective County WIC Providers.
2. WIC serves pregnant, postpartum, and breastfeeding members, as well as children up to age five and parents/guardians and/or other family members in households with a child under age five.

B. Identification and Referral

1. Providers shall assess members for nutritional risk and food insecurity during applicable visits to support identification of WIC eligibility.
~~1.~~2. The primary care provider (PCP) or obstetrician (OB) is responsible for identifying and referring members who are pregnant, breastfeeding or postpartum and children under the age of five who are eligible for WIC supplemental food.
~~2.~~3. During a well-child visit, PCPs will perform a nutritional assessment, as well as hemoglobin or hematocrit laboratory tests following the AAP Bright Futures Periodicity schedule (refer to link: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf for further details~~), and~~) and refer each WIC-eligible member to a county WIC program per Federal WIC requirements for program eligibility.
~~3.~~4. Partnership will be responsible for the cost of hemoglobin or hematocrit laboratory value and lead test. Lab results will be documented in the member's medical record with the PCP.
~~4.~~5. PCP/OB will refer all eligible Partnership members to WIC and include the member's hemoglobin or hematocrit lab results. Referrals shall be followed up to confirm whether member ~~assessed~~accessed WIC services, and this status shall be documented in the medical record.
~~5.~~6. Partnership refers the members and enrollees who are pregnant, breastfeeding, or postpartum, or a legal guardian for a member under the age of five, to the WIC program either as part of the initial evaluation of newly pregnant members pursuant to 42 CFR section 431.635(c) and APL 26~~–~~ ~~-~~005. ~~PL 98-010.~~ Referrals also occur during various outreach activities. All referrals and follow-up outcomes shall be ~~are~~ documented in the member's medical record. Refer to Partnership policy MPNP9007 for lactation guidelines and support services.

C. Follow-up, Education and Training

1. As part of ongoing provider training, Partnership ~~will~~ shall ~~work to~~ ensure that providers understand the WIC program, eligibility requirements, ~~and~~ the referral process, and the expectation to document and follow up on referrals.
2. Partnership, through its member handbook, newsletters, and brochures, seeks to promote member understanding of the WIC program, the need for and how to obtain services, and the benefits to be realized by following instructions received.

~~2.~~3. Partnership shall monitor referral and follow-up practices as part of Quality Improvement activities.

D. Memorandum of Understanding (MOU) Requirements

1. Per APL 23-029 Attachment G WIC MOU, Partnership and the respective WIC Providers in the counties Partnership serves shall ~~make a good faith effort to execute~~ maintain executed ~~a~~ MOUs with WIC providers, or document when an MOU cannot be established, outlining respective responsibilities and obligations. MOUs shall be reviewed periodically and define roles, responsibilities, and referral processes.
2. Refer to Partnership policy MCCP2036~~–~~ Memorandum of Understanding (MOU) Requirements ~~For~~for Medi-Cal Managed Care Plans and Third-Party Entities for more details.

Policy/Procedure Number: MPNP9008 (previously MCCP2021; MCUP3100)			**Lead Department: Health Services** Business Unit: Population Health
Policy/Procedure Title: Women, Infants and Children (WIC) Supplemental Food Program			☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/21/2010			**Next Review Date: 08/13/202608/12/2027** **Last Review Date: 08/13/202508/12/2026**
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

VII. REFERENCES:

A. Title 42 Code of Federal Regulations (CFR) Section 431.635(c)
B. Title 22 California Code of Regulations (CCR) Sections 50157 and 50184
C. Contract between Department of Health Care Services (DHCS) and Partnership: Contract Exhibit A, Attachment III Section 4.3.19
D. California Department of Public Health WIC Program Overview: https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/AboutWIC.aspx
E. DHCS APL 23-029– Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (01/08/2025)
   - Attachment G: Women, Infant, & Children Memorandum of Understanding- Template
F. ~~DHCS Policy Letter (PL) 98-010: Breastfeeding Promotion (12/10/1998)~~ DHCS APL 26-005 Maternity Services for Pregnant and Postpartum Medi-Cal Members (03/25/2026
G. 42 CFR § 422.107, Requirements for dual eligible special needs plans

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

Medi-Cal (MPNP9008)
~~MPNP9008 (Effective~~ 08/13/25~~)~~; 08/12/26
~~N/A~~

Partnership Advantage (Program effective January 1, 2028~~7~~)
08/13/25; 08/12/26 ~~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:

MCCP2021 (02/15/17 to 08/1~~23~~/25)
*03/14/18; 03/13/19; 03/11/20; 03/10/21; 03/09/22; 03/08/23; 03/13/24; 03/12/25

MCUP3100 (04/21/2010 to 02/15/2017)
05/15/13; 05/20/15; 05/18/16 to 02/15/2017

*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.

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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

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3041 (previously UP100341)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Treatment Authorization Request (TAR) Review Process</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: (UM-2) 04/25/1994
(Effective 06/19/2013 - TAR/RAF Review Policy split)</td><td colspan="4">Next Review Date: ~~08/13/2026~~08/12/2027
Last Review Date: ~~08/13/2025~~08/12/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☐ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~08/13/2025~~08/12/2026</td></tr>
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I. RELATED POLICIES:

A. MCUP3124 – Referral to Specialists (RAF) Policy
~~A.~~B. MPUP3014 – Emergency Services
~~B.~~C. MPUP3026 – Inter-Rater Reliability Policy
~~C.~~D. MCUP3141 – Delegation of Inpatient Utilization Management
~~D.~~E. MPUD3001 – Utilization Management Program Description
~~E.~~F. MCRP4068 – Medical Benefit Medication TAR Policy
~~F.~~G. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
~~G.~~H. CGA024 – Medi-Cal Member Grievance System
~~H.~~I. CMP36 – Delegation Oversight and Monitoring
~~I.~~J. CMP26 – Verification of Caller Identity and Release of Information
~~J.~~K. CMP30 – Records Retention and Access Requirements
~~K.~~L. MPUP3139 – Criteria and Guidelines for Utilization Management
~~L. MCUP3064 – Communication Services~~

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Medical Necessity: Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
B. 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.
C. Cosmetic Surgery: Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.
D. 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.

E. 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.

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

G. Pre-service Request: A request for coverage of medical care or services that the organization must approve in advance, in whole or in part.

H. Post-service Request: A request for coverage of medical care or services that have been received (e.g., retrospective review).

IV. ATTACHMENTS:

A. Partnership TAR Requirements list (including Outpatient Surgical Procedures CPTs Requiring TAR list and Pain Management CPTs Requiring TAR list

V. PURPOSE:

To describe the procedures used by the Partnership HealthPlan of California (Partnership) Utilization Management (UM) Department to process Treatment Authorization Requests (TARs) based upon the medical necessity of the request.

VI. POLICY / PROCEDURE:

A. GENERAL PROCEDURES

1. Partnership pays for authorized services according to the specific terms of each physician, hospital, or other provider contract. Partnership will reimburse only if individuals are eligible at the time the service is rendered.
2. Resources necessary to help in determining review decisions, include, but are not limited to the published, current, InterQual® criteria; Medi-Cal (State of California) criteria, Medicare criteria, and Partnership's internally developed and approved guidelines. Determinations also take into account individual M~~m~~ember needs and characteristics of the local delivery system. (See policy MPUP3139 Criteria and Guidelines for Utilization Management for more details.)
   a. The Provider of service must verify eligibility of the Member via Partnership systems at the time of service. This verification is necessary for all service authorizations.
   b. Partnership's Online Services (OLS) portal https://provider.partnershiphp.org/UI/Login.aspx is available 24 hours per day, 7 days per week to verify eligibility and determine the Member's assigned primary care provider (PCP). Information required to verify the eligibility of an individual is as follows:
      1) Provider NPI (National Provider Identifier)
      2) Member Social Security number or Partnership Member ID number
      3) Date of Service
3. TARs are not processed by Partnership until the TAR form is complete; meaning that it ~~and~~ includes all M~~m~~ember information and all attachments noted on the TAR are received. When completing information fields for the provider of service and the service(s) being requested, the correct and valid

codes must be utilized.

4. Authorizations are only valid for the timeframe approved by Partnership. If the timeframe is exceeded due to an unforeseen delay, the Provider may submit a request for an extension of the time period, noting the reason for the delay.

B. SERVICES REQUIRING TREATMENT AUTHORIZATION

1. Certain procedures, services, and medications require prior authorization from Partnership before reimbursement is made.
   a. Non-behavioral (medical) healthcare ~~Those~~ services requiring a Treatment Authorization Request (TAR) that will be processed by Partnership's Utilization Management (UM) department are described in this policy and listed ~~as~~ in A~~a~~ttachment A, Partnership TAR Requirements. ~~to this policy. The attachment consists of:~~
      ~~1) Partnership TAR Requirements List~~
      ~~2) HCPCS Codes Requiring a TAR~~
      ~~3) Outpatient Surgical Procedures Requiring TAR~~
   ~~c.~~b. Behavioral healthcare: Partnership covers Non-Specialty Mental Health Services (NSMHS) without prior authorization requirements. (See policy MPBP8003 Mental Health Services for further information.)
   ~~d.~~c. Pharmacy: Partnership covers Physician-Administered Drugs for Medi-Cal Members as described in policy MCRP4068 Medical Benefit Medication TAR Policy.
      1) 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, as per the implementation of Medi-Cal Rx described in APL 25-013.
2. Medicare coverage: For those providers contracting with Partnership, if a Member has primary coverage through Medicare Part A, a TAR is not required until the Member exhausts the benefits available under Medicare. Once benefits have been exhausted, the TAR must be submitted along with written verification from Medicare that the benefits have been exhausted. The TAR must be submitted within 15 business days of the date the benefits exhausted or within 60 calendar days of retrospective eligibility. This requirement applies only when Medicare coverage is primary and applicable to the requested service.
   a. Exception: If the provider receives a denial from Medicare or any other primary payor source, they must submit a TAR to Partnership's Health Services Department, along with a copy of the Medicare denial and the medical record documentation. The TAR must be received by Partnership within 60 calendar days of the issue date of the denial from Medicare or the other payor source.
   b. Note that requests for durable medical equipment (DME) for dually eligible Medi-Cal/ Medicare Members are exempt from the process outlined above in VI.B.2. Medicare does not issue denials and Explanations of Benefits (EOBs) for non-covered DME services.
3. TARs are not required for certain services, including but not limited to, services related to emergency services, minor consent, family planning and preventive services, basic prenatal care, sexually transmitted disease services and human immunodeficiency virus (HIV) testing.
4. Authorizations granted for single-encounter, outpatient medical services (dental anesthesia, sleep studies, surgical procedures, interventional pain management procedures, genetic testing, and laboratory studies) ~~will~~ may be limited to a 6-month authorization period. Services excluded from this limit ~~will~~ may include: Transplants, Dialysis, Palliative Care, Cardiac Rehabilitation, and Pulmonary Rehabilitation. Please note this limit is only applicable to single-encounter, outpatient medical services requiring a TAR. Requests for extension of authorization when a service is not rendered within the authorization period should continue to be submitted as a correction (as described in VI.C.8 below) and will be reviewed on a case~~-~~-by-~~-~~case basis.

C. TAR SUBMISSION PROCESS

TARs for Members who require services should be submitted electronically via Partnership's Online Services (OLS) portal https://provider.partnershiphp.org/UI/Login.aspx. TARs must be received by Partnership within fifteen (15) business days of the date of service or within 60 calendar days of either a denial from the primary insurance carrier or retrospective eligibility. (TARs submitted beyond these timeframes are considered late but will still be reviewed for medical necessity.) Electronic submission will allow for more expedient processing. If online submission is not possible, the TAR may be submitted via fax (707) 863 - 4118 or mail to Partnership's Health Services Department for review.

1. Urgent TAR Requests
   a. Urgent TAR submission is available for requests in which the provider indicates, or Partnership determines, that the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.
   b. Requests for an urgent determination should be submitted by the provider and clearly marked "Urgent" or "Expedited" and should indicate the reason there is an urgent need for authorization.
   ~~a.~~c. A TAR for an elective (non-emergent) surgery submitted urgently due only to an imminent date of service is NOT considered to be urgent. TARs submitted under these circumstances will be reviewed as a non-urgent pre-service request.
2. Non-urgent Elective Requests
   a. All elective inpatient hospital admissions require prior authorization EXCEPT anticipated two (2) day post vaginal delivery stays and four (4) day post C-Section stay.
      1) Obstetrical admissions do not require a TAR prior to admission, for obstetrical delivery. The hospital must notify Partnership if the mother and/or baby require additional days of acute care. The Nurse Coordinator concurrently reviews the case within 24 hours (1 calendar day) of receipt of clinical information.
   b. A service being provided that is not pregnancy-related requires the admitting physician to submit the TAR for the elective procedure prior to the actual hospital admission. ~~Although an approved TAR will assign a specified number of initial days approved, the hospital is required to notify Partnership within one business day of the actual date of admission.~~
      1) Please note that Partnership will assign a number of initially-approved days, however, it is the hospital's responsibility to notify Partnership within one business day of the date of the actual admission.
      2) If the patient's condition necessitates hospitalization beyond the pre-approved timeframe, Partnership will perform concurrent review on the remainder of the stay.
   ~~b.~~c. Authorization for non-obstetric elective hospital admissions must be submitted by the admitting physician and include the following:
      1) Procedure code or service being performed
      2) Facility where procedure will be performed
      3) Anticipated date of procedure
      4) Number of days being requested if inpatient admission
      5) Diagnosis
   d. Managed care plans are not required to cover cosmetic surgery (see definition in III.C).
3. Emergency Admissions
   a. For all emergency and obstetrical admissions, the hospital ~~or long term care (LTC) facility~~ must notify Partnership and the Member's PCP of the admission as soon as possible, but no~~t~~ later than the first business day following the date of admission.
   b. The case is reviewed by the Nurse Coordinator and a decision on length of stay is authorized based on Partnership established criteria within 24 hours (1 calendar day).

4. Dialysis Services
   a. Initial TAR requests for Dialysis services for Members who have no other insurance will be authorized for a 90 calendar ~~-~~day period only.
   b. Per CCR Title 22 sections 50763 and 50777, ~~"~~Medi-Cal beneficiaries must apply for any available health care coverage when no cost is involved.~~"~~ All Members receiving dialysis must submit an application to Social Security for Medicare benefits.
   c. The provider must submit a denial from Medicare for Partnership to approve services beyond the initial 90 calendar days.
   d. Once a Medicare determination of denial of coverage is received, Partnership will assign the Member to a Direct Member status for End Stage Renal Disease (ESRD) as described in policy MPUP3039 Direct Members. This status will allow dialysis services to be approved ~~issue a TAR that will remain valid~~ for the Member's lifetime or until the Member receives a kidney transplant.
5. Hospice Services
   Hospice services do not require a TAR ~~ONLY for~~ unless services are provided in an inpatient setting such as ~~service~~an ~~s (i.e.~~ acute or skilled nursing ~~facility [SNF]/LTC~~ facility.
   a. ~~.) However,~~ To ensure proper hospice claim processing and reimbursement for outpatient or inpatient services, all licensed and certified hospice providers must submit the Medi-Cal Hospice Program Election Notice form (*DHCS 8052*) to Partnership within five calendar days of a Medi-Cal Member's certification and election of hospice services.~~a Hospice election form signed by the Member or their legal representative must accompany any initial claim for hospice services (all outpatient and inpatient services) .~~See policy MCUP3020 Hospice Services for further details.
6. ~~Long Term~~Extended Care~~/Skilled~~ Nursing Services
   All ~~Skilled Nursing or~~ Extended Care (Custodial/ Long Term Care/ Skilled Nursing/ Subacute) ~~Care~~ facility admissions require approval prior to the admission, and throughout the length of stay.
   a. When a Member is admitted for custodial care, a TAR submission may be approved for an initial six (6) month period and the Member's condition will be re-evaluated at six (6) month increments. (See also policy MCUG3038)
   b. For continued custodial care, a new TAR must be submitted within 15 calendar days of the expiration date of the original TAR.
7. Post-service (Retrospective) Requests
   Retrospective (Retro) TARs must be received by Partnership within fifteen (15) business days of the date of service or within 60 calendar days of a denial from the primary insurance carrier. (Note that if a provider incorrectly submits a TAR for a Partnership M~~m~~ember to the State Medi-Cal field office, Partnership will apply these timeliness requirements beginning on the date the request is received in our office.) Retro TARs received after that timeframe are considered for review only under the following conditions:
   a. When a Member does not identify their self to the provider as a Partnership Member by deliberate concealment or because of physical or mental incapacity to so identify their self.
   b. If a Member has obtained retroactive eligibility. The TAR must be received by Partnership within 60 calendar days of the Member having obtained Medi-Cal eligibility.
8. Correction TAR Requests
   a. The provider has up to 12 months from the approved date of the ORIGINAL authorized TAR to submit modifications of approved services. A new TAR must be submitted with the requested modifications and MUST reference the ORIGINAL TAR number and code(s) or date(s) to be modified. Modifications will be accepted or made only on approved TARS for the following:
      1) Types of service. For example, only similar items or procedures may be modified

(e.g. ~~micropore tape versus paper tape,~~ right wheels versus left wheels~~, etc.~~).

2) Minor extension or change of dates may be requested (e.g. start of service May 15 versus May 20).

3) Units of service (e.g. 9 visits versus 6 visits). This usually coincides with a change of, or extension of, dates of service requested.

9. Note that if a provider incorrectly submits a TAR for a Partnership Member to the State Medi-Cal field office, Partnership applies timeliness requirements to that request. If the Member was eligible with Partnership at the time of the request, TARs submitted beyond the 15 business day requirement are considered late but will still be reviewed for medical necessity.

D. UM REVIEW PROCESS

1. Nurse Coordinator Review

a. A Nurse Coordinator can approve, modify, defer (pend) or deny the TAR for non-medical necessity determinations.

1) The Nurse Coordinator reviews the information received from the provider utilizing Partnership approved review guidelines. The Nurse Coordinator approves the request if it meets medical necessity criteria.

2) Requests that do not meet review guidelines and require clinician review due to questions of medical necessity are referred to the Chief Medical Officer (CMO) or Physician Designee for further evaluation. The Nurse Coordinator attaches all relevant documentation, InterQual® criteria and the Medical Director Worksheet.

3) ONLY the Chief Medical Officer or Physician Designee can deny TARs for reasons of medical necessity.

2. Chief Medical Officer (CMO)~~-~~/ Physician Designee Review

a. The ~~Chief Medical Officer or~~CMO/ Physician Designee must be available physically or by telephone during business hours to assist with evaluating TAR requests.

b. The ~~Chief Medical Officer or~~CMO/~~-~~Physician Designee review is done in all cases of potential denial due to medical necessity, interpretation issues, or other issues as requested by the UM staff. Partnership's ~~Chief Medical Officer or~~CMO/ Physician Designee reviews all TARs referred to him/her, taking the action deemed appropriate.

c. The CMO/~~Chief Medical Officer or~~ Physician Designee may contact involved providers or consultants for additional information as required to assist them in rendering a decision about the case. They may contact the requesting provider for further information. The CMO/~~Chief Medical Officer or~~ Physician Designee documents the rationale for any decision on the Medical Director Worksheet. Once the CMO/~~Chief Medical Officer or~~ Physician Designee approves or modifies the request, the TAR will be returned to the Nurse Coordinator for completion.

d. The ~~Chief Medical Officer or~~ CMO/Physician Designee is the only person authorized to sign denials for medical necessity or to make any exceptions or modifications to the established Partnership medical criteria. Denials for medical necessity are made only by the ~~Chief Medical Officer or~~CMO/ Physician Designee.

e. Partnership makes a physician reviewer available (~~Chief Medical Officer or~~CMO/~~-~~Physician Designee) to discuss medical necessity determinations with providers by telephone (peer to peer review).

f. For information on the process for a Member, Member's authorized representative, or a provider on behalf of a Member, to appeal Partnership UM decisions, see Partnership policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions.

3. Delegated Entity Review

a. Partnership uses delegated entities to perform some aspects of utilization management. They make determinations on service requests for their assigned Members. All delegates will follow the decision making and notification timeframes set out below in section VI.D.6. for medical and behavioral health services.

b. Partnership's Associate Director of UM Regulations is responsible for monitoring the Utilization Management activities of delegated entities. On a daily basis (during business days), the UM Associate Director of UM Regulations and the Delegation Program Manager monitor authorizations performed by delegated entities through Partnership's electronic authorization system. On a weekly basis, they generate timeliness reports for all delegated entities and analyze trends. Delegated entities are notified immediately of any areas of concern. On a quarterly basis, timeliness data reports are prepared for review and audit with each delegated entity. Reports are also reviewed by the CMO or physician designee at least annually or more often as needed if areas of concern are noted.

c. Multi-specialty medical groups do not require pre-authorization from Partnership for services for which they are delegated. All elective hospital admissions must be pre-authorized by the medical group and reported to Partnership at the time of admission.

4. Non-Contracted Hospital Review
   a. Elective admissions to non-contracted hospitals require approval of a TAR, which is subject to Partnership's timeline policies. When the admission is elective and has been given prior authorization, no further communication is required until the approved number of days is nearing expiration and the Member is expected to remain hospitalized beyond the days previously approved. The facility is required to provide to the Nurse Coordinator appropriate clinical information supporting the medical necessity of continued stay.
   b. As most admissions to non-contracted hospitals are for emergency conditions, the procedure for non-contracting hospital review is as follows:
      1) If the admission does not meet admission criteria, it is referred to the Chief Medical Officer (CMO) or Physician Designee for review. The Nurse Coordinator notifies the non-contracting hospital of the ~~Chief Medical Officer or~~CMO/~~-~~Physician Designee's decision and provides the process for appeal or the opportunity to discuss the determination with the CMO/Physician Designee (peer to peer review).
      2) Until the Member is medically stable for discharge or transfer to a lower level of care, clinical review should be sent to Partnership's Nurse Coordinator.
      3) For a Member capitated to an in-plan hospital who is admitted to a non-capitated hospital, please refer to policy MCUP3141 Delegation of Inpatient Utilization Management.
5. Post Stabilization Services
   Upon receipt of an authorization request from an emergency services provider, UM shall render a decision within 30 minutes ~~-~~or the request is deemed approved, pursuant to Title 42 CFR section 438.114 and Title 28 CCR Section 1300.71.4.
6. UM Decision and Notification Timelines
   a. Urgent Concurrent Review
      1) For urgent concurrent review, Partnership will render a decision (approve, modify, defer/pend, deny) within 72 hours.
      2) If the request to extend urgent concurrent care was not made prior to 24 hours before the expiration of the authorized period of time or number of treatments, the request will be reviewed as an urgent pre-service and a decision will be rendered within 72 hours from the original date of receipt.

3) If the request to approve additional days for urgent concurrent care is related to care not approved by Partnership previously, Partnership will attempt to obtain necessary information related to the request ~~within 24 hours~~as soon as possible. The decision will be rendered no later than 72 hours from the original date of receipt of the request.

~~4)~~ For urgent concurrent denials, Partnership will~~may~~ inform the hospital Utilization Review ~~(UR)~~ department staff of the decision. ~~, with the understanding that staff will inform the attending/treating prescriber.~~

~~5)~~4) If it is determined that additional information is required, or if a Member requests an extension, Partnership will extend the time frame one time by up to 14 calendar days. Partnership will document the specific reason for the extension in Partnership's electronic authorization system. The provider is then notified immediately in writing of the extension and what specific additional information is required to complete the review.

~~6)~~5) Electronic or written notification of the decision is communicated to the provider within 24 hours of the decision, and no later than 72 hours after receipt of the request. If the time frame was extended, the provider will be notified at the time of decision, but no longer than 72 hours from receipt of the additional information requested, not to exceed 14 calendar days from the date of the original request. Partnership is not required to notify the Member of an urgent concurrent decision as the Member is not at financial risk for the services being requested.

b. Urgent Pre-service Review

1) For urgent pre-service review, Partnership will render a decision (approve, modify, defer/pend, deny) within 72 hours.
2) If it is determined that additional information is required, or if a Member requests an extension, Partnership will extend the time frame one time by up to 14 calendar days. Partnership will document the specific reason for the extension in Partnership's electronic authorization system. The Member and the provider are then notified immediately in writing of the extension and what specific additional information is required to complete the review. Any decision delayed beyond the time limits will be escalated to a Physician Designee for review of medical necessity. Partnership will re-review the request if the clinical information requested is received after a decision has been made.
3) Electronic or written notification of the decision and how to initiate a routine or expedited appeal, if applicable, is communicated to the provider within 24 hours of the decision and no later than 72 hours from the receipt of the request. Written notification is mailed to the Member within two (2) business days of the decision. If the time frame was extended, the notification is communicated at the time of decision, but no later than 72 hours from receipt of the additional information requested, not to exceed 14 calendar days from the date of the original request.

c. Non-urgent Pre-service Review and Non-urgent Concurrent ~~and~~ Review

1) For non-urgent pre-service review, Partnership will render a decision (approve, modify, defer/pend, deny) within ~~five~~ seven (~~5~~7) ~~business~~ calendar days from the receipt of the request, but no later than 14 calendar days from the receipt of the request.
2) For non-urgent concurrent review (inpatient care e.g. LTC/SNF), Partnership will render a decision (approve, modify, defer/pend, deny) within 72 hours of receipt of the request and will continue concurrently reviewing the authorization within one (1) business day of receipt each time clinical information is received.
3) If the request is received during non-business hours, Partnership will process the request the next business day.
4) If the TAR lacks clinical information necessary to render a decision, the TAR may be

deferred/pended up to 14 calendar days from the date of the original receipt of the request. Partnership will document the specific reason for the extension in Partnership's electronic authorization system. The Member and the Provider are then notified immediately in writing of the extension and what specific additional information is required to complete the review. In addition to electronic or written notification, the UM Staff will contact the Provider and/or designated office staff member to remind them of the specific information requested and the regulatory timeframe for submission. ~~. In the event that a Member requests an extension on a deferred/pended TAR with Partnership's grievance department, or if Partnership determines an extension of the pended request is in the best interest of the Member after the initial 14 calendar days are exhausted, Partnership may extend the deferred/pended period up to an additional 14 calendar days, for a total of 28 calendar days from the original date of receipt of the request.~~ Any decision delayed beyond the time limits will be escalated to a Physician Designee for review of medical necessity. Partnership will re-review the request if the specified clinical information requested is received after a decision has been made.

5) Notification of Decision:
   a) Non-urgent pre-service review: Electronic or written notification of the decision and how to initiate a routine or expedited appeal, if applicable, is communicated to the provider within 24 hours of the decision and written notification is mailed to the Member within two (2) business days of the decision. If the time frame for the review was extended, the notification will be provided at the time of decision, but no longer than ~~five~~ seven (7~~5~~) ~~business~~ calendar days from receipt of the additional information requested, not to exceed 14 calendar days from the date of the original request. ~~or 28 calendar days if a second extension is applied.~~
   b) For a non-urgent concurrent review, electronic or written notification of the decision is communicated to the provider within 24 hours of the decision and no later than 72 hours after receipt of the request. Partnership is not required to notify Members of non-urgent concurrent review decisions as the Member is not at financial risk for the services being requested.

d. Post-service (Retrospective) Review
   1) For post-service review, Partnership will render a decision (approve, modify, defer/pend, deny) no longer than 30 calendar days from the receipt of the request.
   2) Electronic or written notification of the decision and how to initiate a routine or expedited appeal if applicable, is communicated to the provider within 24 hours of decision, but no longer than 30 calendar days from the date of the receipt of the request. Written notification is mailed to the Member within two (2) business days of the decision.

E. MONITORING OF THE TAR PROCESS
1. Aggregate TAR data is subject to retrospective analysis by Partnership's UM Department. This review is designed to:
   a. Identify individual provider practice patterns relative to standards of medical practice.
   b. Evaluate over and under-utilization of services.
2. Partnership monitors turnaround times of internal processing for compliance with standards.
3. Denials or modifications for medical necessity are monitored weekly to ensure accuracy in regulatory requirements, review processes, and correspondence.
4. Partnership performs inter-rater reliability (IRR) audits as outlined in policy MPUP3026 Inter-Rater Reliability Policy, at least biannually on both physician and nurse reviewers. (IRR audits are also conducted with pharmacist reviewers and lead pharmacy technicians for TARs reviewed by Partnership's pharmacy department according to policy MCRP4068 Medical Benefit Medication

TAR Policy.)

5. Member & provider grievances, as well as Partnership's member and provider satisfaction survey responses, serve as an evaluation tool.
6. Administrative denials (as defined in policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions) are reviewed monthly by the Chief Medical Officer. A summary is presented to the Internal Quality Improvement Committee (IQI) at least annually or more often as needed.
7. 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:
   a. Consistent with sound clinical principles and processes
   b. Evaluated and updated at least annually
   c. 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~~ Member upon request
   d. 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.
   e. Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment III Section 2.3~~5~~ Utilization Management Program
B. DHCS All Plan Letter (APL) 21-011 *Revised* Grievance and Appeals Requirements, Notice and "Your Rights" Templates (~~08/31/2021~~08/31/2022)
C. 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)
D. California Health and Safety Code (HSC) Sections 1363.5 and 1367.01(h)(3)
E. Title 42 Code of Federal Regulations (CFR) section 438.114 *Emergency and Poststabilization Services* and 438.910 *Parity requirements for financial requirements and treatment limitations*~~and~~
F. Title 22 California Code of Regulations (CCR) Section 50763 *Beneficiary Responsibility - Other Health Care Coverage* and Section 50777 Requirements to Apply for Medicare
~~E.~~G. Title 28 California Code of Regulations (CCR) Section 1300.71.4 *Emergency Medical Condition and Post-Stabilization Responsibilities for Medically Necessary Health Care Services*
~~F.~~ Centers for Medicare & Medicaid Services (CMS) Interoperability and Prior Authorization Final Rule (CMS-0057-F) Federal Register 89, no. 11 (January 17, 2024): 8758-8973.
H.
~~G.~~I. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 2026~~5~~) UM 5 Timeliness of UM Decisions ~~Elements A and E~~

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

Policy/Procedure Number: MCUP3041 (previously UP100341)			**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Treatment Authorization Request (TAR) Review Process			☒ **External Policy** ☐ **Internal Policy**
Original Date: (UM-2) 04/25/1994 (Effective 06/19/2013 - TAR/RAF Review Policy split)		**Next Review Date:** ~~06/12/2025~~08/12/2027 **Last Review Date: 08/13/202508/12/2026**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

X. REVISION DATES: TAR Procedure [UM-2]: 11/19/96; 12/15/99; 01/12/00 – RAF Procedure [UM-1]: 12/27/95; 05/27/99); (TAR/RAF [UP100341] - 06/21/00; 04/18/01; 03/20/02, 05/21/03 attachments revised 10/01/03; 04/21/04; 01/19/05; 04/20/05; 09/21/05, 10/18/06, 08/20/08, 07/15/09; 05/19/10; 07/20/11); 06/19/13; 06/17/15; 09/16/15; 05/18/16; 04/19/17; *06/13/18; 02/13/19; 05/08/19; 09/11/19; 04/08/20; 09/09/20; 04/14/21; 08/11/21; 05/11/22; 06/14/23; 06/12/24; 08/13/25; 08/12/26

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

PREVIOUSLY APPLIED TO: N/A

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Administrative denials are reviewed monthly by the Chief Medical Officer and monitored quarterly to identify trends and/or the need for additional provider education, outreach, or other intervention. A summary is presented to the Internal Quality Improvement Committee every six months. 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 TAR REQUIREMENTS

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

A. **Acupuncture** *(see policy MPUG3002 Acupuncture Service Guidelines)*
A RAF is required for the first visit, and then members are limited to 2 visits per month. A TAR is required if services exceed two visits per month.

B. **Behavioral Health Treatment** *(see policy MCUP3126 Behavioral Health Treatment (BHT) for Members Under the Age of 21)*

C. **Cardiac Rehabilitation** – Phase II and pediatric *(see policy MCUP3128 Cardiac Rehabilitation)*

D. **Chiropractic Services** *(see policy MPUG3010 Chiropractic Services)*
A RAF is required for the first visit, and then members are limited to 2 visits per month. A TAR is required if services exceed two visits per month.

E. **Community Health Worker (CHW) Services** *(see policy MPAP7004 Community Health Worker (CHW) Services Benefit)* Partnership does not require prior authorization for CHW services as preventive care for the first 12 units. A TAR is required for Members who need multiple CHW services or continued CHW services in excess of 12 units.

F. **Community Supports** A TAR is required for all members receiving a Community Supports service. *[see policies MCAP7003 CalAIM Community Supports (CS) and MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)]*

G. **Dental Anesthesia** *(see policy MPUP3048 Dental Services (including Dental Anesthesia)*

H. **Diagnostic Studies**

A. Magnetic Resonance Angiography (MRA) ~~(MR Angiogram)~~
B. Mass Spectrometry Imaging (MSI)
C. Magnetoencephalography (MEG)
D. PET scan *[see policy MPUP3116 Positron Emission Tomography Scans (PET Scans)]*
E. Transcranial Doppler
F. Sleep Studies / Polysomnography: Facility based sleep studies/polysomnography always require a TAR. Home based studies/polysomnography require a TAR when more than 1 per year is requested. *(see policy MPUG3110 Evaluation and Management of Obstructive Sleep Apnea in Adults (Medi-Cal)*
G. Non-specific radiology codes for X-rays and ultrasound including 76497, 76380, 76506

Note: *No TAR is required for CT scans or MRIs*

I. **Doula Services** *(see policy MP~~C~~NP9006 Doula Services Benefit*) While most doula services are provided with no TAR requirement, please refer to the policy for details on when a TAR may be required for additional visits (beyond eight) during the postpartum period.

J. **Durable Medical Equipment (DME) Supplies** – *(see policy MCUP3013 DME Authorization*)

1. Orthotics – Cumulative costs for repair/maintenance or purchase exceeds $250 / item (*see policy MCUG3032 Orthotic and Prosthetic Appliances Guidelines*)
2. Prosthetics – Cumulative costs for repair / maintenance or purchase exceeds $500 / item (*see policy MCUG3032 Orthotic and Prosthetic Appliances Guidelines). **Also any unlisted / miscellaneous code and any custom made item that does not have a Medi-Cal rate (by-report or by-invoice)***
3. Hearing Aids and Cochlear Implant Replacement Supplies – (*see policy MPUG3019 Hearing Aid Guidelines*)
4. Repairs or maintenance over $250.00 / item – (Out-of-guarantee repairs are to be guaranteed for at LEAST three (3) months from the date of repair. Reimbursement will NOT be allowed for parts or labor

during a guarantee period if due to a defect in material or workmanship)

5. Oxygen and related supplies
6. Positive Airway Pressure (PAP) devices - No TAR is required for PAP supplies for a PAP machine owned by the member (as per Medi-Cal guidelines for ordering/quantity limits).
7. Purchase items when the cumulative cost of items within a group exceeds $100.00 within the calendar month. Providers may refer to the *Durable Medical Equipment (DME): Billing Codes and Reimbursement Rates* section in the Medi-Cal manual to determine if items are related within a group. Items grouped together under specific headings, such as "Hospital Beds" or "Bathroom Equipment," are considered within the same group. (Vendor to guarantee for a MINIMUM of six (6) months from the date of purchase)
8. Rental items when the cumulative cost of rental for items within the group exceeds $50.00 within a 15-month period. This includes any daily amount that an individual item, or a combination of a similar group of DME items, exceeds the $50 threshold. The 15-month period begins on the date the first item is rented. (Rental rate includes equipment related supplies.)
9. Purchase of any wheelchairs for Medi-Medi members
10. Purchase of knee scooters with appropriate criteria met. Invoice is required and maximum payable benefit amount is $200. *(see policy MCUP3013 DME Authorization*)
11. Incontinence Supplies *(see policy MCUG3022 Incontinence Guidelines*)
    a. Note that codes A4335 for skin wash and A4665 for skin cream for members with incontinence do not require a TAR unless claim quantity exceeds normal frequency limits. However, providers are encouraged to include these items on the incontinence supply TAR as the authorization will be good for one year and the provider will be able to submit claims electronically without attaching the prescription each month. If these items are not included on the incontinence supply TAR, then the provider must submit a paper claim and attach a prescription form with each submission.

K. **Enhanced Care Management (ECM)** A TAR is required for all members receiving the ECM Benefit. *[see policies ~~MCCP2032~~ MCAP7002 CalAIM Enhanced Care Management (ECM) and MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)]*

L. **EPSDT** (Early and Periodic Screening, Diagnosis and Treatment) Supplemental Services (*see policy MCCP2022 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services)*

M. **Fecal Microbiota Transplant (FMT) and Microbiota-Based Therapeutics (MBT)** A TAR is required for all procedures related to microbiota-based therapeutics, including fecal microbiota transplant. *(see policy MPUP3136 ~~Fecal~~ Microbiota-Based ~~Transplant~~Therapeutics [MBT])*

N. **Gender Dysphoria** – A TAR is required for all procedures related to gender dysphoria. *(see policy MCUP3125 Gender Dysphoria/ Surgical Treatment)*

O. **Genetic Testing and Screening** – A TAR is required for certain genetic testing and screening as outlined in Attachment A of policy *MCUP3131 Genetic Screening and Diagnostics*

P. **Hearing Aids** *(see policy MPUG3019 Hearing Aid Guidelines)*

Q. **Home Health Care** *(see policy MPUG3011 Criteria for Home Health Services)*

R. **Home Infusion Therapy**

S. **Hysterectomy**

PARTNERSHIP TAR REQUIREMENTS

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

T. **Hospice Care (Inpatient Only)** *(see policy MCUP3020 Hospice Service Guidelines*)

U. **Hospitalization**
1. The hospital must notify Partnership of any admission within 24 hours of the admission.
2. Authorization for elective admission must be requested by the admitting physician prior to the admission.

V. **Hyperbaric Oxygen Pressurization**

W. **Intermediate Care Facility for developmentally disabled services** *(see policy MCUG3058 Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities*)

X. **Long Term Care**
The LTC facilities must notify Partnership of any admissions, transfer, bed hold/ leave of absence, or change in payor status within one working day. (Examples include Medicare non-coverage or exhaustion of benefits/ hospice election.) *See policy MCUG3038 Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled or Subacute) ~~(LTC)~~ Facilities.*

Y. **Medical Supplies***
1. Nebulizers – When the billed price including tax is $200 or more *(see policy MPUG3031 Nebulizer Guidelines*)
2. Ostomy Supplies+ (Note: NU modifier may not be used for "disposable" ostomy supplies)
3. Urological Supplies+ (Note: NU modifier may not be used for "disposable" urological supplies)
4. Tracheostomy Supplies+
5. Wound Care Supplies+ TAR requirements may vary.
6. Negative Pressure Wound Therapy Devices [*see policy MPUP3059 Negative Pressure Wound Therapy (NPWT) Device/Pump]*
7. Nutritional Supplements - *(see policy MCUP3052 Medical Nutrition Services*) Physician administered nutritional supplements require a TAR to be submitted to Partnership when the item is billed to Partnership's medical benefit and is not included in Partnership's Medical Drug List (MDL) Navigator, or when the Partnership MDL indicates a prior authorization is required. Nutritional supplements provided by a Pharmacy must be submitted through Medi-Cal Rx TAR processes* when not on the Medi-Cal Rx Contract Drugs List (CDL). Enteral formulas require a Medi-Cal Rx TAR when provided by a pharmacy.

***Note:** *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 APL ~~22-012~~25-013 ~~Revised~~. TARs will be operationally denied if submitted to Partnership for supplies which are carved out from managed care reimbursement and are only provided through Medi-Cal Rx as Pharmacy claims. See Medi-Cal Rx Provider Manual for covered medical supplies and limits. Supplies that can only be billed to Medi-Cal Rx include Insulin Syringes, Pen needles, Lancets, Diabetic Test Strips, Peak Flow Meters, and Inhaler Assistive Devices.*
+ **Note**: *For detailed information regarding Medi-Cal frequency limits and TAR requirements for ostomy, urological, tracheostomy and wound care supplies, please reference Medi-Cal Provider Manual/ Guidelines section Medical Supplies Billing Codes, Units and Quantity Limits*

Z. **Medications Provided by a Pharmacy:** 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 APL 25-013~~22-012 *Revised*~~ and all medications (Rx and OTC) which are provided by a pharmacy must be billed to State Medi-Cal/DHCS contracted pharmacy administrator instead of Partnership.

AA. **Medications Administered in a Medical Setting, and Billed as a Medical Claim [Physician Administered Drugs (PADs) given in an outpatient clinic, office, dialysis center, hospital]:**

Partnership requires a TAR for certain prescription drugs, over-the-counter drugs and injectable drugs (including drugs compounded for IV infusion therapy) as outlined in policy *MCRP4068 Medical Benefit Medication TAR Policy*.

BB. **Non-Emergency Medical Transportation:** [*see policy MCCP2016 Transportation Guidelines for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)*]

CC. **Occupational Therapy** *(see policy MPUP3114 Physical, Occupational and Speech Therapies)*
a. Partnership Members under age 21 can be referred by a licensed clinician for one consultation visit through a physician order. Partnership's referral authorization system need not be used. Following the initial evaluation, the service provider must submit a TAR for the requested services.
Note: *No TAR is required for Members age 21 and over up to 12 visits (limit one visit per day) for OT services in a rolling 12-month period. (A TAR will be required for services in excess of 12 visits.)*
b. A TAR is required for all OT services provided as Home Health or by Non-contracted Providers

DD. **Outpatient Hemo / Peritoneal Dialysis** Initial authorization will be limited to 90 days and a lifetime authorization may be granted with annual certification, only after submission of Medicare determination.)

EE. **Outpatient Surgical Procedures** – see **CPTs Requiring TAR** list (page 5)

FF. **Pain Management** – see **Pain Management CPTs Requiring TAR** list (page 8) and policy *MCUP3049 Pain Management Specialty Services*

GG. **Phototherapy** for dermatological condition

HH. **Physical Therapy** *(see policy MPUP3114 Physical, Occupational and Speech Therapies)*
a. Partnership Members under age 21 can be referred by a licensed clinician for one consultation visit through a physician order. Partnership's referral authorization system need not be used. Following the initial evaluation, the service provider must submit a TAR for the requested services.
Note: *No TAR is required for Members age 21 and over for up to 12 visits (limit one visit per day) for PT services in a rolling 12-month period. (A TAR will be required for services in excess of 12 visits.)*
b. A TAR is required for all PT services provided as Home Health or by Non-contracted Providers

II. **Pulmonary Rehabilitation** *(see policy MPUP3111 Pulmonary Rehabilitation)*

JJ. **Speech Therapy** *(see policy MPUP3114 Physical, Occupational and Speech Therapies)*
a. Partnership Members under age 21 can be referred by a licensed clinician for one consultation visit through a physician order. Partnership's referral authorization system need not be used. Following the initial evaluation, the service provider must submit a TAR for the requested services.
Note: *No TAR is required for Members age 21 and over for up to 12 visits (limit one visit per day) for ST services in a rolling 12-month period. (A TAR will be required for services in excess of 12 visits.)*
b. A TAR is required for all ST services provided as Home Health or by Non-contracted Providers

KK. **Transplants** (*see policy MCUP3104 Transplant Authorization Process)*

LL. **ANY UNLISTED OR MISCELLANEOUS CODE**

HCPCS Codes	Description
P9020	Platelet rich plasma unit
V2531	Contact Lens, Scleral, Gas Permeable, Per Lens

PARTNERSHIP TAR REQUIREMENTS

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

HCPCS Codes	Description
C9757	Spine/Lumbar Surgery

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
10040	Acne Surgery
15769	Graft of Autologous Soft Tissue, Other, Direct Excision
15771	Graft of Autologous Fat Harvested by Liposuction; 50cc or less injectate
15772	Graft of Autologous Fat Harvested by Liposuction; each additional 50cc
15773	Graft of Autologous Fat Harvested by Liposuction; 25cc or less injectate
15774	Graft of Autologous Fat Harvested by Liposuction; each additional 25cc
15788 Thru 15793	Chemical Peel, Facial Et Al
15820 Thru 15823	Revision Of Lower or Upper Eyelid
15845	Skin and Muscle Repair, Face
17360	Skin Peel Therapy
17999	Skin Tissue Procedure
19300	Mastectomy for Gynecomastia
19316	Mastopexy
19318	Reduction Mammoplasty
19324/25	Breast Augment; W/O Prosthetic Implant
19499	Correction of Inverted Nipples
19380	Revise Breast Reconstruction
19396	Design Custom Breast Implant
19499	Unlisted Procedure, Breast
20999	Musculoskeletal Surgery
21208	Augmentation of Facial Bones
22899	Spine Surgery Procedure
22999	Abdomen Surgery Procedure
28292, 28296, 28297, 28298, 28299, 28899	Correction of Bunion
28289	Repair Hallux Rigidus
28300 Thru 28345	Osteotomy / Repair / Reconstruction
30400, 30410, 30420, 30430, 30435, 30450, 30460, 30465, 30468, 30520	Reconstruct of Nose
30520	Repair Nasal Septum
32999	Chest Surgery Procedure
36299	Vessel Injection Procedure
36522	Photopheresis, extracorporeal
37700	Ligation and Division of Long Saphenous Vein at Saphenofemoral Junction, or Distal Interruptions

PARTNERSHIP TAR REQUIREMENTS

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
37718	Ligation, Division, and Stripping, Short Saphenous Vein
37722	Ligation, Division, and Stripping, Long (Greater) Saphenous Veins from Saphenofemoral Junction to Knee or Below
37735	Ligation and Division and Complete Stripping of Long or Short Saphenous Veins With Radical Excision of Ulcer and Skin Graft and/or Interruption of Communicating Veins of Lower Leg, With Excision of Deep Fascia
37760	Ligation of Perforator Veins, Subfascial, Radical (Linton Type) Including Skin Graft, When Performed, Open, 1 Leg
37761	Ligation of Perforator Vein(S), Subfascial, Open, Including Ultrasound Guidance, When Performed, 1 Leg
37765	Stab Phlebectomy Of Varicose Veins, 1 Extremity; 10-20 Stab Incisions
37766	More Than 20 Incisions
37780	Ligation and Division of Short Saphenous Vein at Saphenopopliteal Junction (Separate Procedure)
37785	Ligation, Division, and/or Excision Of Varicose Vein Cluster(S) 1 Leg
38205, 38206	Stem Cell Harvesting
38230	Bone Marrow Harvesting
36511	Therapeutic Apheresis of WBC ‘s
36512	Therapeutic Apheresis of RBCs
38204	Unrelated Harvesting of Cells
38205	Stem Cell Harvesting from Siblings
38207	Stem Cell Storage
41899	Gum Surgery Procedure
43770	Laparoscopy, Surgical, Gastric Restrictive Procedure
43771	Laparoscopy, Surgical, Revision of Adjust Gastric Band
43772	Laparoscopy, Surgical, Removal of Adjustable Gastric Band
43773	Laparoscopy, Surgical, Removal & Placement of Adj Gastric Band
43774	Laparoscopy, Surgical, Removal of Adjustable Gastric Band
43775	Lap Sleeve Gastrectomy
43842	Gastroplasty, Vertical Banded, for Morbid Obesity
43843	Gastroplasty, Other Than Vertical-Banded, for Morbid Obesity
43845	Gastroplasty
43846	Gastric Bypass for Obesity
43847	Gastric Restrictive Procedure with Gastric Bypass
43848	Revision of Gastric Restrictive
43886	Gastric Restrictive Procedure
43887	Gastric Restrictive Procedure, Removal of Subcutaneous Port Component
43888	Gastric Restrictive Proc, Removal & Replacement of Subcutaneous Port
43999	Stomach Surgery Procedure

PARTNERSHIP TAR REQUIREMENTS

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
48160	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells transplantation of pancreas or pancreatic islet cells
49999	Abdomen Surgery Procedure
54161	Circumcision –TAR not required if patient < 4 months of age (See policy MCUP3121 Neonatal Circumcision)
54360	Penis Plastic Surgery
54400, 54406 - 54440	Penile Prosthesis / Plastic Procedure for Penis
55175/80	Revision Of Scrotum
55200	Incision Of Sperm Duct
56800	Repair Of Vagina
58150 Thru 58294, 58570	Hysterectomy
58350	Reopen Fallopian Tube
58550 Thru 58554	Laparoscopy, Surgical; With Vaginal Hysterectomy With or Without Removal of Tube(s), With or Without Removal of Ovary(ies) (Laparoscopic Assisted Vaginal Hysterectomy)
58578/79	Unlisted Procedure, Uterus
58999	Unlisted procedure, female genital system
61867, 61868, 61880, 61888, 64999	Insertion, Revision or Removal of Cranial Neurostimulator
62287	Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumber (e.g. manual or automated percutaneous discectomy,
62290, 62291	Discography, Lumbar (62290) and Cervical/Thoracic (62291)
63650, 63655, 63662, 63664, 63685	Insertion or Revision of Spinal Neurostimulator
66987	Extracapsular Cataract Removal W/ Insertion of Intraocular Lens Prosth complex
66988	Extracapsular Cataract Removal W/ Insertion of Intraocular Lens Prosth
67900 Thru 67924	Repair Brow, Ptosis, Blepharoptosis, Lid
67950 Thru-66	Revision of Eyelid
67971-75	Reconstruction of Eyelid
67999	Unlisted Eyelid Procedure
69300	Revise External Ear
69399	Outer Ear Surgery Procedure
72285	Cervical and Thoracic Discography
72295	Lumbar discography

PARTNERSHIP TAR REQUIREMENTS

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

Pain Management CPTs Requiring TAR	
CPT Code	**Description**
22510, 22511, 22512, 22513, 22514, 22515	Percutaneous vertebroplasty and percutaneous vertebral augmentation
27096	Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid
62263	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiological localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days
62264	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiological localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day
62290, 62291	Injection procedure for Discography, Lumbar (62290) and Cervical/Thoracic (62291)
62360, 62362	Implantable or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
63650, 63655, 63661, 63662, 63663, 63664, 63685, 63688	Insertion or revision of spinal neurostimulator
64479	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level
64480	Cervical or thoracic, each additional level
64483	Lumbar or sacral, single level
64484	Lumbar or sacral, each additional level
64490	Injection(s), diagnostic or therapeutic agent, Paravertebral facet (zygapophyseal) joint with image guidance (fluoroscopy or CT), cervical or thoracic; single level.
64491	Second level (List separately in addition to code for primary procedure)
64492	Third level (List separately in addition to code for primary procedure
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT, lumbar or sacral; single level)
64494	Second level (List separately in addition to code for primary procedure)
64495	Third level (List separately in addition to code for primary procedure)
64633	Destruction by neurolytic agent, paravertebral facet joint nerve. cervical or thoracic, single level
64634	Cervical or thoracic, each additional level
64635	Destruction by neurolytic agent, paravertebral facet joint nerve. single level lumbar or sacral
64636	Lumbar or sacral, each additional level
72285	Radiological supervision and interpretation for Cervical and Thoracic Discography
72295	Radiological supervision and interpretation for Lumbar discography

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UM 2A CLINICAL CRITERIA FOR UM DECISIONS FACTORS 4 AND 5

Annual Review of UM and InterQual® Criteria

Partnership HealthPlan of California (Partnership) utilizes InterQual® criteria in its utilization management (UM) decision making process as well as policies and procedures developed for specific situations. Partnership's UM policies are developed by Partnership Medical Directors and subject matter expert specialists. Specific UM policies may be created when the following situations apply:

1. InterQual® does not have criteria available for a particular service/procedure
2. The most current clinical information in recent nationally recognized literature conflicts with InterQual criteria
3. The California Department of Health Care Services (DHCS) Provider Manuals or "All Plan Letter" directives require development of a policy to provide additional information to Providers

All Partnership UM policies are reviewed annually by the Quality/Utilization Committee (Q/UAC) and the Physician Advisory Committee (PAC) which also include board-certified specialists.

Partnership HealthPlan of California utilizes the following InterQual criteria modules in its UM decision making process. A summary of content for each module is provided in this document. Arrangements can be made to provide further criteria for review upon request. (*Please send request by email to* UMRegulationsHD@partnershiphp.org)

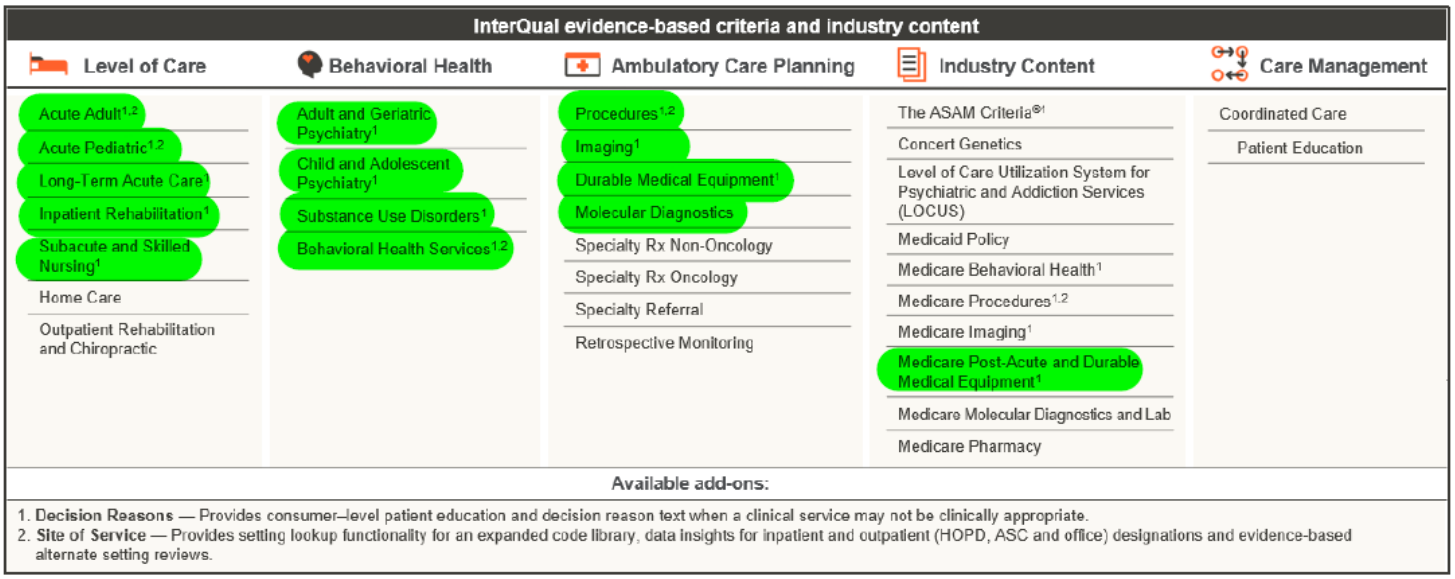
InterQual® Clinical Content

Optum

InterQual® 2026

InterQual development process

The InterQual portfolio of content modules includes our proprietary InterQual content as well as a growing body of industry content from 3rd party sources (i.e., Centers for Medicare and Medicaid Services, American Society of Addiction Medicine).



InterQual content is produced using a rigorous development process based on the principles of evidence-based medicine (EBM). InterQual clinical content is created by the Optum research and content development staff of over 55 research and clinical decision support specialists including physicians, registered nurses, physician assistant, nurse practitioners, social workers, physical and occupational therapists, and other healthcare professionals, including a medical librarian. The physicians' backgrounds include experience or specialization in internal medicine, neurology, psychiatry, substance use disorders, hospital medicine, pulmonary medicine, and critical care medicine. Most of the clinical staff hold advanced degrees (e.g., MD, DO, Masters, Ph.D.), certifications (e.g., nurse practitioner, physician assistant), and/or case management certification. All InterQual research and content development staff receive comprehensive, ongoing training at least quarterly in the concepts and methods of EBM and value-based clinical improvement to ensure that InterQual uses the best available evidence to support improved clinical decision-making, outcomes, quality, and value. New content staff receive comprehensive training in the principles of evidence-based medicine, including the completion of 9 modules. Additionally, all staff participate in annual refresher training regarding mental health parity to reinforce that the processes, strategies, factors, and evidentiary standards are applied consistently and no more

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stringently between the development of our medical/surgical content and behavioral health content. The InterQual clinical content development process relies on, and is generally consistent with, the following:

- AHRQ Methods Guides, the Cochrane Handbook, and the NICE guideline development manual for literature searching, critical appraisal, and combining results of studies
- GRADE methodology for compiling evidence and determining recommendations

The InterQual clinical development team uses a multi-step standardized development process across our medical/surgical (physical medicine), care management, and mental health/substance use disorders content that synthesizes the best quality relevant scientific evidence and standards of care to ensure that the content reflects unmatched clinical rigor and integrity. The process is the same across all areas of medical and behavioral health literature. (Figure 1.)

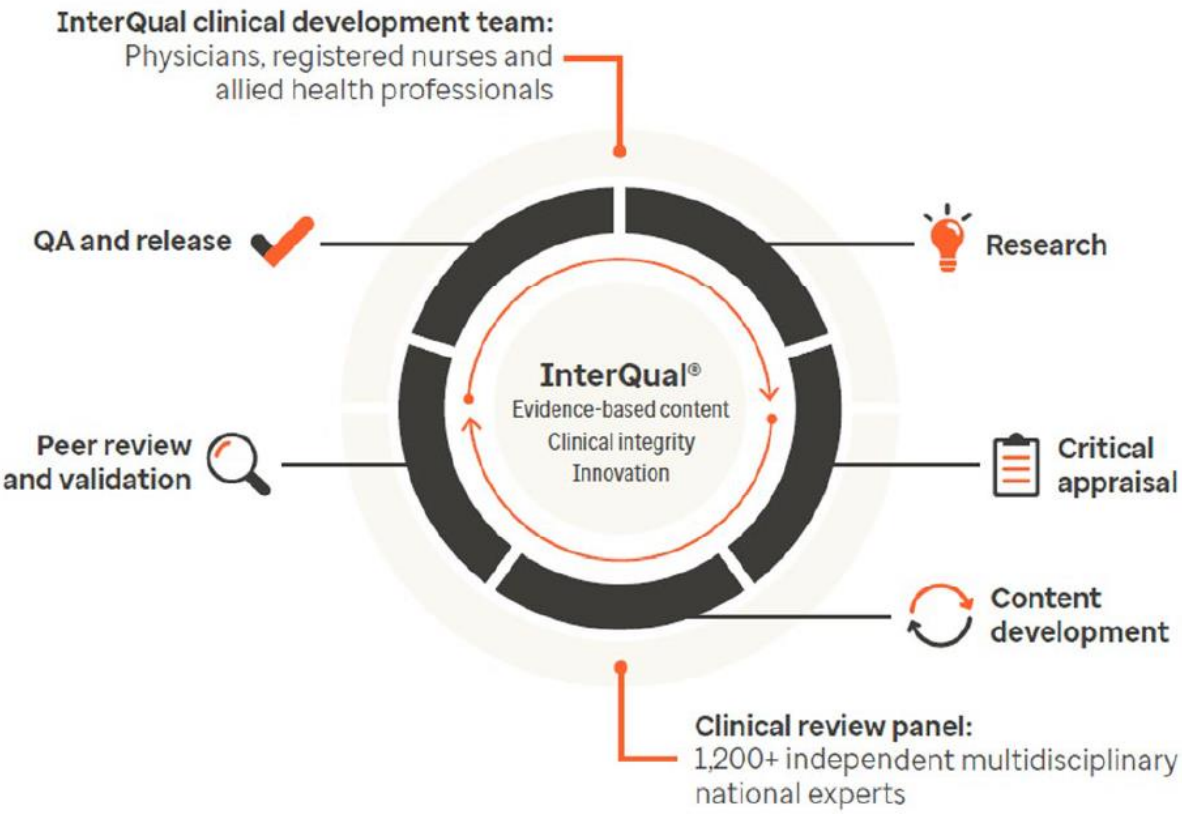

Figure 1. InterQual evidence-based content is reviewed at least annually and updated as necessary through a rigorous and comprehensive development cycle.

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Step 1: Research

Optum observes a planned schedule for reviewing and updating every InterQual subset and module it produces. Our automated literature surveillance processes ensure that, when a critical publication emerges that may necessitate an interim update, our staff are immediately alerted.

InterQual is supported by over 50,000 citations; sources include but are not limited to:

- **General databases:** PubMed
- **Specialty guidelines:** Examples include but are not limited to: American Academy of Family Physicians, American Academy of Orthopedic Surgeons, American College of Cardiology, American Academy of Pediatrics, Society of Critical Care Medicine, American College of Medical Genetics and Genomics, American College of Obstetrics and Gynecology, American College of Radiology, American Society of Addiction Medicine, American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Psychological Association, American Association of Community Psychiatrists, Association For Ambulatory Behavioral Healthcare, American Thoracic Society, National Comprehensive Cancer Network, Infectious Diseases Society of America, Surviving Sepsis Campaign
- AHRQ-contracted Evidence-based Practice Centers (EPCs) and Cochrane Review Groups
- **Accreditation organizations' standards:** URAC, NCQA, The Joint Commission, and CARF
- **National guidelines:** Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), U.K.'s National Institute for Health and Care Excellence (NICE), Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Medicare and Medicaid Services (CMS) Coverage Determinations, U.S. Food and Drug Administration

Step 2: Critical appraisal

The research and content development team conducts a critical appraisal of the search results to identify studies that include best available, peer reviewed evidence. The certainty of each primary research study is assessed using critical appraisal from tools such as the Agency for Healthcare Research and Quality (AHRQ) Methods Guide for Effectiveness and Comparative Effectiveness Reviews, the Cochrane Handbook for Systematic Reviews Chapter 8, the AHRQ Methods Guide for Medical Test Reviews, the Cochrane Handbook for DTA Reviews Chapter 9, NICE Methodology Checklists, and QUADAS-2. Principles found in the Cochrane Handbook for Systematic Reviews and

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methods promoted by the GRADE Working Group are used to combine findings from multiple primary studies so that the overall certainty of evidence is evident for each clinically relevant outcome. Landmark studies are acknowledged when applicable. The quality of each systematic review and health technology assessment, including those embedded in clinical practice guidelines, is assessed using tools such as the Cochrane Handbook for Systematic Reviews, AHRQ Methods Guide, and AMSTAR.

Step 3: Content development

Based on the outcome of the critical appraisal phase, content drafts are updated accordingly, noting the evidence base. Each multidisciplinary content development team is physician-led and includes members with licensure and expertise specific to the services being reviewed. Initial drafts of the InterQual content are created by the Optum research and content development staff, based on the exhaustive review and critical appraisal of external guidelines, medical and behavioral literature, and extensive internal peer review.

Step 4: External peer review

Once a subset or module is created or updated, it is sent for external peer review by a group of independent experts drawn from the Optum external peer review panel. This multidisciplinary panel is comprised of over 1,200 board-certified, practicing clinicians (two thirds of whom are MDs or DOs), all of whom have been screened for conflicts of interest and are credentialed every two years. Clinicians are widely dispersed geographically and practice in various settings, including academic and community-based practices. These experts serve two purposes: first, to ensure that the interpretation of the literature is correct and that they are not aware of any other practice-changing new literature about to be published, and second, to validate the application of evidence underpinning the standard of care into best practice medical appropriateness criteria. The number of external clinicians assembled is in inverse correlation to the strength of the evidence for the topic. For cases that do not lend themselves to formalized study, larger geographically dispersed groups of clinical experts are used to better establish the standard of care. When clinically meaningful changes are made during the external peer review process and/or there is a lack of consensus among the panel members, the content is vetted again, and additional external peer reviewers are added when necessary to ensure accuracy.

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Step 5: Quality assurance and release

Quality is central throughout the development process to help ensure effectiveness and the correct interpretation and application of the evidence. Prior to release, certified medical coders work with the team to help ensure appropriate codes are applied to the relevant areas of content and the team conducts a final quality assurance check. The content is reviewed for clinical accuracy, consistency and completeness across products and approved content is prepared for distribution. A physician medical director provides oversight throughout the development process and helps to ensure clinical accuracy of the content. Extensive clinical revision documents accompany each release outlining the changes made and their rationale along with extensive bibliographies. Releases occur at least annually in the spring for all content modules and as often as monthly to reflect key changes in the literature or regulatory content for any module affected.

Summary

We are proud of our objective process, our large external expert peer review panel, and the quality that we incorporate into every InterQual clinical content set we develop. These processes, based on the principles of evidence-based medicine (EBM), continue to drive value and confidence for our customers, as they have for almost 50 years.

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InterQual® Acute Adult Criteria 2026

Subset	Product	Version
Acetaminophen Overdose	LOC:Acute Adult	InterQual 2026
Acute Coronary Syndrome (ACS)	LOC:Acute Adult	InterQual 2026
Acute Kidney Injury	LOC:Acute Adult	InterQual 2026
Anemia	LOC:Acute Adult	InterQual 2026
Antepartum	LOC:Acute Adult	InterQual 2026
Arrhythmia, Atrial	LOC:Acute Adult	InterQual 2026
Arrhythmia, Blocks	LOC:Acute Adult	InterQual 2026
Arrhythmia, Ventricular or Abnormal ECG Finding	LOC:Acute Adult	InterQual 2026
Asthma	LOC:Acute Adult	InterQual 2026
Bowel Obstruction	LOC:Acute Adult	InterQual 2026
Carbon Monoxide Poisoning	LOC:Acute Adult	InterQual 2026
COPD	LOC:Acute Adult	InterQual 2026
Cystic Fibrosis	LOC:Acute Adult	InterQual 2026
Deep Vein Thrombosis	LOC:Acute Adult	InterQual 2026
Dehydration	LOC:Acute Adult	InterQual 2026
Diabetes Mellitus	LOC:Acute Adult	InterQual 2026
Diabetic Ketoacidosis	LOC:Acute Adult	InterQual 2026
Eating Disorders	LOC:Acute Adult	InterQual 2026
Electrolyte or Mineral Imbalance	LOC:Acute Adult	InterQual 2026
Epilepsy	LOC:Acute Adult	InterQual 2026
Extended Stay	LOC:Acute Adult	InterQual 2026
Gallbladder Disorders	LOC:Acute Adult	InterQual 2026
Gastrointestinal (GI) Bleeding	LOC:Acute Adult	InterQual 2026
General Medical	LOC:Acute Adult	InterQual 2026
General Surgical	LOC:Acute Adult	InterQual 2026
General Trauma	LOC:Acute Adult	InterQual 2026

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InterQual® Level of Care Criteria 2026 Acute Adult

Subset	Product	Version
Genitourinary Obstruction	LOC:Acute Adult	InterQual 2026
Heart Failure	LOC:Acute Adult	InterQual 2026
Hematology/Oncology: Complications or Disease Progre...	LOC:Acute Adult	InterQual 2026
Hematology/Oncology: Hemolytic Uremic Syndrome	LOC:Acute Adult	InterQual 2026
Hematology/Oncology: Treatments	LOC:Acute Adult	InterQual 2026
Hepatic Disorders	LOC:Acute Adult	InterQual 2026
Hospital in the Home	LOC:Acute Adult	InterQual 2026
Hyperglycemic Hyperosmolar State	LOC:Acute Adult	InterQual 2026
Hypertension	LOC:Acute Adult	InterQual 2026
Hypertensive Disorders of Pregnancy	LOC:Acute Adult	InterQual 2026
Hypoglycemia	LOC:Acute Adult	InterQual 2026
Infection: Cellulitis	LOC:Acute Adult	InterQual 2026
Infection: CNS	LOC:Acute Adult	InterQual 2026
Infection: COVID-19	LOC:Acute Adult	InterQual 2026
Infection: Endocarditis	LOC:Acute Adult	InterQual 2026
Infection: General	LOC:Acute Adult	InterQual 2026
Infection: GI/GYN	LOC:Acute Adult	InterQual 2026
Infection: Musculoskeletal	LOC:Acute Adult	InterQual 2026
Infection: Pneumonia	LOC:Acute Adult	InterQual 2026
Infection: Pyelonephritis or Complex UTI	LOC:Acute Adult	InterQual 2026
Infection: Sepsis	LOC:Acute Adult	InterQual 2026
Infection: Skin	LOC:Acute Adult	InterQual 2026
Inflammatory Bowel Disease	LOC:Acute Adult	InterQual 2026
Intestinal Ischemia	LOC:Acute Adult	InterQual 2026
Labor and Delivery	LOC:Acute Adult	InterQual 2026
Non-Traumatic Bleeding	LOC:Acute Adult	InterQual 2026

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InterQual® Level of Care Criteria 2026 Acute Adult

Subset	Product	Version
Pancreatitis	LOC:Acute Adult	InterQual 2026
Postpartum Complication After Discharge	LOC:Acute Adult	InterQual 2026
Pulmonary Embolism	LOC:Acute Adult	InterQual 2026
Rhabdomyolysis or Compartment Syndrome	LOC:Acute Adult	InterQual 2026
Sickle Cell Disease	LOC:Acute Adult	InterQual 2026
Stroke	LOC:Acute Adult	InterQual 2026
Syncope	LOC:Acute Adult	InterQual 2026
TIA	LOC:Acute Adult	InterQual 2026
Transition Plan	LOC:Acute Adult	InterQual 2026
Withdrawal Syndrome	LOC:Acute Adult	InterQual 2026

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InterQual® Acute Pediatric Criteria 2026

Subset	Product	Version
Acetaminophen Overdose	LOC:Acute Pediatric	InterQual 2026
Acute Kidney Injury	LOC:Acute Pediatric	InterQual 2026
Anemia	LOC:Acute Pediatric	InterQual 2026
Antepartum	LOC:Acute Pediatric	InterQual 2026
Asthma	LOC:Acute Pediatric	InterQual 2026
Bone Marrow Transplant/Stem Cell Transplant (BMT/SCT)	LOC:Acute Pediatric	InterQual 2026
Bowel Obstruction	LOC:Acute Pediatric	InterQual 2026
Brief Resolved Unexplained Event (BRUE)	LOC:Acute Pediatric	InterQual 2026
Bronchiolitis	LOC:Acute Pediatric	InterQual 2026
Carbon Monoxide Poisoning	LOC:Acute Pediatric	InterQual 2026
Croup	LOC:Acute Pediatric	InterQual 2026
Cystic Fibrosis	LOC:Acute Pediatric	InterQual 2026
Dehydration or Gastroenteritis	LOC:Acute Pediatric	InterQual 2026
Diabetes Mellitus	LOC:Acute Pediatric	InterQual 2026
Diabetic Ketoacidosis	LOC:Acute Pediatric	InterQual 2026
Eating Disorders	LOC:Acute Pediatric	InterQual 2026
Electrolyte or Mineral Imbalance	LOC:Acute Pediatric	InterQual 2026
Epilepsy	LOC:Acute Pediatric	InterQual 2026
Extended Stay	LOC:Acute Pediatric	InterQual 2026
Failure to Thrive	LOC:Acute Pediatric	InterQual 2026
Gastrointestinal (GI) Bleeding	LOC:Acute Pediatric	InterQual 2026
General Medical	LOC:Acute Pediatric	InterQual 2026
General Surgical	LOC:Acute Pediatric	InterQual 2026
General Trauma	LOC:Acute Pediatric	InterQual 2026
Genitourinary Obstruction	LOC:Acute Pediatric	InterQual 2026

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InterQual® Level of Care Criteria 2026 Acute Pediatric

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InterQual® Level of Care Criteria 2026 Acute Pediatric

Subset	Product	Version
Labor and Delivery	LOC:Acute Pediatric	InterQual 2026
Non-Traumatic Bleeding	LOC:Acute Pediatric	InterQual 2026
Nursery	LOC:Acute Pediatric	InterQual 2026
Pancreatitis	LOC:Acute Pediatric	InterQual 2026
Postpartum Complication After Discharge	LOC:Acute Pediatric	InterQual 2026
Rhabdomyolysis or Compartment Syndrome	LOC:Acute Pediatric	InterQual 2026
Sickle Cell Disease	LOC:Acute Pediatric	InterQual 2026
Transition Plan	LOC:Acute Pediatric	InterQual 2026
Withdrawal Syndrome	LOC:Acute Pediatric	InterQual 2026

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InterQual® Long-Term Acute Care (LTAC) Criteria 2026

Subset	Product	Version
Medically Complex	LOC:Long-Term Acute Care	InterQual 2026
Respiratory Complex	LOC:Long-Term Acute Care	InterQual 2026
Transition Plan	LOC:Long-Term Acute Care	InterQual 2026
Ventilator Weaning	LOC:Long-Term Acute Care	InterQual 2026
Wound / Skin	LOC:Long-Term Acute Care	InterQual 2026

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InterQual® Inpatient Rehabilitation Criteria 2026

Subset	Product	Version
Burns	LOC:Inpatient Rehabilitation	InterQual 2026
CNS / TBI	LOC:Inpatient Rehabilitation	InterQual 2026
Medically Intensive Rehabilitation	LOC:Inpatient Rehabilitation	InterQual 2026
Orthopedic / Amputation	LOC:Inpatient Rehabilitation	InterQual 2026
Pediatric Rehabilitation	LOC:Inpatient Rehabilitation	InterQual 2026
Spinal Cord Injury	LOC:Inpatient Rehabilitation	InterQual 2026
Subacute Rehabilitation	LOC:Inpatient Rehabilitation	InterQual 2026
Transition Plan	LOC:Inpatient Rehabilitation	InterQual 2026

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InterQual® Subacute / SNF Criteria 2026

Subset	Product	Version
Acute Infections (SAC-SNF)	LOC:Subacute / SNF	InterQual 2026
Acute Neurologic (SNF)	LOC:Subacute / SNF	InterQual 2026
Cancer (SAC-SNF)	LOC:Subacute / SNF	InterQual 2026
Cardiovascular and Coagulation Disorders (SAC-SNF)	LOC:Subacute / SNF	InterQual 2026
General Surgery (excludes Orthopedic Surgery, Major Joint Replacement and Spinal Surgery) (SAC-SNF)	LOC:Subacute / SNF	InterQual 2026
Major Joint Replacement or Spinal Surgery (SNF)	LOC:Subacute / SNF	InterQual 2026
Medical Management (SAC-SNF)	LOC:Subacute / SNF	InterQual 2026
Orthopedic Surgery (excludes Major Joint Replacement or Spinal Surgery) (SNF)	LOC:Subacute / SNF	InterQual 2026
Orthopedic/Musculoskeletal (SNF)	LOC:Subacute / SNF	InterQual 2026
Pediatric (SAC)	LOC:Subacute / SNF	InterQual 2026
Pulmonary (SAC-SNF)	LOC:Subacute / SNF	InterQual 2026
Transition Plan	LOC:Subacute / SNF	InterQual 2026

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InterQual® Durable Medical Equipment Criteria 2026

Subset	Product	Version
Aerosol Delivery Devices	CP:Durable Medical Equipment	InterQual 2026
Airway or Secretion Clearance Devices	CP:Durable Medical Equipment	InterQual 2026
Bone Growth Stimulators, Noninvasive	CP:Durable Medical Equipment	InterQual 2026
Cardioverter Defibrillator, Wearable (WCD)	CP:Durable Medical Equipment	InterQual 2026
Continuous Glucose Monitors, Insulin Pumps, and Automated Insulin Delivery Technology	CP:Durable Medical Equipment	InterQual 2026
Continuous Passive Motion Device (CPM), Knee	CP:Durable Medical Equipment	InterQual 2026
Continuous Passive Motion Device (CPM), Upper Extremity	CP:Durable Medical Equipment	InterQual 2026
Enteral and Parenteral Nutrition Therapy	CP:Durable Medical Equipment	InterQual 2026
Hearing Aids	CP:Durable Medical Equipment	InterQual 2026
Home International Normalized Ratio (INR) Monitoring Device	CP:Durable Medical Equipment	InterQual 2026
Home Mechanical Ventilation Devices: Invasive, Noninvasive, and Multifunction	CP:Durable Medical Equipment	InterQual 2026
Home Oxygen Therapy	CP:Durable Medical Equipment	InterQual 2026
Home Phototherapy for Neonatal Hyperbilirubinemia	CP:Durable Medical Equipment	InterQual 2026
Hospital Beds, Cribs, and Accessories	CP:Durable Medical Equipment	InterQual 2026
Negative Pressure Wound Therapy (NPWT) Devices	CP:Durable Medical Equipment	InterQual 2026
Noninvasive Airway Assistive Devices	CP:Durable Medical Equipment	InterQual 2026
Orthoses, Cranial Remodeling	CP:Durable Medical Equipment	InterQual 2026
Orthoses, Lower Extremity, Knee	CP:Durable Medical Equipment	InterQual 2026
Orthoses, Lower Extremity, Knee-Ankle-Foot (KAFO) and Ankle-Foot (AFO)	CP:Durable Medical Equipment	InterQual 2026
Orthoses, Thoracic, Lumbar, and Sacral Spine	CP:Durable Medical Equipment	InterQual 2026
Orthoses, Upper Extremity	CP:Durable Medical Equipment	InterQual 2026
Patient Lift System	CP:Durable Medical Equipment	InterQual 2026
Pediatric Gait Trainers	CP:Durable Medical Equipment	InterQual 2026
Pneumatic Compression Devices	CP:Durable Medical Equipment	InterQual 2026
Power Operated Vehicles (POV)	CP:Durable Medical Equipment	InterQual 2026
Prosthetics, Lower Extremity	CP:Durable Medical Equipment	InterQual 2026
Prosthetics, Myoelectric, Upper Extremity	CP:Durable Medical Equipment	InterQual 2026
Seat Lift Mechanism	CP:Durable Medical Equipment	InterQual 2026

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InterQual® Durable Medical Equipment Criteria 2026

Subset	Product	Version
Speech Generating Devices (SGD)	CP:Durable Medical Equipment	InterQual 2026
Standing Frames	CP:Durable Medical Equipment	InterQual 2026
Stretching Devices, Upper Extremity	CP:Durable Medical Equipment	InterQual 2026
Support Surfaces	CP:Durable Medical Equipment	InterQual 2026
Therapeutic Shoes and Inserts for Persons with Diabetes	CP:Durable Medical Equipment	InterQual 2026
Transcutaneous Electrical Nerve Stimulation (TENS)	CP:Durable Medical Equipment	InterQual 2026
Trigeminal and Vagus Nerve Stimulator Devices, Noninvasive	CP:Durable Medical Equipment	InterQual 2026
Tumor Treatment Field Therapy (TTFT) Devices	CP:Durable Medical Equipment	InterQual 2026
Wheelchair Cushions or Seating System	CP:Durable Medical Equipment	InterQual 2026
Wheelchair Options and Accessories	CP:Durable Medical Equipment	InterQual 2026
Wheelchairs or Strollers, Pediatric	CP:Durable Medical Equipment	InterQual 2026
Wheelchairs, Manual	CP:Durable Medical Equipment	InterQual 2026
Wheelchairs, Power	CP:Durable Medical Equipment	InterQual 2026
Wheels or Wheelchairs, Power-Assist	CP:Durable Medical Equipment	InterQual 2026

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InterQual® Medicare: Post Acute & Durable Medical Equipment Criteria 2026

Subset	Product	Version
Ankle-Foot/Knee-Ankle-Foot Orthosis	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Automatic External Defibrillators	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Billing and Coding: Medical Necessity of Therapy Services Noridian	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Billing and Coding: Pulmonary Rehabilitation Services Noridian	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Bowel Management Devices	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Canes and Crutches	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Cardiac Rehabilitation Programs for Chronic Heart Failure NCD	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Cervical Traction Devices	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Chiropractic Services CGS	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Chiropractic Services NGS	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Chiropractic Services Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Chiropractic Services WPS	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Chiropractor Services Noridian	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Cold Therapy	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Commodes	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Continuous Passive Motion Device NCD	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Enteral Nutrition	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
External Breast Prostheses	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
External Infusion Pumps	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
External Upper Limb Tremor Stimulator Therapy	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Eye Prostheses	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Facial Prostheses	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Fluidized Therapy Dry Heat for Certain Musculoskeletal Disorders NCD	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Frequency and Duration for Cardiac Rehabilitation Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Glucose Monitors	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Heating Pads and Heat Lamps	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
High Frequency Chest Wall Oscillation Devices	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Home Health Occupational Therapy Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Home Health Physical Therapy Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Home Health Psychiatric Care Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026

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InterQual® Medicare: Post Acute & Durable Medical Equipment Criteria 2026

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InterQual® Medicare: Post Acute & Durable Medical Equipment Criteria 2026

Subset	Product	Version
Orthopedic Footwear	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Osteogenesis Stimulators	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Ostomy Supplies	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Outpatient Occupational Therapy Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Outpatient Physical and Occupational Therapy Services CGS	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Outpatient Physical and Occupational Therapy Services NGS	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Outpatient Physical Therapy Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Outpatient Speech Language Pathology Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Oximetry Services Novitas	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Parenteral Nutrition	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Patient Lifts	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Percussors NCD	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Physical Therapy - Home Health CGS	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Pneumatic Compression Devices NCD	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Power Mobility Devices	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Pressure Reducing Support Surfaces (Group 1)	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Pressure Reducing Support Surfaces (Group 2)	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Pressure Reducing Support Surfaces (Group 3)	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Refractive Lenses	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Respiratory Assist Devices	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Respiratory Care Noridian	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Respiratory Therapy (Respiratory Care) Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Respiratory Therapy and Oximetry Services Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Seat Elevation Equipment (Power Operated) on Power Wheelchairs NCD	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Seat Lift Mechanisms	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Speech Generating Devices (SGD)	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Speech-Language Pathology (SLP) Services: Communication Disorders Novitas	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Speech-Language Pathology CGS	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Speech-Language Pathology NGS	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Spinal Orthoses: TLSO and LSO	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Suction Pumps	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD...	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026
Supervised Exercise Therapy for the Treatment of Peripheral Arterial Disease with Sy...	Medicare:Post Acute & Durable Medical Equipment	InterQual 2026

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InterQual® Medicare: Post Acute & Durable Medical Equipment Criteria 2026

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InterQual® Imaging Criteria 2026

Subset	Product	Version
Angiogram, Coronary +/- Left Heart Catheterization	CP:Imaging	InterQual 2026
Cardiac Catheterization, Right Heart with Coronary Angiogram (Imaging)	CP:Imaging	InterQual 2026
Cardiac Imaging, Computed Tomography (CT) or Magnetic Resonance Imaging (MRI)	CP:Imaging	InterQual 2026
Echocardiogram, Transthoracic (TTE) or Transesophageal (TEE)	CP:Imaging	InterQual 2026
Hysterosalpingogram (HSG)	CP:Imaging	InterQual 2026
Imaging, Abdomen and Pelvis	CP:Imaging	InterQual 2026
Imaging, Ankle	CP:Imaging	InterQual 2026
Imaging, Bone Mineral Density (BMD)	CP:Imaging	InterQual 2026
Imaging, Brain	CP:Imaging	InterQual 2026
Imaging, Breast	CP:Imaging	InterQual 2026
Imaging, Cardiac, Stress	CP:Imaging	InterQual 2026
Imaging, Carotid	CP:Imaging	InterQual 2026
Imaging, Chest, Noncardiac	CP:Imaging	InterQual 2026
Imaging, Elbow	CP:Imaging	InterQual 2026
Imaging, Extremity	CP:Imaging	InterQual 2026
Imaging, Face or Ear or Orbit or Sinonasal	CP:Imaging	InterQual 2026
Imaging, Foot	CP:Imaging	InterQual 2026
Imaging, Hip	CP:Imaging	InterQual 2026
Imaging, Knee	CP:Imaging	InterQual 2026
Imaging, Musculoskeletal Pelvis	CP:Imaging	InterQual 2026
Imaging, Neck	CP:Imaging	InterQual 2026
Imaging, Obstetrical	CP:Imaging	InterQual 2026
Imaging, Peripheral Vascular	CP:Imaging	InterQual 2026
Imaging, Pituitary	CP:Imaging	InterQual 2026

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InterQual® Imaging Criteria 2026

Subset	Product	Version
Imaging, Shoulder	CP:Imaging	InterQual 2026
Imaging, Spine, Cervical	CP:Imaging	InterQual 2026
Imaging, Spine, Lumbar	CP:Imaging	InterQual 2026
Imaging, Spine, Thoracic	CP:Imaging	InterQual 2026
Imaging, Temporomandibular Joint (TMJ)	CP:Imaging	InterQual 2026
Imaging, Wrist	CP:Imaging	InterQual 2026
Musculoskeletal Nuclear Medicine Scan	CP:Imaging	InterQual 2026
Positron Emission Tomography (PET), Cardiac	CP:Imaging	InterQual 2026
Positron Emission Tomography (PET), Whole Body	CP:Imaging	InterQual 2026

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InterQual® Procedures Criteria 2026

Subset	Product	Version
Ablation or Excision, Endometriosis, Laparoscopic	CP:Procedures	InterQual 2026
Ablative or Transarterial Therapy, Liver	CP:Procedures	InterQual 2026
Achilles Tendon Repair	CP:Procedures	InterQual 2026
Adenoidectomy	CP:Procedures	InterQual 2026
Adenoidectomy (Pediatric)	CP:Procedures	InterQual 2026
Amputation of Digit or Extremity	CP:Procedures	InterQual 2026
Angiogram, Coronary +/- Left Heart Catheterization	CP:Procedures	InterQual 2026
Angioplasty and Stent, Carotid or Vertebral	CP:Procedures	InterQual 2026
Angioplasty, Renovascular	CP:Procedures	InterQual 2026
Antireflux Surgery or Hiatal Hernia Repair	CP:Procedures	InterQual 2026
Aortic Valve Replacement (AVR)	CP:Procedures	InterQual 2026
Appendectomy	CP:Procedures	InterQual 2026
Appendectomy (Pediatric)	CP:Procedures	InterQual 2026
Arthrodesis or Arthroplasty, Interphalangeal Joint, Second-Fifth Toes	CP:Procedures	InterQual 2026
Arthrodesis, Ankle (Talotibial Joint)	CP:Procedures	InterQual 2026
Arthrodesis, First Metatarsophalangeal (MTP) Joint	CP:Procedures	InterQual 2026
Arthrodesis, Triple	CP:Procedures	InterQual 2026
Arthroplasty, Carpometacarpal (CMC) Joint, Thumb	CP:Procedures	InterQual 2026
Arthroplasty, Temporomandibular Joint (TMJ)	CP:Procedures	InterQual 2026
Arthroscopy or Arthroscopically Assisted Surgery, Knee	CP:Procedures	InterQual 2026
Arthroscopy or Arthroscopically Assisted Surgery, Knee (Pediatric)	CP:Procedures	InterQual 2026
Arthroscopy or Arthroscopically Assisted Surgery, Shoulder	CP:Procedures	InterQual 2026
Arthroscopy or Arthroscopically Assisted Surgery, Shoulder (Adolescent)	CP:Procedures	InterQual 2026
Arthroscopy or Arthroscopically Assisted Surgery, Wrist	CP:Procedures	InterQual 2026
Arthroscopy, Diagnostic, +/- Synovial Biopsy, Knee	CP:Procedures	InterQual 2026
Arthroscopy, Surgical, Ankle	CP:Procedures	InterQual 2026

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InterQual® Procedures Criteria 2026

Subset	Product	Version
Arthroscopy, Surgical, Elbow	CP:Procedures	InterQual 2026
Arthroscopy, Surgical, Hip	CP:Procedures	InterQual 2026
Arthroscopy, Surgical, Hip (Pediatric)	CP:Procedures	InterQual 2026
Arthrotomy, Ankle	CP:Procedures	InterQual 2026
Arthrotomy, Elbow	CP:Procedures	InterQual 2026
Arthrotomy, Hip	CP:Procedures	InterQual 2026
Arthrotomy, Knee	CP:Procedures	InterQual 2026
Arthrotomy, Knee (Pediatric)	CP:Procedures	InterQual 2026
Arthrotomy, Shoulder	CP:Procedures	InterQual 2026
Arthrotomy, Wrist	CP:Procedures	InterQual 2026
Artificial Disc Replacement, Cervical	CP:Procedures	InterQual 2026
Artificial Disc Replacement, Lumbar	CP:Procedures	InterQual 2026
Atrial Septal Defect (ASD) Repair	CP:Procedures	InterQual 2026
Balloon Ostial Dilation	CP:Procedures	InterQual 2026
Bariatric or Metabolic Surgery	CP:Procedures	InterQual 2026
Bariatric or Metabolic Surgery (Adolescent)	CP:Procedures	InterQual 2026
Biopsy, Breast, Needle Core	CP:Procedures	InterQual 2026
Biopsy, Prostate, Needle	CP:Procedures	InterQual 2026
Biopsy, Sentinel Lymph Node	CP:Procedures	InterQual 2026
Bladder Neck Suspension/Sling, Female	CP:Procedures	InterQual 2026
Blepharoplasty	CP:Procedures	InterQual 2026
Bone Augmentation, Mandible	CP:Procedures	InterQual 2026
Bone Augmentation, Maxilla	CP:Procedures	InterQual 2026
Bone Graft and Implantable Stimulator, Fracture Nonunion	CP:Procedures	InterQual 2026
Brachytherapy, Prostate	CP:Procedures	InterQual 2026
Breast Implant Removal	CP:Procedures	InterQual 2026
Breast Reconstruction	CP:Procedures	InterQual 2026

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InterQual® Procedures Criteria 2026

Subset	Product	Version
Bronchoscopy	CP:Procedures	InterQual 2026
Bypass, Distal, Peripheral Artery	CP:Procedures	InterQual 2026
Bypass, Proximal, Peripheral Artery	CP:Procedures	InterQual 2026
Capsule Endoscopy	CP:Procedures	InterQual 2026
Capsule Endoscopy (Pediatric)	CP:Procedures	InterQual 2026
Capsulotomy	CP:Procedures	InterQual 2026
Cardiac Catheterization, Right Heart with Coronary Angiogram (Procedure)	CP:Procedures	InterQual 2026
Cataract Removal	CP:Procedures	InterQual 2026
Cesarean Section, During Labor	CP:Procedures	InterQual 2026
Cesarean Section, Prior to Onset of Labor	CP:Procedures	InterQual 2026
Cheilectomy, First Metatarsophalangeal (MTP) Joint	CP:Procedures	InterQual 2026
Cholangiogram, Intraoperative	CP:Procedures	InterQual 2026
Cholecystectomy, Laparoscopic	CP:Procedures	InterQual 2026
Cholecystectomy, Laparoscopic (Pediatric)	CP:Procedures	InterQual 2026
Cholecystectomy, Open	CP:Procedures	InterQual 2026
Circumcision	CP:Procedures	InterQual 2026
Circumcision (Pediatric)	CP:Procedures	InterQual 2026
Cleft Lip or Palate Repair (Pediatric)	CP:Procedures	InterQual 2026
Cochlear Implantation	CP:Procedures	InterQual 2026
Cochlear Implantation (Pediatric)	CP:Procedures	InterQual 2026
Colectomy, Left	CP:Procedures	InterQual 2026
Colectomy, Right	CP:Procedures	InterQual 2026
Colonoscopy	CP:Procedures	InterQual 2026
Colonoscopy (Pediatric)	CP:Procedures	InterQual 2026
Coronary Artery Bypass Grafting (CABG)	CP:Procedures	InterQual 2026
Craniotomy	CP:Procedures	InterQual 2026
Cryoablation, Prostate	CP:Procedures	InterQual 2026

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InterQual® Procedures Criteria 2026

Subset	Product	Version
Cutaneous Lipoma Excision	CP:Procedures	InterQual 2026
Cystolithotomy	CP:Procedures	InterQual 2026
Decompression +/- Fusion, Cervical	CP:Procedures	InterQual 2026
Decompression +/- Fusion, Lumbar	CP:Procedures	InterQual 2026
Decompression +/- Fusion, Thoracic	CP:Procedures	InterQual 2026
Dilatation and Curettage (D & C)	CP:Procedures	InterQual 2026
Ectropion Repair	CP:Procedures	InterQual 2026
Electrocardiography, Ambulatory (AECG)	CP:Procedures	InterQual 2026
Electromyography (EMG) and Nerve Conduction Studies (NCS)	CP:Procedures	InterQual 2026
Electrophysiology (EP) Testing +/- Catheter Ablation, Cardiac	CP:Procedures	InterQual 2026
Endarterectomy, Carotid or Vertebral	CP:Procedures	InterQual 2026
Endoscopy, Upper Gastrointestinal (GI)	CP:Procedures	InterQual 2026
Endoscopy, Upper Gastrointestinal (GI) (Pediatric)	CP:Procedures	InterQual 2026
Endovascular Intervention, Intracranial	CP:Procedures	InterQual 2026
Endovascular Intervention, Peripheral Artery	CP:Procedures	InterQual 2026
Endovascular Repair, Abdominal Aortic Aneurysm (AAA)	CP:Procedures	InterQual 2026
Endovascular Repair, Thoracic Aortic Aneurysm	CP:Procedures	InterQual 2026
Endovenous Ablation, Lower Extremity Superficial Truncal or Perforator Vein	CP:Procedures	InterQual 2026
Entropion Repair	CP:Procedures	InterQual 2026
Epicondyloplasty, Lateral, Elbow	CP:Procedures	InterQual 2026
Epidural or Intrathecal Catheter Placement	CP:Procedures	InterQual 2026
Epidural Steroid Injection	CP:Procedures	InterQual 2026
Ethmoidectomy	CP:Procedures	InterQual 2026
Exercise Treadmill Testing (ETT)	CP:Procedures	InterQual 2026
Exostectomy, First Metatarsophalangeal (MTP) Joint (Bunionectomy)	CP:Procedures	InterQual 2026
Extraction, Third Molar	CP:Procedures	InterQual 2026

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InterQual® Procedures Criteria 2026

Subset	Product	Version
Eyelid Lesion Excision, +/- Reconstruction	CP:Procedures	InterQual 2026
Eyelid Reconstruction	CP:Procedures	InterQual 2026
Facet Joint Injection	CP:Procedures	InterQual 2026
Fusion, Cervical Spine	CP:Procedures	InterQual 2026
Fusion, Lumbar Spine	CP:Procedures	InterQual 2026
Fusion, Thoracic Spine	CP:Procedures	InterQual 2026
Ganglion Cyst Excision	CP:Procedures	InterQual 2026
Gastric Stimulation	CP:Procedures	InterQual 2026
Gender Affirmation Surgery	CP:Procedures	InterQual 2026
Glossectomy, Partial or Hemiglossectomy	CP:Procedures	InterQual 2026
Hearing Device, Bone Anchored or Bone Conduction	CP:Procedures	InterQual 2026
Hearing Device, Bone Anchored or Bone Conduction (Pediatric)	CP:Procedures	InterQual 2026
Hemiarthroplasty, Hip	CP:Procedures	InterQual 2026
Hemorrhoid Procedures, Minimally Invasive	CP:Procedures	InterQual 2026
Hemorrhoidectomy	CP:Procedures	InterQual 2026
Herniorrhaphy, Inguinal (Pediatric)	CP:Procedures	InterQual 2026
Herniorrhaphy, Inguinal or Femoral	CP:Procedures	InterQual 2026
Herniorrhaphy, Umbilical	CP:Procedures	InterQual 2026
Herniorrhaphy, Umbilical (Pediatric)	CP:Procedures	InterQual 2026
Herniorrhaphy, Ventral or Incisional or Epigastric	CP:Procedures	InterQual 2026
Herniorrhaphy, Ventral or Incisional or Epigastric (Pediatric)	CP:Procedures	InterQual 2026
High-Intensity Focused Ultrasound (HIFU)	CP:Procedures	InterQual 2026
Hydrocelectomy	CP:Procedures	InterQual 2026
Hyperbaric Oxygen Therapy	CP:Procedures	InterQual 2026
Hypoglossal Nerve Stimulation (HNS)	CP:Procedures	InterQual 2026
Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy	CP:Procedures	InterQual 2026
Hysterectomy, Radical	CP:Procedures	InterQual 2026

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InterQual® Procedures Criteria 2026

Subset	Product	Version
Hysteroscopy, + Dilatation and Curettage (D & C), Diagnostic	CP:Procedures	InterQual 2026
Hysteroscopy, Operative	CP:Procedures	InterQual 2026
Implantable Cardioverter Defibrillator (ICD) Insertion	CP:Procedures	InterQual 2026
Interspinous Process Device with or without Open Decompression	CP:Procedures	InterQual 2026
Joint Replacement, Elbow	CP:Procedures	InterQual 2026
Joint Replacement, Shoulder	CP:Procedures	InterQual 2026
Joint Replacement, Wrist	CP:Procedures	InterQual 2026
Keloid Excision	CP:Procedures	InterQual 2026
Keratoplasty	CP:Procedures	InterQual 2026
Laparoscopy, Diagnostic (Abdomen)	CP:Procedures	InterQual 2026
Laparoscopy, Diagnostic (Pelvic)	CP:Procedures	InterQual 2026
Laparotomy or Exploratory Laparotomy	CP:Procedures	InterQual 2026
Left Atrial Appendage Closure	CP:Procedures	InterQual 2026
Left Ventricular Assist Device (LVAD) Insertion	CP:Procedures	InterQual 2026
Ligation and Division +/- Stripping or Excision, Lower Extremity Superficial Vein	CP:Procedures	InterQual 2026
Lithotripsy, Extracorporeal Shock Wave (ESWL)	CP:Procedures	InterQual 2026
Lobectomy	CP:Procedures	InterQual 2026
Manipulation Under Anesthesia, Shoulder	CP:Procedures	InterQual 2026
Mastectomy, Modified Radical (MRM)	CP:Procedures	InterQual 2026
Mastectomy, Partial, +/- Axillary Dissection	CP:Procedures	InterQual 2026
Mastectomy, Prophylactic, Total or Simple	CP:Procedures	InterQual 2026
Mastectomy, Total or Simple	CP:Procedures	InterQual 2026
Median Nerve Decompression, +/- Neurolysis, Wrist	CP:Procedures	InterQual 2026
Mitral Valve Replacement (MVR) or Repair	CP:Procedures	InterQual 2026
Morton's or Interdigital Neuroma Excision	CP:Procedures	InterQual 2026
Myomectomy	CP:Procedures	InterQual 2026

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InterQual® Procedures Criteria 2026

Subset	Product	Version
Myringotomy, +/- Tympanostomy Tube	CP:Procedures	InterQual 2026
Nephrectomy, Partial	CP:Procedures	InterQual 2026
Nephrectomy, Radical	CP:Procedures	InterQual 2026
Nephrectomy, Simple	CP:Procedures	InterQual 2026
Nephrolithotomy, Percutaneous	CP:Procedures	InterQual 2026
Nerve Repair, Wrist or Hand or Digit	CP:Procedures	InterQual 2026
Neuroablation, Percutaneous	CP:Procedures	InterQual 2026
Orchiopexy (Pediatric)	CP:Procedures	InterQual 2026
Orthognathic Surgery	CP:Procedures	InterQual 2026
Orthognathic Surgery (Pediatric)	CP:Procedures	InterQual 2026
Osteotomy, Calcaneal	CP:Procedures	InterQual 2026
Osteotomy, Distal Transpositional, First Metatarsal (MT) (Bunionectomy)	CP:Procedures	InterQual 2026
Osteotomy, Pelvic or Proximal Femur	CP:Procedures	InterQual 2026
Osteotomy, Proximal Phalanx, First Toe +/- Bunionectomy	CP:Procedures	InterQual 2026
Osteotomy, Proximal, First Metatarsal (MT) (Bunionectomy)	CP:Procedures	InterQual 2026
Osteotomy, Transpositional, Distal or Proximal, Fifth Metatarsal (MT)	CP:Procedures	InterQual 2026
Pacemaker Insertion	CP:Procedures	InterQual 2026
Pacemaker Insertion, Biventricular	CP:Procedures	InterQual 2026
Pacemaker Insertion, Biventricular + Implantable Cardioverter Defibrillator (ICD) Inse...	CP:Procedures	InterQual 2026
Palmar Fasciectomy	CP:Procedures	InterQual 2026
Panniculectomy, Abdominal	CP:Procedures	InterQual 2026
Pectus Deformity Repair (Pediatric)	CP:Procedures	InterQual 2026
Penile Implant Insertion	CP:Procedures	InterQual 2026
Percutaneous Coronary Intervention (PCI)	CP:Procedures	InterQual 2026
Phlebectomy, Lower Extremity Superficial Tributary Varicose Vein	CP:Procedures	InterQual 2026
Photocoagulation, Focal Laser	CP:Procedures	InterQual 2026

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InterQual® Procedures Criteria 2026

Subset	Product	Version
Plantar Fascial Release	CP:Procedures	InterQual 2026
Polypectomy, Nasal	CP:Procedures	InterQual 2026
Prostatectomy, Open	CP:Procedures	InterQual 2026
Prostatectomy, Radical	CP:Procedures	InterQual 2026
Prostatectomy, Transurethral Ablation	CP:Procedures	InterQual 2026
Prostatectomy, Transurethral Resection	CP:Procedures	InterQual 2026
Proton Beam Radiotherapy (PBRT)	CP:Procedures	InterQual 2026
Ptosis Repair	CP:Procedures	InterQual 2026
Radiofrequency Ablation (RFA) or Cryoablation, Renal	CP:Procedures	InterQual 2026
Reduction and Fixation, Distal Radius +/- Ulna	CP:Procedures	InterQual 2026
Reduction Mammaplasty, Female	CP:Procedures	InterQual 2026
Reduction Mammaplasty, Female (Adolescent)	CP:Procedures	InterQual 2026
Reduction Mammaplasty, Male	CP:Procedures	InterQual 2026
Reduction Mammaplasty, Male (Adolescent)	CP:Procedures	InterQual 2026
Reimplantation, Ureter (Pediatric)	CP:Procedures	InterQual 2026
Removal and Replacement or Revision, Joint Replacement, Shoulder	CP:Procedures	InterQual 2026
Removal and Replacement, Total Joint Replacement (TJR), Hip	CP:Procedures	InterQual 2026
Removal and Replacement, Total Joint Replacement (TJR), Knee	CP:Procedures	InterQual 2026
Resection and Graft, Abdominal Aortic Aneurysm (AAA)	CP:Procedures	InterQual 2026
Resection and Graft, Thoracic or Thoracoabdominal Aortic Aneurysm	CP:Procedures	InterQual 2026
Rhinoplasty	CP:Procedures	InterQual 2026
Sacrocolpopexy	CP:Procedures	InterQual 2026
Sacroiliac (SI) Joint Fusion	CP:Procedures	InterQual 2026
Sacroiliac (SI) Joint Injection	CP:Procedures	InterQual 2026
Salpingectomy	CP:Procedures	InterQual 2026
Salpingo-Oophorectomy, Bilateral or Oophorectomy, Bilateral	CP:Procedures	InterQual 2026
Salpingo-Oophorectomy, Unilateral or Oophorectomy, Unilateral	CP:Procedures	InterQual 2026

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InterQual® Procedures Criteria 2026

Subset	Product	Version
Scar Contracture Release	CP:Procedures	InterQual 2026
Scar Revision	CP:Procedures	InterQual 2026
Sclerotherapy, Lower Extremity Superficial Tributary Varicose Vein	CP:Procedures	InterQual 2026
Scoliosis or Kyphosis Surgery	CP:Procedures	InterQual 2026
Scoliosis or Kyphosis Surgery (Pediatric)	CP:Procedures	InterQual 2026
Septoplasty	CP:Procedures	InterQual 2026
Septoplasty (Adolescent)	CP:Procedures	InterQual 2026
Sigmoidoscopy	CP:Procedures	InterQual 2026
Sinusotomy, Frontal	CP:Procedures	InterQual 2026
Sinusotomy, Maxillary	CP:Procedures	InterQual 2026
Skin Graft	CP:Procedures	InterQual 2026
Skin Substitute Graft	CP:Procedures	InterQual 2026
Sleep Studies	CP:Procedures	InterQual 2026
Sleep Studies (Pediatric)	CP:Procedures	InterQual 2026
Small Bowel Resection	CP:Procedures	InterQual 2026
Spinal Cord Stimulator (SCS) Insertion	CP:Procedures	InterQual 2026
Stereotactic Introduction, Subcortical or Cortical Electrodes	CP:Procedures	InterQual 2026
Stereotactic Radiosurgery, Brain or Skull Base	CP:Procedures	InterQual 2026
Strabismus Repair (Pediatric)	CP:Procedures	InterQual 2026
Subfascial Endoscopic Perforator Surgery (SEPS)	CP:Procedures	InterQual 2026
Sympathetic Blockade	CP:Procedures	InterQual 2026
Tendon Sheath Incision or Excision, Hand, Flexor	CP:Procedures	InterQual 2026
Tendon Transfer, Hand or Forearm	CP:Procedures	InterQual 2026
Thoracoscopy, Video Assisted (VAT)	CP:Procedures	InterQual 2026
Thyroidectomy, Partial or Total	CP:Procedures	InterQual 2026
Tissue Transfer (Flap)	CP:Procedures	InterQual 2026

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InterQual® Procedures Criteria 2026

Subset	Product	Version
Tonsillectomy	CP:Procedures	InterQual 2026
Tonsillectomy (Pediatric)	CP:Procedures	InterQual 2026
Total Joint Replacement (TJR), Ankle	CP:Procedures	InterQual 2026
Total Joint Replacement (TJR), Hip	CP:Procedures	InterQual 2026
Total Joint Replacement (TJR), Knee	CP:Procedures	InterQual 2026
Trabeculoplasty or Trabeculectomy	CP:Procedures	InterQual 2026
Transcatheter Aortic Valve Replacement (TAVR)	CP:Procedures	InterQual 2026
Transcatheter Mitral Valve Edge-to-Edge Repair (TEER)	CP:Procedures	InterQual 2026
Transplantation, Allogeneic Stem Cell	CP:Procedures	InterQual 2026
Transplantation, Allogeneic Stem Cell (Pediatric)	CP:Procedures	InterQual 2026
Transplantation, Autologous Stem Cell	CP:Procedures	InterQual 2026
Transplantation, Autologous Stem Cell (Pediatric)	CP:Procedures	InterQual 2026
Transplantation, Cardiac	CP:Procedures	InterQual 2026
Transplantation, Liver	CP:Procedures	InterQual 2026
Transplantation, Lung	CP:Procedures	InterQual 2026
Transplantation, Renal	CP:Procedures	InterQual 2026
Transurethral Resection, Bladder Tumor (TURBT)	CP:Procedures	InterQual 2026
Tricuspid Valve Replacement (TVR) or Repair or Resection	CP:Procedures	InterQual 2026
Turbinectomy, Inferior, Partial	CP:Procedures	InterQual 2026
Tympanoplasty (Pediatric)	CP:Procedures	InterQual 2026
Tympanostomy Tube (Pediatric)	CP:Procedures	InterQual 2026
Ulnar Nerve Decompression or Transposition, Elbow	CP:Procedures	InterQual 2026
Ulnar Nerve Decompression, Wrist	CP:Procedures	InterQual 2026
Ultrasound, Endobronchial (EBUS) or Endoscopic (EUS)	CP:Procedures	InterQual 2026
Unicondylar or Patellofemoral Knee Replacement	CP:Procedures	InterQual 2026
Ureteroscopy	CP:Procedures	InterQual 2026
Urethroplasty	CP:Procedures	InterQual 2026

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InterQual® Procedures Criteria 2026

Subset	Product	Version
Uterine Artery Embolization (UAE)	CP:Procedures	InterQual 2026
Uvulopalatopharyngoplasty (UPPP)	CP:Procedures	InterQual 2026
Vaginal Delivery, Early Elective	CP:Procedures	InterQual 2026
Vagus Nerve Stimulation (VNS)	CP:Procedures	InterQual 2026
Vagus Nerve Stimulation (VNS) (Pediatric)	CP:Procedures	InterQual 2026
Vertebroplasty or Kyphoplasty	CP:Procedures	InterQual 2026
Video Electroencephalographic (EEG) Monitoring	CP:Procedures	InterQual 2026
Video Electroencephalographic (EEG) Monitoring (Pediatric)	CP:Procedures	InterQual 2026
Vitrectomy, Pars Plana	CP:Procedures	InterQual 2026
Wedge Resection or Segmentectomy, Lung	CP:Procedures	InterQual 2026

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InterQual® Molecular Diagnostics Criteria 2026

Subset	Product	Version
21-Hydroxylase-Deficient Congenital Adrenal Hyperplasia (CYP21A2)	CP:Molecular Diagnostics	InterQual 2026
Achondroplasia	CP:Molecular Diagnostics	InterQual 2026
Acute Myeloid Leukemia (AML)	CP:Molecular Diagnostics	InterQual 2026
Adenomatous Polyposis Coli (APC)-associated Polyposis Conditions	CP:Molecular Diagnostics	InterQual 2026
AlloMap®	CP:Molecular Diagnostics	InterQual 2026
Alpha-1 Antitrypsin Deficiency (AATD)	CP:Molecular Diagnostics	InterQual 2026
Alzheimer's Disease	CP:Molecular Diagnostics	InterQual 2026
Angelman Syndrome (AS)	CP:Molecular Diagnostics	InterQual 2026
ARX-Related X-linked Disorders	CP:Molecular Diagnostics	InterQual 2026
Ataxia-Telangiectasia (A-T)	CP:Molecular Diagnostics	InterQual 2026
BCR::ABL1 Testing in Acute Lymphoblastic Leukemia (ALL)	CP:Molecular Diagnostics	InterQual 2026
BCR::ABL1 Testing in Chronic Myeloid Leukemia (CML)	CP:Molecular Diagnostics	InterQual 2026
Beckwith-Wiedemann Syndrome (BWS)	CP:Molecular Diagnostics	InterQual 2026
Beta globin (HBB) testing for Beta-thalassemia and Sickle Cell Disease	CP:Molecular Diagnostics	InterQual 2026
Bloom's Syndrome	CP:Molecular Diagnostics	InterQual 2026
BRAF Testing for Drug Response in Melanoma	CP:Molecular Diagnostics	InterQual 2026
BRCA1 and BRCA2 in Hereditary Cancer	CP:Molecular Diagnostics	InterQual 2026
Canavan Disease	CP:Molecular Diagnostics	InterQual 2026
Carrier Screening (Genetic) for General Population	CP:Molecular Diagnostics	InterQual 2026
Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts and Leukoencephalopathy (CADASIL)	CP:Molecular Diagnostics	InterQual 2026
Charcot-Marie-Tooth (CMT) Hereditary Neuropathy	CP:Molecular Diagnostics	InterQual 2026
Chimerism Analysis after Allogeneic Stem Cell Transplantation (SCT)	CP:Molecular Diagnostics	InterQual 2026
Chronic Lymphocytic Leukemia (CLL) Prognostic or Predictive Testing	CP:Molecular Diagnostics	InterQual 2026
clonoSEQ® and other Clonality Testing	CP:Molecular Diagnostics	InterQual 2026
Cologuard® and Cologuard Plus	CP:Molecular Diagnostics	InterQual 2026
Comprehensive Genomic Profiling for Solid Tumor, Liquid Biopsy	CP:Molecular Diagnostics	InterQual 2026
Comprehensive Genomic Profiling, Tumor Tissue	CP:Molecular Diagnostics	InterQual 2026
ConfirmMDx® for Prostate Cancer	CP:Molecular Diagnostics	InterQual 2026
Congenital Factor XIII Deficiency	CP:Molecular Diagnostics	InterQual 2026

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InterQual® Molecular Diagnostics Criteria 2026

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InterQual® Molecular Diagnostics Criteria 2026

Subset	Product	Version
Short stature Homeobox-containing gene (SHOX) Haploinsufficiency Disorders	CP:Molecular Diagnostics	InterQual 2026
Spinal Muscular Atrophy (SMA)	CP:Molecular Diagnostics	InterQual 2026
Tay-Sachs Disease	CP:Molecular Diagnostics	InterQual 2026
Testing for Imatinib Response in Melanoma or Systemic Mastocytosis (SM)	CP:Molecular Diagnostics	InterQual 2026
Thiopurine Drug Response Testing	CP:Molecular Diagnostics	InterQual 2026
Thyroid Nodule Genetic Testing	CP:Molecular Diagnostics	InterQual 2026
Transthyretin (ATTR) Amyloidosis	CP:Molecular Diagnostics	InterQual 2026
Trisomy 13 (Patau syndrome)	CP:Molecular Diagnostics	InterQual 2026
Trisomy 18 (Edwards syndrome)	CP:Molecular Diagnostics	InterQual 2026
Trisomy 21 (Down syndrome)	CP:Molecular Diagnostics	InterQual 2026
UGT1A1 Genotyping for Drug Response	CP:Molecular Diagnostics	InterQual 2026
UGT1A1 Genotyping for Gilbert Syndrome	CP:Molecular Diagnostics	InterQual 2026
Von Hippel-Lindau Syndrome (VHL)	CP:Molecular Diagnostics	InterQual 2026
Whole Genome Sequencing (WGS), Whole Exome Sequencing (WES), and Chromosomal Microarray (C...	CP:Molecular Diagnostics	InterQual 2026

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InterQual® Adult and Geriatric Psychiatry Criteria 2026

Subset	Product	Version
Adult and Geriatric Psychiatry	BH:Adult and Geriatric Psychiatry	InterQual 2026
Transition Plan	BH:Adult and Geriatric Psychiatry	InterQual 2026

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InterQual® Child and Adolescent Psychiatry Criteria 2026

Subset	Product	Version
Child and Adolescent Psychiatry	BH:Child and Adolescent Psychiatry	InterQual 2026
Transition Plan	BH:Child and Adolescent Psychiatry	InterQual 2026

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InterQual® Substance Use Disorders Criteria 2026

Subset	Product	Version
Substance Use Disorders	BH:Substance Use Disorders	InterQual 2026
Transition Plan	BH:Substance Use Disorders	InterQual 2026

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InterQual® Behavioral Health Services Criteria 2026

Subset	Product	Version
Applied Behavior Analysis (ABA) Program	BH:Behavioral Health Services	InterQual 2026
Donanemab-azbt (Kisunla) (Non Oncology)	BH:Behavioral Health Services	InterQual 2026
Electroconvulsive Therapy (ECT)	BH:Behavioral Health Services	InterQual 2026
Esketamine (Spravato) (Non Oncology)	BH:Behavioral Health Services	InterQual 2026
Lecanemab-irmb (Leqembi) (Non Oncology)	BH:Behavioral Health Services	InterQual 2026
Multi-Gene Panels for Autism Spectrum Disorder (ASD)	BH:Behavioral Health Services	InterQual 2026
Neuropsychological and Developmental Testing	BH:Behavioral Health Services	InterQual 2026
Outdoor Behavioral Healthcare (OBH) Residential Wilderness Program	BH:Behavioral Health Services	InterQual 2026
Paliperidone palmitate (Invega Hafyera) (Non Oncology)	BH:Behavioral Health Services	InterQual 2026
Paliperidone palmitate (Invega Sustenna) (Non Oncology)	BH:Behavioral Health Services	InterQual 2026
Paliperidone palmitate (Invega Trinza) (Non Oncology)	BH:Behavioral Health Services	InterQual 2026
Pharmacogenomic Testing for Psychotropic Medication Drug Response	BH:Behavioral Health Services	InterQual 2026
Psychological Testing	BH:Behavioral Health Services	InterQual 2026
Psychosocial Rehabilitation (PSR), Adult	BH:Behavioral Health Services	InterQual 2026
Stereotactic Introduction, Subcortical or Cortical Electrodes	BH:Behavioral Health Services	InterQual 2026
Transcranial Magnetic Stimulation (TMS)	BH:Behavioral Health Services	InterQual 2026
Urine Drug Testing (UDT)	BH:Behavioral Health Services	InterQual 2026
Vagus Nerve Stimulation (VNS)	BH:Behavioral Health Services	InterQual 2026

Synopsis of Changes to MPND9001

Below is an overview of MPND9001, which will be bundled with the PHM Grand Analysis presentation at the June 17, 2026 Q/UAC.

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	External Documentation (Notice required outside of originating department)
Policy Owner: Population Health		*Presenter: DeLorean Ruffin, DrPH, MPH; Director of Population Health*	
MPND9001 – Population Health Management Strategy & Program Description	273 – 274	**Annual update includes revisions and updated All Plan Letter (APL) references to further align the document with National Committee on Quality Assurance (NCQA) and state requirements.** Many small changes for grammar, clarity, and/or readability. Highlights below: **P. 9-10 Population Needs and Local Planning Requirements (CHA/CHIP) Community Needs Assessments: N**oted that the Population Needs Assessment Committee was disbanded in early 2026 (March). Described 2025 requirement for county behavioral health departments to integrate into their local county CHA/CHIP processes, and that Partnership works with them to advance statewide behavioral health goals. Gave more details about the DHCS PHM Strategy Deliverable. **P. 14 Population Risk Stratification & Segmentation:** Clarified Partnership's proprietary risk scoring vs. DHCS's RSST, and the use of both in tandem in the future. **P. 19-20 Future Risk Stratification, Segmentation, and Risk Tiering:** Updated language to reference Medi-Cal Connect. Added that in 2026, Partnership is piloting DHCS's RSST into operational workflows to inform member identification, outreach, and intervention planning. Described plans following the implementation of Medi-Cal Connect, and actions Partnership takes when members are identified as high risk. **P. 22-23 Wellness, Prevention, and Chronic Disease Management Programs:** Added language about offering of chronic disease management programs, and direct the reader to refer to the Growing Together Program charter and Basic Population Health Management chronic disease management program charter for more information. **P. 26 Organizational Support for PHM:** Added that providers have on-demand access to care gap data via eReports, and that the Partnership Quality Dashboard (PQD) is updated monthly. **P. 29:** Updated an intervention for moderate/rising risk pregnant members, saying "Offer a pay-for-performance program that incentivizes chronic disease management, which can enable purchasing POC devices." **P. 37 Practitioner Education and Training:** Explained that DEI training for providers, partnership staff, and subcontractors and downstream subcontractors is called "CARES training." Added reference forthcoming policy MCEP6004 DEI/Cultural Connection Training Policy **P. 40 Informing Members About Available PHM Programs:** Added "Partnership also has the ability to inform providers of various programs through Partnership's website, various provider newsletters, in-person meetings, fax blasts, email, and flyer distribution."	Grievance & Appeals Member Services Pharmacy Utilization Management Communications

Synopsis of Changes to MPND9001

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)
		Clarified that providers are informed as appropriate to support referrals and coordination of member care. **P. 43 Community Engagement and Coordination of PHM Programs:** Updated list of Partnership MOUs and refer to MCCP2036 Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities **P. 45 Delivery-System Supports for Population Health Management:** Updated this section with more detail. **P. 48 Partnership Quality Dashboard (PQD):** Added detail for data available through PQD, and information about QI trainings. **P. 50-55 Team Roles and Responsibilities:** Rewrote various department position descriptions to better mirror official job descriptions.	

Population Health Management Strategy & Program Description

MPND9001
(previously MCND9001, MCCD2027)

June 2026~~5~~

Original Date: 11/13/2019
Previously Applied to MCCD2027 11/13/19 to 04/08/20
Revision Dates: MCND9001 04/08/20; 08/11/21; 08/10/22; 08/09/23; 08/14/2024; MPND9001 08/13/2025; 08/12/2026

Table of Contents

Program Purpose

To identify the strategy and organizational structure Partnership HealthPlan of California (Partnership) utilizes to assess, segment, and act in order to meet the needs of its member population and subpopulations within the context of the various communities in which Partnership's members live.

Introduction

Partnership HealthPlan of California operates a Medicaid (Medi-Cal) line of business. In addition, 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~~ Enrollee Handbook.

Partnership's Population Health Management (PHM) Strategy & Program Description outlines a cohesive plan of action for addressing Partnership's member needs across the continuum of care engaging not only the Population Health department, but also multiple departments within the organization. The unique characteristics and needs of Partnership's member population determine the programs and services designed to help individual members and subpopulation groups, in alignment with California's Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA) requirements. This document also highlights Partnership-sponsored delivery system supports designed to enhance population health management within our provider network, describes the process for annual assessment of member needs, and the effectiveness of our population health strategy in meeting those needs. As part of Partnership's Population Health strategy, Partnership is committed to identifying root causes of health disparities for its members and collaborating across the organization, with providers, and with other community agencies to reduce inequities for the members we serve and to address Social Drivers of Health.

As part of NCQA requirements, Partnership performs an annual Population Needs Assessment (PNA), which identifies factors leading to health disparities for Partnership subpopulations. In addition, as part of DCHS' updated PNA requirement, Partnership collaborates with Local Health Jurisdictions (LHJs), and other community stakeholders as appropriate, on their Community Health Assessments (CHAs) and Community

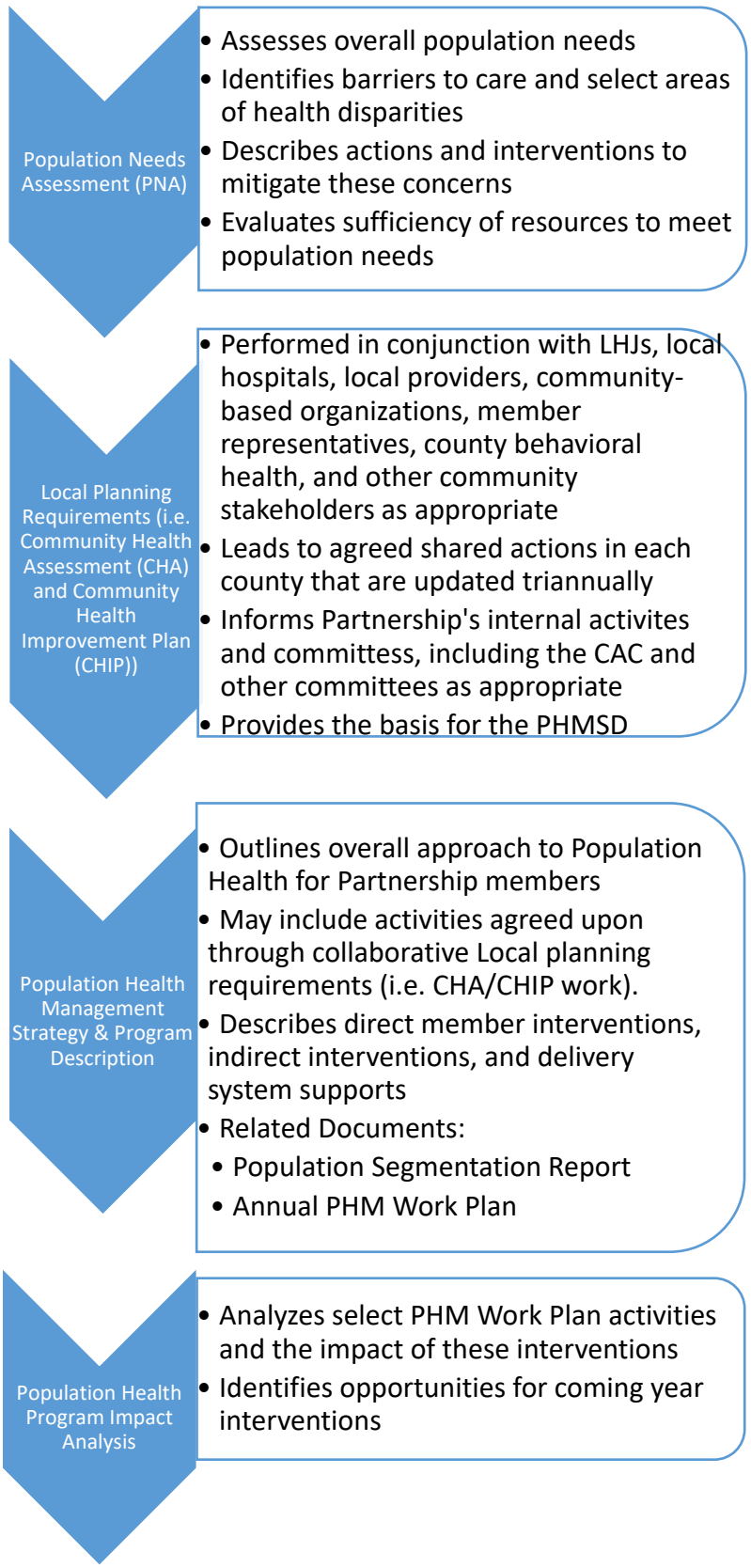
Health Improvement Plans (CHIPs), documenting the shared work in accordance with each of the LHJ reporting cadences in all Partnership's counties of operation.

Data Analysis and Strategy

Partnership uses several methods to identify member needs, and to strategize the best means to meet them. Both the annual PNA and county CHAs/CHIPs describe the overall health, social, health education, and cultural and linguistic needs of Partnership's membership, including members who are less than 21 years of age, by analyzing service utilization patterns, disease burden, and gaps in care for our members, taking into account their risk level, geographic location, and age groups and recommends interventions, or highlights existing interventions, to address barriers and disparities. The PNA identifies community resources to integrate in program offerings (including Partnership's Community Resource pages), and describes Partnership's collaboration with network providers, LHJs, and community leaders, and other community partners in support of the population. The PNA and county CHA/CHIP findings inform Partnership's overall PHM strategies and activities and are electronically submitted to the appropriate governing bodies by their respective reporting timelines. Key stakeholders within Partnership review the PNA and CHA/CHIP findings, both of which are used to complete the annual DHCS PHM Strategy Deliverable (PHMSD). These findings may also be used to complete, and the annual PHM Work Plan, Segmentation Report, and appropriate health education and shared community interventions; findings may also be used to update Partnership's Strategy and Program description (MPND9001) as appropriate. An impact analysis of the previous year's activities is also drafted based on select programs.

The PHM Strategy & Program Description (MPND9001) provides a high-level overview of Partnership's approach to improving the health and wellbeing of the population we serve. The PHM Work Plan previously mentioned work plan outlines specific interventions to mitigate health disparities both on a member and system level. The PHM Work Plan provides details on specific member-facing interventions, staff who will perform the interventions, method of contact, and outcome measures Partnership will implement during the year, and more (refer to the workplan for full details). The PHM Impact Analysis report evaluates select Partnership's programs and services to determine if the benefits offered are adequate to meet our member needs and identifies opportunities for further intervention. The PHM Segmentation Report categorizes Partnership's subpopulations into the appropriate categories on the continuum of risk as defined by DHCS and NCQA and as described under "Organizational Support for PHM." for targeted interventions.

The following diagram shows the relationship ~~of~~between these activities:


Population Needs Assessment (PNA)
• Assesses overall population needs
• Identifies barriers to care and select areas of health disparities
• Describes actions and interventions to mitigate these concerns
• Evaluates sufficiency of resources to meet population needs
Local Planning Requirements (i.e. Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP))
• Performed in conjunction with LHJs, local hospitals, local providers, community-based organizations, member representatives, county behavioral health, and other community stakeholders as appropriate
• Leads to agreed shared actions in each county that are updated triannually
• Informs Partnership's internal activites and committess, including the CAC and other committees as appropriate
• Provides the basis for the PHMSD
Population Health Management Strategy & Program Description
• Outlines overall approach to Population Health for Partnership members
• May include activities agreed upon through collaborative Local planning requirements (i.e. CHA/CHIP work).
• Describes direct member interventions, indirect interventions, and delivery system supports
• Related Documents:
• Population Segmentation Report
• Annual PHM Work Plan
Population Health Program Impact Analysis
• Analyzes select PHM Work Plan activities and the impact of these interventions
• Identifies opportunities for coming year interventions

Quality Improvement and Health Equity Committee (QIHEC)

The proceedings and recommendations from the written PNA, and/or updates from the CHA/CHIP efforts, are presented to Partnership's QIHEC for review. The QIHEC consists of 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. The committee identifies, reviews, and recommends actions and/or activities designed to promote health equity for Partnership members in their communities. It also reviews the PNA, ~~regular~~ CHA/CHIP updates as needed, and other reports and data that represent Partnership's activity to promote the quality and equity of program offerings. For more information, see Policy MCEP6002 Quality Improvement and Health Equity Committee (QIHEC).

Population Needs and Local Planning Requirements (CHA/CHIP) Community Needs Assessments

Partnership routinely collects data regarding cultural, ethnic, racial, linguistic, health education and environmental needs of its members, and conducts a quantitative and qualitative evaluation to determine unmet needs and areas of health disparities. Data sources may include, but are not limited to, US census and enrollment data, member surveys, member grievances, and other published health statistics, as well as other sources such as local community needs assessments. Partnership analyzes the data collected no less than annually with the goal of ensuring Partnership and its providers deliver services that equitably meet the needs of our culturally and linguistically diverse member population.

Population Health staff prepare an annual Population Needs Assessment (PNA) for NCQA that describes our membership and region, including Partnership's demographics, community-identified needs and resources, health education, and cultural and linguistic needs, select health inequities, social and structural barriers to care, and more. The PNA proposes actions to address identified care gaps and ~~disparities and~~disparities and promotes health equity. The PNA also analyzes language preferences (including limited English proficiency [LEP]), reported ethnicity, and beliefs about health and health care utilization.

A summary report of the NCQA PNA findings is prepared for the Community Advisory Committee (CAC) (formerly known as the Consumer Advisory Committee) session and the Family Advisory Committees (FAC) (see MPND9002 for more information on these committees). Members of both committees are given an opportunity to provide input and advice on Partnership's targeted, priority health education, and cultural and linguistic strategies and outreach programs as appropriate. The NCQA PNA and its proposed

actions also undergo review by Partnership's ~~Population Needs Assessment Committee (PNA), the~~ Quality Improvement Health Equity Committee (QIHEC), Internal Quality Improvement Committee (IQI), Quality/Utilization Advisory Committee (Q/UAC), Physician Advisory Committee (PAC), by the Board of Directors and other committees before submission and approval to appropriate governing bodies and per regulatory requirements. PNA findings are also sent to providers via Partnership's quarterly provider newsletter and corresponding fax blast notice. Please note ~~the PNA committee will be disbanded in 2026. .~~the Population Needs Assessment Committee, which has reviewed the PNA since its founding, reviewed it for the last time in March 2026 before the committee was disbanded.

In addition to the annual PNA, and in alignment with DCHS's Population Health Management Policy Guide[1] and the ~~2024~~ DHCS Contract, Partnership works collaboratively with LHJs~~, ,~~ hospitals, community providers, other payers, community-based organizations, member representatives, other local MCPs, and other community stakeholders on each Partnership county's CHA and CHIP process. As of 2025, county behavioral health departments are also required to integrate into their local county CHA/CHIP processes as part of their newly required Integrated Plan. Partnership and its local county behavioral health departments are also tasked with working together to help advance the statewide population behavioral health goals.

This collaborative work on the CHA/CHIP ~~work~~process, referred to as the Local Planning requirements, has replaced DHCS's historically mandated PNA and PNA Action Plan. The county CHAs/CHIPs represent the overall community needs and priorities and provides an opportunity for health plans to work with LHJs, local hospitals, and other community stakeholders to prioritize local needs and agree upon a shared plan of action. CHA/CHIP updates are sent to providers via Partnership's quarterly provider newsletter and corresponding fax blast notice. The PNA committee, CAC, and QIHEC receive ~~regular~~ updates on the CHA/CHIP collaborative work as needed and are provided with an opportunity to give feedback as appropriate. ~~CHA/CHIP updates are sent to providers via Partnership's provider newsletter and corresponding fax blast notice.~~

~~As of 2025,~~Currently, each Partnership county has its own schedule for CHA/CHIP work; Partnership will align ~~its reporting~~ with each county's distinct timeline as needed until timelines are standardized in 2028. The shared action plans and findings from these county collaborations on the CHA/CHIP work lead to the development of Partnership's annual PHM Strategy Deliverable (PHMSD) that demonstrates

[1] ~~2024 PHM Policy Guide~~2026 PHM Policy Guide

commitment to the implementation of prioritized actions and responses to community needs. The PHMSD is also leveraged to report on how Partnership has supported each of its LHJs' CHA/CHIP processes through resource contributions, data sharing, stakeholder engagement, progress towards various DHCS goals/quality measures, and other required elements as specified in the DHCS-provided template. The PHMSD is submitted to DHCS annually, along with an NCQA-approved version of this document (MPND9001) and the annual NCQA-approved PNA. ~~An overview of the PHMSD is shared with Partnership committees as needed.~~

Findings from these collaboratives ~~are~~ may be used to guide the following efforts:

- Targeted health education materials for members, and the creation of member-facing outreach materials for any identified gaps in services and resources, including but not limited to, Non-Specialty Mental Health Services~~.~~
- Cultural and linguistic and quality improvement strategies to address identified population-level health and social needs; and
- Wellness and prevention programs

Per the PHM Policy Guide, Partnership also strives to use input/advice from their Community Advisory Community (CAC) on how to use findings from the CHAs/CHIP collaborative work. Partnership also encourages CAC members to join their local county's CHA/CHIP planning process. The CAC is a committee that acts as a liaison between Partnership and its members (see MPND9002 for more information). As appropriate, feedback may be used to influence:

- Partnership's strategies and workstreams related to the Bold Goals defined in the PHM P~~p~~olicy G~~g~~uide,
- W~~w~~ellness and prevention strategies
- H~~h~~ealth equity needs
- H~~h~~ealth education needs, and
- C~~c~~ultural and linguistic needs

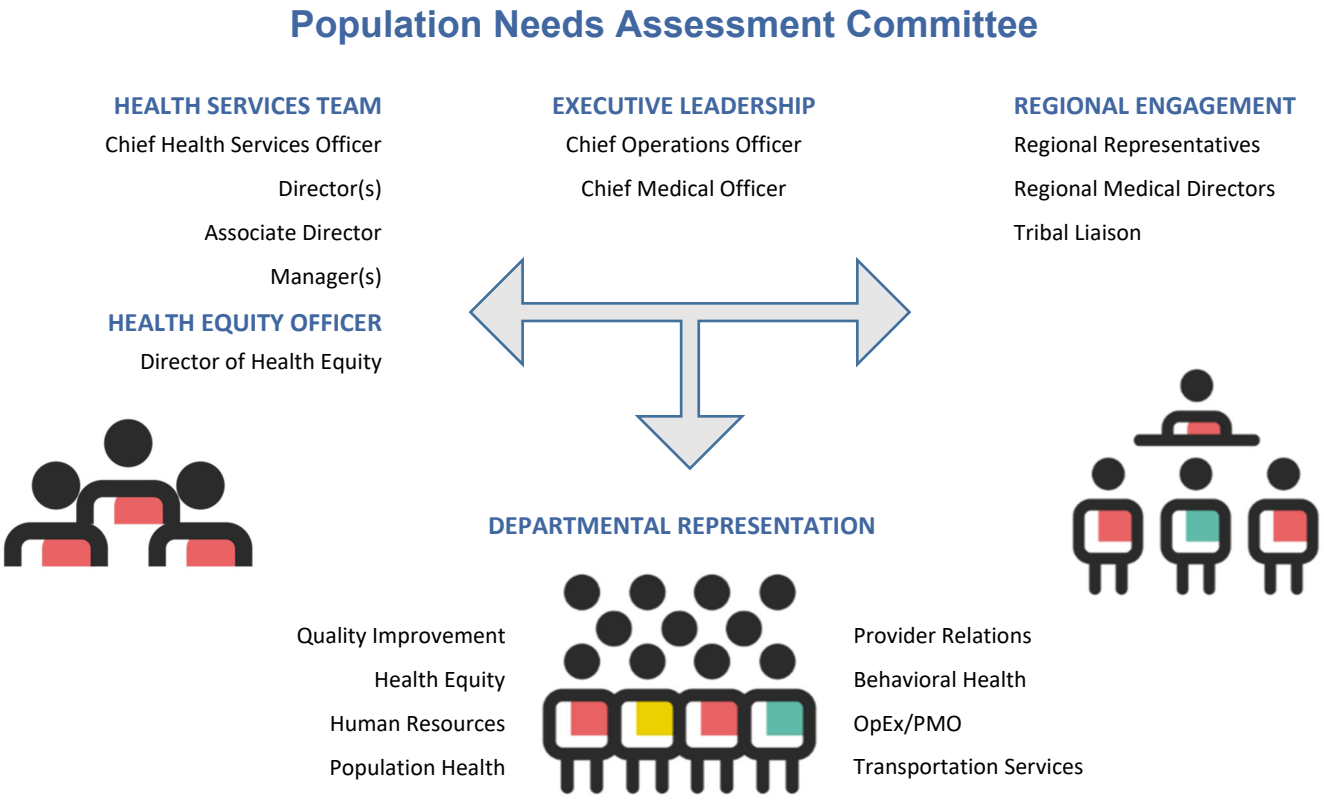
Lastly, Partnership also publishes the CHAs/CHIPs of all LHJ's in its Service Area on Partnership's website, along with a description of how Partnership ~~'s~~ collaborated~~ion~~ on the report(s).

Population Needs Assessment (PNA) Committee

In late 2023, Partnership replaced the Population Health Management and Health Equity Committee with the internal Population Needs Assessment (PNA) Committee. The PNA Committee is an internal committee serving as a multi-departmental decision-

making body whose goal is to ~~carry~~ support ~~out~~ the DHCS mandate to meaningfully participate in each Local Health Jurisdiction's (LHJs) Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). PNA Committee m~~M~~eetings occur on a bi-monthly basis to review requests from the counties, and general progress towards shared work on the CHA/CHIP collaborative in Partnership's service areas, including the implementation of the shared ~~SMART~~ goals/SMART objectives between Partnership and each of the LHJs in Partnership's service. On an annual basis, this committee also reviews and makes recommendations for the Population Needs Assessment (PNA) used to fulfill NCQA requirements. The PNA Committee activities and recommendations are shared with the Internal Quality Committee (IQI), Quality/Utilization Advisory Committee (Q/UAC), and Physician Advisory Committee (PAC). Please note, the PNA committee was disbanded in early 2026. This was due in part to DHCS retiring the requirement to report out on the shared goal/SMART objectives requirement in the annual PHMSD.

~~This was DHCS retiring the requirement to report out on the shared requirement in the annual PHMSD~~



Social Drivers of Health and Community Needs

Partnership's Health Analytics department estimates the impact of Social Drivers of Health (SDOH) for the region and membership through proxy data sources. One such source is the California Healthy Places Index (HPI) data produced by the Public Health Alliance of Southern California (healthyplacesindex.org). This freely available data set ranks California census tracts on a composite score of health disadvantage by incorporating data on 25 individual indicators organized in eight domains: economy, education, healthcare access, housing, neighborhoods, clean environment, transportation, and social environment. In every census tract, each indicator is shown on standardized scales (Z-scores) of increasing disadvantage and averaged for each domain. The overall score is calculated as the weighted sum of domain scores. The HPI data set also includes the percentiles of each domain and individual indicator, as well as the overall composite values ranking each census tract.

Using the residential addresses of members found in the Membership data files received from DHCS, Partnership's Health Analytics team determines the geographic coordinate of each member's valid address and finds the corresponding census tract. The calculated census tract for each member is then ~~joined~~ matched ~~with the~~to the corresponding HPI scores (https://healthyplacesindex.org/about/). These HPI scores are used in combination with the rest of the SDOH data to estimate the SDOH risks for each of Partnership's members.

Member-specific sources for SDOH data include location, distance from providers, and non-medical transportation claims that demonstrate member needs for services; demographic attributes found in membership data; specific social risk factors identified from diagnosis codes; and homelessness data derived from members' addresses and diagnosis coding. Members who are new to Partnership and have either a Senior or Person with Disability (SPD) aid ~~code, or~~code or identified as California Children's Services (CCS) beneficiaries complete a detailed assessment of their social supports, barriers to care, food security, and financial resources, as well as their medical history and current care needs.

Members who have serious mental illness, a ~~or~~ serious emotional disturbance (SMI/SED), or both, receive specialty mental health care for those conditions through county-administered Mental Health Managed Care, which is carved out of Partnership's benefit package and assigned to the county in which the member lives (see ~~All Plan~~

~~Letter 22-006~~All Plan Letter 26-002: Medi-Cal Managed Care Health Plan Responsibilities For Non-Specialty Mental Health Services[2]).

In July 2020, ~~0,~~ Partnership began administering ~~ing~~ the Drug Medi-Cal Organized Delivery System (DMC ODS) substance use treatment services on behalf of participating counties. Partnership works together with our providers and partners in seven Partnership counties (Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano) to provide integrated physical health and SUD services for the Medi-Cal population. By 2026 yearend, Partnership plans to transition the administration of this benefit back to these counties. The following counties have their own county-managed programs: Lake, Marin, Napa, Nevada, Placer, Sonoma and Yolo over which Partnership has no regulatory oversight.

Effective January 1, 2028~~7~~, Partnership will also cover behavioral health services for Partnership Advantage members. Services include:

- Inpatient psychiatric hospital services as a basic Medicare Part A benefit
- Outpatient behavioral health services under Medicare Part B including diagnostic and therapeutic services, incident-to-physician services, and mental health counselor services. Additionally, the treatment of Opioid Use Disorder is a covered service in Partnership Advantage provided by Opioid Treatment Programs (OTPs).

In addition, Partnership's disease registry flags members with SMI or ~~/~~SED, and/or both conditions, such as schizophrenia or major depression. Partnership uses diagnosis from claims data and prescription data for anti-psychotic and specific anti-manic medications as a means of identifying members who may have any SMI/SED, and/or both, and leverages this data to ensure members with SMI/SED, and/or both, ~~-~~receive care for comorbid medical conditions.

Population Risk Stratification & Segmentation

~~Currently, Partnership analyzes and segments the population by need and appropriate intervention(s), as described~~ demonstrated ~~in the Population Segmentation Report. Partnership also assesses and reassesses member risk scores on a monthly basis. Once DHCS has launched the PHM Service (Medi-Cal Connect) and associated Risk Stratification and Segmentation methodology, Partnership will incorporate those data~~

[2] ~~All Plan Letter 22-006~~All Plan Letter 26-002: Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services

~~points and methods to further stratify populations for intervention. Partnership's RSS and Risk Tiering approach is available upon DHCS request.~~

~~Partnership has developed a proprietary method currently in use for assigning members to a risk level, which will be used until DHCS launches the PHM Service's Risk Stratification and Segmentation and Risk Tiering Tool (RSST). Post launch, Partnership and DHCS' methods will be used in tandem.~~

Currently, Partnership analyzes and segments the population by need and appropriate intervention(s), as demonstrated in the Population Segmentation Report. Partnership currently utilizes a proprietary risk scoring and stratification method to assign members to risk levels. Partnership assesses and reassesses member risk scores on a monthly basis. DHCS recently launched its initial risk stratification, segmentation, and tiering (RSST) methodology, which Partnership is actively evaluating through pilot programs across various risk domains. DHCS plans to fully implement this methodology starting in late 2026. Once the official implementation begins, Partnership will incorporate DHCS's data points and methods to further stratify populations for targeted interventions. Moving forward, both Partnership's and DHCS's methods will be used in tandem. Partnership's Risk stratification and tiering approach remains available upon DHCS's request.

Partnership's Risk Stratification Process

Partnership's Health Analytics team has developed a risk score model that predicts member's risk for becoming a high utilizer at individual level by applying the following data sources: member demographic data, claims (behavioral, medical, and pharmacy), case management enrollment, and external data (California's health index and census tract). This risk score model forecasts the likelihood of a member becoming a high utilizer within the next six months. A member will be classified as a high utilizer if they meet any of these four criteria within a six-month period:

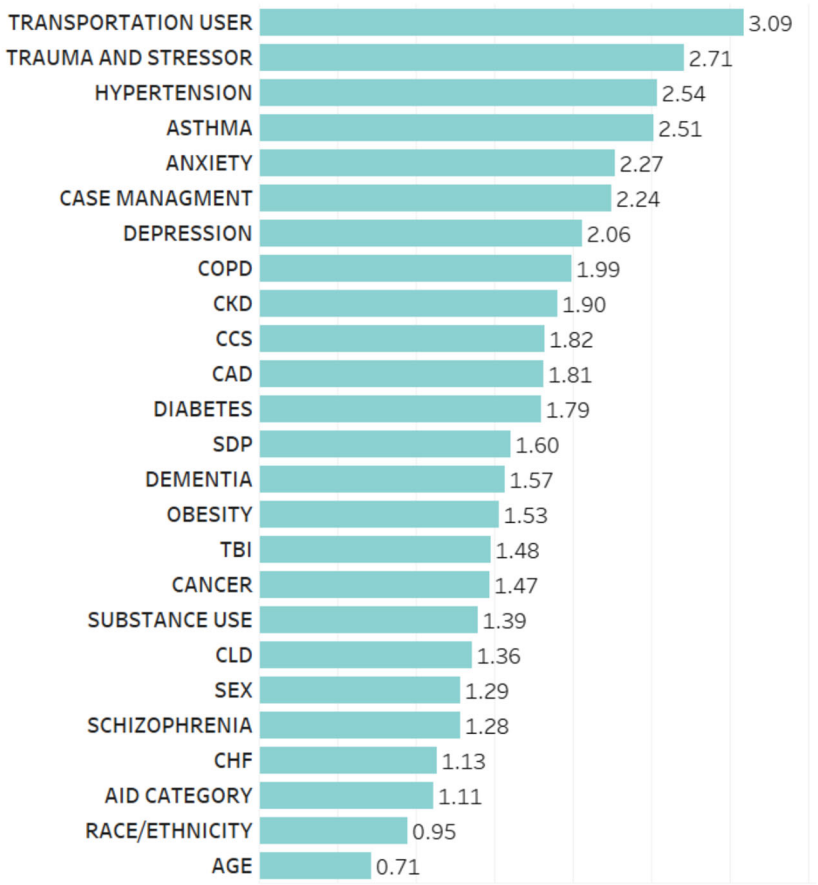
1. ~~(a)~~ Ffive or more ED visits,
2. ~~(b)~~ Oone or more acute hospital admission,
3. ~~(c)~~ Ffifteen or more distinct drug prescriptions, or
4. ~~(d)~~ Ttotal paid claims of more than $50,000 for medical costs (hospital and pharmacy)

~~.~~ During the development of the risk score model, the health utilization of the entire Partnership population was included in the study to avoid any sampling bias and also ensured no bias from other factors like race and ethnicity. The risk score model adjusts

for social determinants, demographics, member's aid category, chronic disease conditions (up to 19 chronic conditions as defined through HEDIS or CMS protocols), as well as the member's eligibility criteria under the CCS program or SPD aid codes. In the realm of social determinants, the risk score adjusts for homelessness, non-emergency transportation usage, and the Healthy Places Index. Similarly, in the demographic category, the adjustments include gender, age, and race/ethnicity.

The relative significance of these factors on the member's overall risk score is estimated using the odds ratio. The higher the odds ratio, the higher the contribution of that factor to the risk score. The bar chart below shows the odds ratios of all the factors that have a statistically significant contribution to the risk score. For example, members who use non-medical transportation benefit are 3.09 times more likely to become high utilizers compared to those who do not use this benefit, holding all other conditions constant. Similarly, considering the race and ethnicity factor, the white population (with an odd ratio of 0.95) is slightly less likely to experience the risk ~~comparing~~compared to other race and ethnicity groups.

The influence of isolated factors on a member becoming a high utilizer



The risk score generated from this model has values ranging between zero and one, going up to 5 decimal places. In addition, the entire Partnership membership is segmented into four risk tiers by defining risk score ranges that delineate homogenous risk groups.

Accordingly, the risk tiers are assigned as follows:

No Risk:	Risk score is less than 0.02004
Low Risk:	Risk score is between 0.02004 and 0.0742
Medium Risk:	Risk score is between 0.0742 and 0.20038
High Risk:	Risk score is above 0.20038

Within every risk tier, we evaluated the distribution of race and ethnicity and ensured that there were no significant biases due to the risk segmentation.

Risk scores prove valuable in assigning members to risk-tiered programs for individuals whose health and well-being require the support of intensive interventions.

Partnership's Health Analytics team runs the risk stratification report every month so that members who have a significant change in health status are captured and offered appropriate interventions to support their health and wellbeing. In addition, Partnership's Quality team often uses HEDIS data to evaluate Population Health interventions. Partnership analyzes HEDIS performance by race/ethnicity and language to identify statistically significant disparities that drive development of interventions to promote health equity within its membership.

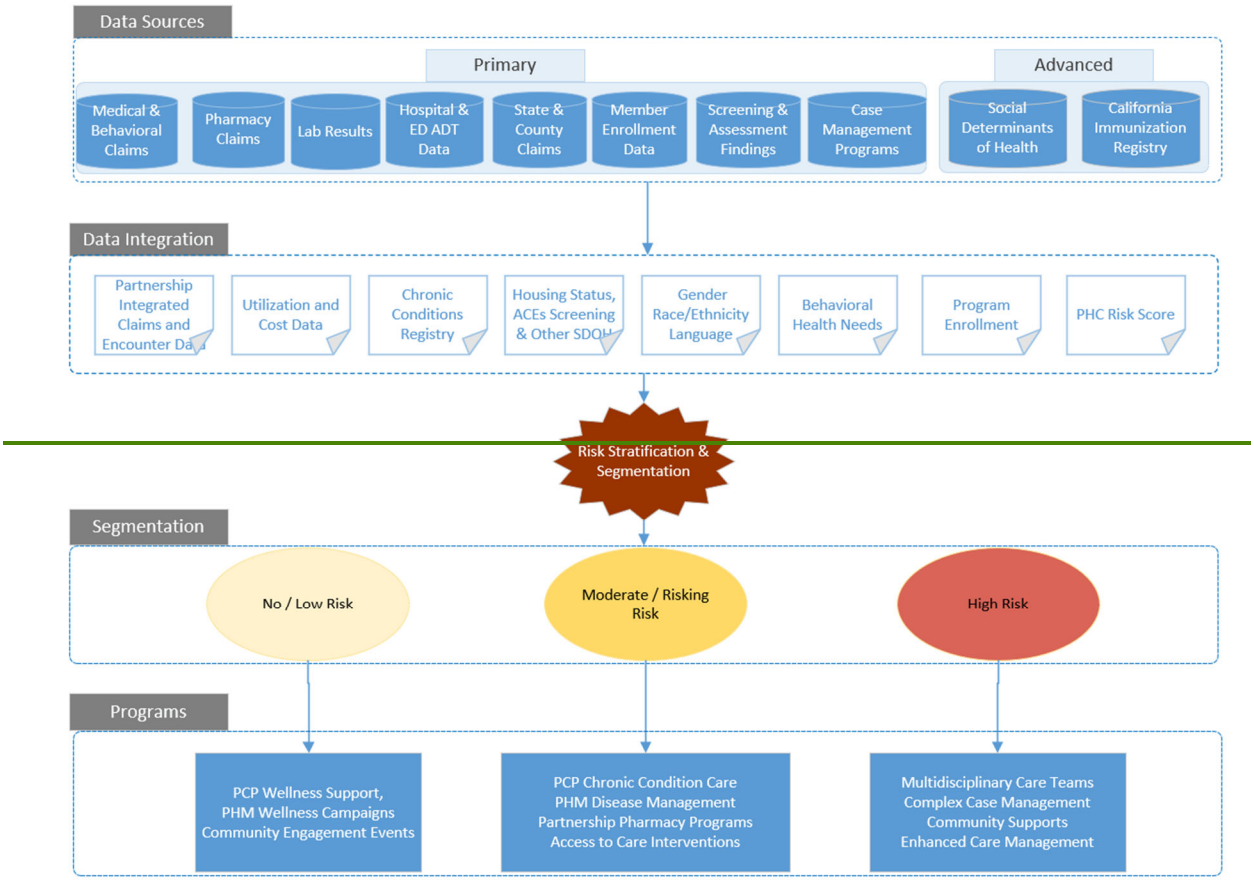
HEDIS measures provide insight intoon members ~~having~~ experiencing gaps in care, and this information is shared with providers to help members obtain preventive and chronic care. Partnership's Population Health team has various member-facing campaigns that are designed to positively impact various HEDIS measures. The care gaps report allows the team to be better informed aboutton where focuses for campaigns should be.

Partnership's PNA and the Annual Reducing Health Disparities report describes how Partnership analyzes select HEDIS Measure results in aggregate, by race/ethnicity, and by language, and examines individual measures for evidence of subpopulations experiencing disparities that warrant intervention. Census, Healthy Places Index, and County Health Rankings data provide insight into the challenges faced by communities and racial groups that lead to health disparities, such as food insecurity, housing problems, tobacco use, and other concerns. Data provided by our providers and community partners also helps identify opportunities and interventions for members with

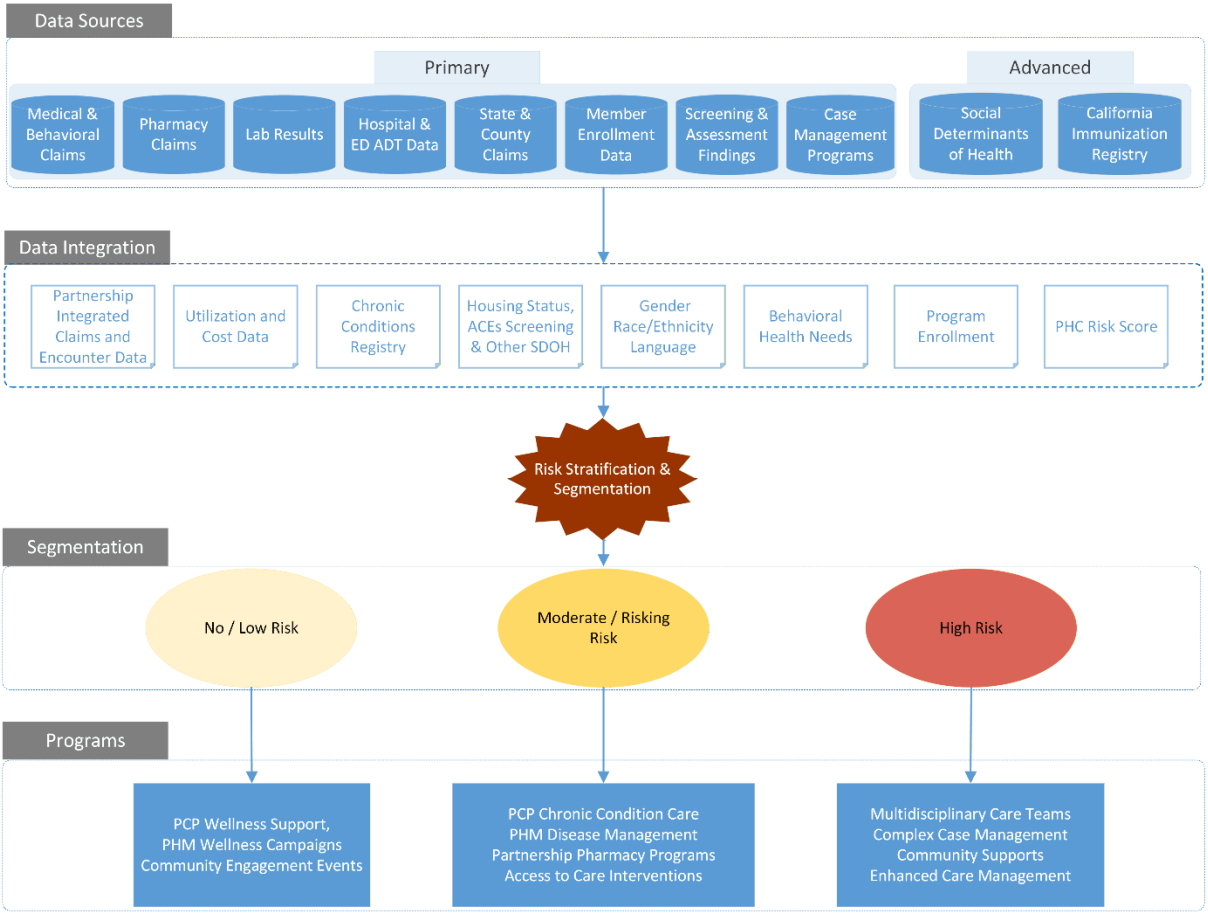
low-risk scores, insufficient data to assign a risk score, or members who may benefit from intervention regardless of risk score. Partnership recognizes that cost and utilization data is insufficient to identify the needs of all racial, language, and gender groups. Therefore, Partnership mitigates the impact of racial bias that could result from risk stratification based solely on utilization patterns by evaluating the entire population through multiple lenses (including race, language, housing status, and other social factors) for enrollment into a wide variety of programs that meet subpopulation needs according to shared identifiers. Partnership will continuously reassess the effectiveness of the RSS methodologies and tools.

Partnership works in collaboration with local providers and community resources to analyze, develop, and implement interventions that support the health and well-being of the entire population (see diagram).

Partnership's Risk Stratification and Segmentation Process



NOTE: Members transitioning from one level of care to another receive Transitions of Care Interventions in addition to services related to their risk tier



NOTE: Members transitioning from one level of care to another receive Transitions of Care interventions in addition to services related to their risk tier

Future Risk Stratification, ~~and~~ Segmentation, and Risk Tiering

Medi-Cal Connect serves as ~~After the release of the~~ the platform for DHCS's PHM Service~~'s~~ RSST methodology~~ies~~. As of 2026, Partnership ~~incorporates~~is piloting DHCS's RSST in~~to~~ operational workflows to inform member identification, outreach, and intervention planning. Medi-Cal C~~c~~onnect was ~~through the Medi-Cal Connect platform~~released in the latter half of 2025 ~~(estimated late 2025).~~ ~~,~~ ~~In light of this release,~~Following the implementation of Medi-Cal Connect, Partnership will assign member risk first based on the DHCS methodology and will ensure members who are identified as high-risk are assessed for appropriate intervention, including care management programs, BPHM, and Transitional Care Services. Partnership will also evaluate members through its proprietary methodology to find members not identified through the DHCS RSST methodology, who may benefit from Partnership interventions, programs, and services. ~~Partnership will perform the RSST process no less than annually and/or upon each member's enrollment, a significant change in health status/level of care, and upon an occurrence of events or when new information arises that poteTrantially changes a member's needs.~~ Partnership uses RSST risk-tiering data

to identify members who are newly classified as high risk within each tier. When a member is triggered high risk, Partnership ensures they receive outreach and engagement specific to that tier at least once annually. This approach supports consistent, timely follow-up for all high-risk members while ensuring each tier's requirements for annual engagement are met whenever a new high-risk designation occurs.

Programs and Services

Partnership leverages committees and multidisciplinary workgroups to design and implement programs and services. Using the risk stratification and segmentation method described above, the Population Health department maintains a PHM Work Plan that describes the interventions offered to members along the continuum of risk. These interventions outlined in the workplan represent Partnership's key basic population health management and case management service offerings to improve the health of our members and to promote and demonstrate commitment to health equity within the communities we serve. These programs are measured for effectiveness as appropriate. Beyond the interventions described in the PHM Work Plan, Partnership collaborates with providers, specialty groups, community-based organizations (CBOs), public health agencies, local education agencies, justice programs, and other agencies to support the health and well-being of the members within Partnership's service area. Partnership regularly monitors its own PHM program for areas of improvement.

Basic Population Health Management

In alignment with the DHCS ~~2024~~ contract and ~~2024~~the PHM P~~p~~olicy G~~g~~uide, Partnership's BPHM is for all members and is further described below. BPHM includes services such as ensuring members have an ongoing source of care, care coordination, navigation and referrals across health and social services, sharing resources, providing education to improve the health of members and to access resources and/or services available to members, Community Health Worker services, wellness and prevention programs, chronic disease programs, programs focused on improving maternal health outcomes, and ~~and~~ more, with referral to higher-intensity services when appropriate.[3,4]

[3] 2024 Contract, Exhibit A, Attachment III, section 4.3.8
[4] 2026 PHM Policy Guide

Partnership works to ensure each member has an ongoing source of care that is appropriate, ongoing, and timely to meet the member's needs. Partnership also works to ensure~~s~~ members are engaged with their assigned PCP and receive all needed preventive services. Member utilization reports are reviewed to identify members who do not use primary care. As part of the Population Health BPHM programs, Member utilization reports are also reviewed to identify members who have not gotten their A1C within 1 year and who have recently been diagnosed with hypertension. Reports can be stratified by race and ethnicity to identify health disparities that result from differences in utilization of outpatient and preventive services. Under the BPHM programs, member utilization reports are also reviewed to identify members who have recently had a stroke or myocardial infraction, as they are more vulnerable to depression. Strategies are then developed to address differences in utilization to promote health equity for all members as needed in a culturally and linguistically appropriate manner.

Partnership works to ensure the member's PCP plays a key role in the member's care coordination. Members receiving care from out-of-network providers will maintain efficient care coordination and continuity of care. Members have access to the services needed including but not limited to:

- Care coordination
- Navigation and referrals to services that address a member's developmental, physical, mental health, substance use disorder, dementia, long-term services and supports, palliative care, and oral health needs
- Assist with making appointments
- Assist with arranging ~~non-emergency~~non-emergency or medically appropriate transportation
- Health education on the importance of Primary Care when disengaged with their PCP, especially among members less than 21 years of age

To address members' needs, health and social services are coordinated between settings of care, across other Medi-Cal MCPs as appropriate, delivery systems, and programs (e.g., Targeted Case Management, Specialty Mental Health Services).~~,~~ Coordination also occurs with external entities ~~outside of Partnership's network~~, ~~and with Community Supports~~for services such as CalAIM programs (i.e. Community Supports and Enhanced Care Management), and other community-based resources~~,~~ even if they are not Covered Services. Referrals are ~~coordinated~~ managed to ensure ~~Care Coordination~~alignment with public benefits programs. Members, and when appropriate, members' parents, family members, legal guardians, authorized representatives (ARs), caregivers, or authorized support persons can receive

assistance with navigating the health delivery systems in order to access care and services that may benefit the member. All care coordination activities ~~are~~ provided to a member are~~and is~~ communicated to the members' parents, family members, legal guardians, ARs, caregivers, or authorized support persons ~~to~~ to members as appropriate. Partnership maintains processes to prevent ~~ensure there is no~~ duplication of services and/or benefits.

Members ~~are further provided with~~receive resources and education ~~about~~on how to access the various programs and services offered by organizations that Partnership has established relationships with or by agencies and third-party entities with whom Partnership has or will have an executed Memorandums of Understanding (MOUs). Members are also ~~provided~~ supported through ~~with~~ resources to address the progression of a disease, condition, or disability, and improve behavioral (including mental health and substance use disorder), developmental, physical, and oral health outcomes. All services are delivered in a culturally and linguistically competent manner that ~~promotes~~advances health equity for all members.

Providers serving Partnership members must maintain and share, as appropriate, the members' Medical Records, and any necessary member information, in accordance with professional standards and State and federal privacy laws and regulations.

Wellness, ~~and~~ Prevention, and Chronic Disease Management Programs

In alignment with the DHCS 2024 contract and 2026~~4~~ PHM policy guide, Partnership provides wellness and prevention programs that strive to align with NCQA PHM standards and DHCS requirements, including access to NCQA accredited, evidence-based self-management tools through our member portal. All members also have culturally and linguistically appropriate health education materials available to them.

Partnership also offers chronic disease management programs. This collection of programs and services aims to improve the health outcomes of all members~~Partnership provides wellness and prevention programs and disease management programs to improve the health outcomes of all members~~.

Eligible members have access to evidence-based disease management and improvement programs that may incorporate health education interventions, target Members for engagement, work to improve health equity, and/or seek to close care gaps for participating members that include, but are not limited to:

- Diabetes

- Hypertension
- Cardiovascular disease
- Asthma
- Depression
- Improving access to preventative health visits, developmental screenings, and treatment services for members less than 21 years of age
- Improving pregnancy outcomes for women, including through 12 months post-partum
- Ensuring adults have access to Preventive Care
- Other Evidence-based Risk-Reduction and Wellness & Prevention programs

For more information on these programs, refer to Partnership's program charters for the Growing Together Program and the Basic Population Health Management chronic disease management programs. Please also see the "Health Education" section of this program description (MPND9001 Population Health Strategy and Program Description) to learn more about the Evidence-based Risk-Reduction and Wellness & Prevention programs.

Partnership works to ensure there is a process for monitoring the provision of wellness and preventive services by PCPs as part of its contractor's site review process. Partnership also submits its wellness and prevention programs to DHCS for review and approval as appropriate ~~and strives to align its wellness and prevention programs with the DHCS Comprehensive Quality Strateg.y.~~ Please see the Health Education section for additional programs.

On an annual basis, Partnership~~'s~~ also ~~DHCS PHMSD reports~~ surveys CAC members on how to use ~~how~~ community-specific information and stakeholder input from the CHA/CHIP collaborations ~~are used~~ to inform wellness and prevention strategies and other Partnership programs, as applicable. Findings from ~~the NCQA~~Partnership's annual, NCQA-approved Population Needs Assessment may also be incorporated into the design and implementation process of wellness and prevention strategies and other programs as appropriate.

Organizational Support for PHM

As an organization, Partnership is engaged in promoting the health and well-being of members. Various departments address particular segments of the population, per NCQA's four areas of focus and DHCS's three levels of risk. For example, Member Services, Quality Improvement, the Population Health department with the Health

Education Unit, all provide outreach to members with no identified risk or low risk to Keep Members Healthy, offer BPHM interventions, and promote health equity where there are barriers to health. Population Health's Health Education Unit, Quality Improvement, Pharmacy, and Care Coordination collaborate to identify and support Members with Emerging Risk, including racial or language groups with health disparities. Care Coordination collaborates with Utilization Management and Member Services to assist members with their Outcomes Across Settings and to bolster provider communication along the continuum of care. Care Coordination's clinical and social work teams provide highly skilled support to assist members who are Managing Multiple Chronic Conditions.

Members may move up and down the acuity continuum as their needs change, and services are matched to the members' evolving level of need. A member may have few identified risks but might have difficulty navigating the healthcare system and require an intensive level of intervention through Partnership's Complex Case Management (CCM), or through other member benefits such as Community Health Worker (CHW) support or Enhanced Care Management (ECM). Conversely, a member with multiple chronic conditions may have well-established support systems and not require assistance from the Care Coordination team in order to access care. The information in the following table outlines Partnership's approach to population health management. The PHM Work Plan and supporting desktop procedures provide details about each service and the associated goals for member segments.

DHCS Risk Segment	NCQA Program/Services	Organizational Support
No/Low Risk: ~~Pregnant members with no complications;~~ Members with no known risk of disease or for whom we have no claims data; focus on supporting wellness.	*Keeping Members Healthy* 1) Healthy Babies Growing Together 2) Healthy Kids Growing Together 3) Health Care Transitions 4) Medi-Cal for Kids and Teens (EPSDT) Awareness campaign 5) Routine Member Newsletters	*Member Needs:* To understand benefits and how to access them; ~~universal prenatal care and perinatal case management;~~ identify and access providers for primary care; help with prescriptions or DME; access to non-Partnership services (Denti-Cal, In Home Support Services, etc.).

DHCS Risk Segment	NCQA Program/Services	Organizational Support
	6) Community Resource Connections 7) Mobile Mammography Clinics 8) School-Based Vaccination Education & Clinics 9) Community Outreach / Engagement Events 10) Health Equity/Disparity Community Outreach Events	*Population Health Interventions:* Member outreach campaigns to promote well-child visits or other wellness care. Collaborate with local agencies to identify community events for underserved communities (immigrant populations, homeless members, rural and frontier communities, etc.) to promote Partnership services and benefits; host events focused on addressing disparities; promote local community resources on Partnership's external website and refer members to Partnership's Care Coordination team as needed to address additional clinical, social, or care coordination needs identified through outreach activities. *Health Education Interventions*: Develop and distribute member newsletters and benefits information targeting various demographics (including members under 21). Create educational materials on various health topics in threshold language groups and racial groups that have outcome data revealing inequities. *Member Services Interventions:* Explain benefits and how they may be accessed; connect members to providers. *Quality Interventions:* Provide HEDIS-based gap reports to providers, showing which members are missing well care visits, timely immunizations, and cancer prevention screenings; evaluate interventions conducted in the provider setting where members are directly

DHCS Risk Segment	NCQA Program/Services	Organizational Support
		engaged and receive services; share resulting best practices for improving HEDIS measure performance and the quality of care members receive. Offer incentives to providers to encourage outreach and provide preventative care visits. Support preventive care events (such as for vaccines and mammography screenings). Providers have on-demand access to their care gap data via the eReports online platform, which is updated biweekly. Partnership's secure, online platform Partnership Quality Dashboard (PQD) is updated monthly and contains current year as well as prior year quality care gap data..

DHCS Risk Segment	NCQA Program/Services	Organizational Support
Moderate / Rising Risk/ Moderate – intensity for Pregnancy Pregnant members with risk factors, or members at risk of disease/ disease exacerbation, or a newly diagnosed chronic illness. Racial groups with inequitable access to health care, e.g., American Indian access to timely postnatal care, and members identified as moderate risk through Partnership's risk stratification.	*Managing Members with Emerging Risk* 1) Perinatal Growing Together – Prenatal 2) Perinatal Growing Together - Post-Partum 3) Disaster Preparedness 4) BPHM - Asthma Control / Improvement Program 5) BPHM - Hypertension Lifestyle Control Program Management 6) BPHM - Diabetes Management Program 7) BPHM Depression Management Program	*Member Needs:* Access to specialty care and/or behavioral health providers to manage emerging or stable chronic conditions; resources/education supporting lifestyle management to maximize health and wellness, and mitigating effects of chronic disease; education on managing new diagnoses. *Population Health Interventions*: Offer BPHM services to engage members to understand barriers to care; provide member coaching on how to manage chronic illnesses (such as hypertension, diabetes, depression and asthma). Post emergency preparedness materials online for members to encourage them to prepare for disasters and wildfires. Schedule mobile mammography clinic days in conjunction with Tribal Health and other rural clinics. Refer members to Partnership's Care Coordination team as needed to address additional clinical, social, or care coordination needs identified through outreach activities, including escalation to higher-intensity services when appropriate. *Care Coordination Interventions:* Outreach to CCS members who have not had an annual well-child visit to encourage them to maintain program eligibility; coordinate care for members who identify (or whose provider identified) a care gap or equipment gap, who need basic case management support.

DHCS Risk Segment	NCQA Program/Services	Organizational Support
		Grievance Interventions: Streamlined grievance process and produced educational videos in multiple languages to educate non-English speaking or LEP members on how to report dissatisfaction. Conduct ongoing grievance process improvement efforts. *Health Education Interventions:* Develop and distribute educational member materials on staying healthy, common conditions, and their management, aligning with member age, sex, education, culture, and at a 6th-grade reading level. *Quality Interventions:* Develop reports that identify members with chronic conditions showing gaps in HEDIS measures specific to monitoring chronic disease management. These reports are used to create (eEPrompts) in our Call Center System. This allows Member Service Representatives, while speaking to the member, to identify when the caller has a can also be used when specific preventive screenings due; Member Services staff uses these reports to remind members of these care gaps during member calls. Evaluate interventions conducted in the provider setting where members are directly engaged and receive services; share resulting best practices for improving HEDIS measure performance and member-level outcomes. Provide grants to providers to purchase Point of Care

DHCS Risk Segment	NCQA Program/Services	Organizational Support
		~~(POC) devices to address or diagnosis chronic disease earlier.~~ Offer a pay-for-performance program that incentivizes chronic disease management, which can enable purchasing POC devices.
Transitional Care Services: Members going through transitions in their care, and members identified through Partnership's risk stratification, in alignment with DHCS-defined Transitional Care Service categories based on member risk and pregnancy status.~~.~~	*Outcomes Across Settings* 1) Transitional Care Services	*Member Needs:* Assistance with transitions between settings, such as acute care to home or skilled nursing facility to home. *Member Services Interventions:* Support members who contact Partnership post hospital discharge who may need to establish care with a PCP. ~~If necessary R~~, ~~r~~efers members to Care Coordination to assess the needs of the member and whether a primary care assignment is appropriate. *Utilization Management Interventions:* Collaborate with facility discharge planners to ensure all necessary prior authorizations required for member discharge are completed in timeframes consistent with member's condition and regulatory requirements. *Care Coordination Interventions:* Review and implement hospital discharge plan; coordinate services; assess member's need for ongoing case management; help schedule follow-up appointments; ensure transportation is available to attend appointments; collaborate with the PCP office to ensure a full transition of

DHCS Risk Segment	NCQA Program/Services	Organizational Support
		care; and provide medication reconciliation.

DHCS Risk Segment	NCQA Program/Services	Organizational Support
High Risk/High-Intensity Pregnancy: ~~Members with~~Members with high intensity pregnancies, multiple chronic conditions, unmanaged conditions like asthma or diabetes, medically fragile, frequent visits to emergency department and/or inpatient admissions; may also have poor social supports or other psychosocial issues; and members identified as high risk through Partnership's risk stratification.	*Managing Members with Multiple Chronic Conditions* 1) Complex Case Management 2) High Risk (*High Intensity)* Pregnancies	*Member Needs:* Coordination of medically complex care needs. Members may have multiple chronic conditions or unmanaged chronic conditions or may be complex due to other factors such as disorganized care delivery, cognitive or developmental impairment, behavioral health challenges, or lack a wellness support structure. *Care Coordination Interventions:* Complex case management support; personalized assessments; individualized care plans; motivational interviewing; medication reconciliation; education/support for disease(s); coordination of services; assistance accessing social and community supports; interagency coordination to reduce duplication of efforts; may include face-to-face interactions.

Health Education

The Health Education team is ~~integrated into~~a part of the Population Health department and works closely with all Partnership departments to assess member needs, to evaluate and improve established programs/activities, and to develop and implement new programs/activities and ~~/~~materials as needed to help members improve their health. The Health Education Team promotes a variety of strategies and methods to deliver health education programs, services, and education materials directly to members (including members under age 21), and through members' health care providers according to members' health education and cultural and linguistic needs and preferences.

The Health Education team uses general health education, health promotion, and patient education methods to help Partnership's members prevent sickness and disease; improve their health; manage their illnesses; effectively use health care services; ensure that members who have not had a recent visit with their assigned medical home or PCP receive health education on the importance of primary care (including members under age 21); and more. Partnership also provides health education opportunities to members directly through resources offered on the Partnership Member Portal and via select subcontracted providers who are skilled in delivering health education services as needed and whose performance is monitored. W~~Select w~~ritten h~~H~~ealth e~~E~~ducation materials are available on Partnership's website for members, providers, and the community at large. Partnership members can also call in or email Population Health to request additional health education materials or resources in the language and format they prefer. Finally, Partnership promotes health education information and Population Health programs through the member newsletter, the provider newsletter, the Partnership website, social media, and through targeted outreach as needed.

Partnership's Health Education system promotes member health through 3 categories of educational interventions:

- Effective use of managed health care services: Partnership provides written information ~~(~~at a 6th grade reading level~~)~~ to help members effectively use the services of their managed care plan. This includes accessing preventive and primary health care services, Medi-Cal benefits, obstetrical care, appropriate use of complementary and alternative care, and dental and vision care.~~, management of health conditions, and health education services.~~
- Evidence-based Risk-Reduction as well as Wellness & Prevention programs: Partnership connects members to educational interventions designed to modify

health behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes based on member needs. Programs can include: smoking and tobacco cessation; managing stress; injury prevention; and nutrition/healthy eating, weight maintenance, physical activity; avoiding risky drinking; and identifying depressive symptoms. These interventions are available on Partnership's Member Portal as NCQA accredited Healthy Living Tools under action plans.

- Evidence-based Healthy Lifestyle, Self-Care, and Management of Health Conditions: Partnership provides or connects members to health educational interventions that can help members learn about and follow self-care management for existing chronic diseases or health conditions like, pregnancy, depression, asthma, diabetes, and hypertension.

This collection of health education strategies forms the health education system. The health education system is maintained and monitored to ensure equal access to all Partnership programs for all members, including accessibility for Limited English Proficient (LEP) members; to ensure appropriate allocation of health education resources; and to conduct appropriate levels of program evaluation. All programs and materials are available to members at no charge. Programs will not discriminate against Partnership members for any reason.

The Senior Health Educator participates in Partnership's internal committees, addressing quality and compliance with Partnership's programs. The Senior Health Educator ensures that all health education programs and materials are appropriate for members of varying demographics, including but not limited to: language, age, race, ethnicity, national origin, disability, sex and gender per Section 1557 of the Patient Protection and Affordable Care Act (ACA 1557).[5]

Material Development

In collaboration with Population Health, Care Coordination, Communications, Pharmacy, Quality Improvement, and other internal departments, the Health Education team develops targeted health education materials to help members modify health behaviors, achieve healthy lifestyles, and promote health equity (See Appendix A). Data from the PNA, CHA/CHIP collaboratives, other resources, and regulatory requirements also guide decisions regarding the availability and creation of health educational materials and resources for specific member populations. Furthermore, the health education team may assess~~es~~ member health care needs and barriers to care by consulting ~~regularly~~ with the Community Advisory Committee (CAC), the Family

[5] Section 1557, HHS, 2020

Advisory Committee (FAC), community organizations, Partnership's Chief Medical Officer, and also through community outreach such as through CHA CHIP efforts, ~~use of Healthy Living Tools,~~ and analysis of Partnership's data. Materials are available to members through direct mail, their network provider's office, community events, on the Partnership website and Member Portal, and via email ~~by~~ request.

In alignment with APL 18-016,[6] the Senior Health Educator assesses written, member-facing materials for readability and suitability according to state and national guidelines, which ensures that member facing materials are written at the 6th~~sixth~~ grade reading level using a readability formula that is most appropriate and reliable for the type of materials and target audience. The Senior Health Educator also ensures that health education materials are culturally and linguistically appropriate for the intended audience with special attention to concept, density, tone, key messages, including format, page design and graphics, and that documents are up to date. Member facing materials (which includes health education materials) are made available in Partnership's threshold languages, large font, in any of California's top 18 non-English languages upon the request of the member, and in specific languages as requested; alternative formats such as braille, large font, or audio are also available upon request (see MNCD9002 Cultural and Linguistic Program Description for more information on this). Partnership's qualified Health Educator(s) can approve written member health education materials as long as the following conditions are met:

- Materials purchased to distribute for member health education are from a DHCS approved company. The Health Education team will maintain a list of approved companies as these are updated by DHCS throughout each year.
- Materials are field-tested to ensure written health education materials are understood by the target audience. A~~The~~ qualified ~~Senior~~ Health Educator will provide oversight of the ~~field-testing~~field testing of all materials. ~~Field-testing~~Field testing is designed to garner feedback from the targeted audience for the materials and may include community focus groups, key informant interviews, simple review and surveys by community members, and/or review during Community Advisory Committee and Family Advisory Committee meetings. The H~~h~~ealth E~~e~~ducation team will review the results and adapt materials as needed and as appropriate.
- Health Education materials are assessed using the Readability and Suitability Checklist (per DHCS requirements). They are approved when:
    - A majority of the Readability and Suitability Checklist provisions are met.

[6] APL 18-016

    - When some of the Readability and Suitability Checklist provisions are somewhat met and/or not met, so long as the qualified Health Educator provides justification, and keeps the justification on file with the Suitability Checklist.
    - The signed/approved Readability and Suitability Checklist, along with the approved health education material, must be kept (electronic file or hard copy) by the health plan and made available to DHCS for auditing/monitoring purpose upon request.
- The assessment and approval process must be conducted by a qualified Hhealth Eeducator/Hhealth Eeducation Sspecialist with the equivalent training and background required by DHCS per APL 18-016.

Health education staff who do not meet the definition of a "qualified Hhealth Eeducator" as listed above will not approve health education materials for Partnership. If Partnership does not have a qualified health educator on staff to assess and approve health education materials, Partnership will submit health education materials to the Managed Care Quality and Monitoring Division (MCQMD) of DHCS for review and prior approval, along with a completed Readability and Suitability Checklist.

Member Incentives

In alignment with APL 16-005,[7] Non-monetarynon-monetary member incentives (MI) may be used in conjunction with, or as a component of, Partnership education programs and Basic Population Health Management programs to motivate members to adopt heathy behaviors, enhance health education activities, including participation in focus groups, or to gain feedback on member experiences. Member incentives must meet DHCS guidelines and follow Partnership's approval process for Member, Survey and Focus Groups (see Appendix B). MI program components include, but are not limited to:

- Increasing member participation, learning, and motivation to effectively use health care services including preventive and primary care services.
- Appropriate health care utilization includes, but is not limited to:
    - Timely prenatal and post-partum care
    - Timely immunizations
    - Timely well child visits
    - Timely screenings (i.e., mammograms, colorectal screening)
    - Regular monitoring tests for chronic diseases
    - Other as appropriate

[7] APL 16-005 Requirements for Use of Non-Monetary Member Incentives for Incentive Programs, Focus Groups, And Member Surveys

- Non-monetary member incentives may range in value depending on the components and complexity of the health education program.
- A Member Incentive Request, Focus Group Request, or Survey Request form (per APL 16-005) that includes:
    - Completion of the MI request form by a qualified Health Educator
    - Review by Partnership's Regulatory Affairs and Compliance Coordinator
    - Submission to DHCS Health Education Consultants for final review and approval at least 2~~two~~ weeks prior to implementing new MI programs or focus groups.

- Annual Member Incentive, Focus Group, and Survey Incentive Evaluation forms are required to be submitted to the DHCS Health Education Consultant thirteen (13) months after the planned program start date, covering the prior 12 months. If the program has ended, a Member Incentive Evaluation form must be submitted to the DHCS Health Education Consultant within 45 days from the date the program ended. Focus group and survey incentive program evaluation forms are due 60 days after the due date for completed surveys.

For more information on incentives, please refer to APL 16-005.

Point of Service Education

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). Partnership abides by DHCS guidance for member screening and assessment, and monitors assessments through the Site Review process. The IHA must include the member's physical and behavioral health history, past medical history, social history, Review of Systems, identification of risks, an assessment of any needs for preventive screens or services, referrals to health education where appropriate, a member risk assessment, and if applicable, the diagnosis and treatment plan for any diseases.

Primary Care Providers (PCPs) are responsible for the screening and identification of members with specific health educational needs. PCPs are also responsible for providing appropriate health education information or referring the member and/or the caregiver to Partnership's Population Health department for assessment of appropriate health education activities or materials, and for following up on referrals (including providing anticipatory guidance). For more information on IHA, please refer to MCQP1021 Initial Health Appointment policy.

Members can also identify their own needs for health education. Partnership makes educational materials, benefits and resource information, and other tools (such as the Healthy Living Tools) available to members and network providers. Select health education materials are available on Partnership's website or upon request.

Partnership health education materials and resource topics are also available on Partnership's Member Portal and include, but are not limited to, topics such as:

- Age-Specific Anticipatory Guidance (adult and child routine checkups)
- Alcohol and drug use
- Asthma
- COPD
- Chronic Disease Management
- Diabetes Management
- Family Planning (contraception)
- Heart Disease & Prevention
- HIV/STD Prevention
- Immunizations (vaccines)
- Injury Prevention
- Living Well with a Disability
- Medication Management
- Nutrition (healthy eating)
- Parenting
- Perinatal/Breastfeeding
- Physical Activity
- Preventive Screening (health screenings)
- Senior Services
- Stress Management
- Tobacco Prevention & Cessation
- Weight Management & Exercise

Practitioner Education and Training

~~Starting in 2025,~~ Partnership provides Diversity, Equity, and Inclusion (including sensitivity, communication skills, cultural competency/humility training, health equity, and related trainings) for practitioners of our network providers, Partnership staff, and subcontractors and downstream subcontractors. This training is referred to as the CARES training. Partnership staff will receive the staff-specific DEI training on an annual basis. For more information on these ~~trainings~~training courses, please see MPND9002 Cultural and Linguistic Program Description and the forthcoming policy MCEP6004 DEI/Cultural Connection Training Policy ~~on~~ which describes requirements for the Diversity, Equity, and Inclusion Training Program ~~Requirements~~ for External Practitioners.

Health Education Interventions

The CHA/CHIP efforts, PNA, ~~and~~ community needs, and other regulatory requirements serve as the basis of setting the Health Education Program goals and activities. The written PNA findings and conclusions drawn from CHA/CHIP efforts ~~are~~ may be used to evaluate and make recommendations for appropriate allocation of health education resources, provider trainings, Partnership staff trainings, and intervention evaluation

efforts. The departments responsible for monitoring outcomes for specific interventions to ensure program objectives are being met. Performance improvement plans are implemented as necessary to improve Partnership and provider performance in delivering programs and services to our members.

Other Activities – Interventions that Indirectly Affect Members

There are many opportunities to collaborate through joint action with providers, county initiatives, and local care management programs to meet the needs of individual members. The following table describes the strategies used to promote population wellness through partnerships with community resources and organizations.

Initiative Type	Definition
Partnership Provider Population Reports	An automated list of members with missing services supplied to providers that are specific to low-performing HEDIS measures and immunization status updates. s. Supports providers in conducting direct outreach to close gaps in preventive care. County Health Officer Forums are held to disperse annual data and encourage collaboration and alignment.
Outreach/ Scheduling Calls	Based on the list of care gaps provided by Partnership, provider offices call members to remind them about scheduling needed services.
Scheduling Block	Clinic days at provider sites or health centers where blocks of appointment time are scheduled for Partnership members to receive missing services. Incentives are may be provided to add operational days / hours to expand access to members.
Poster Campaign, School Engagement	Educational events where students create art projects that amplify a health topic (e.g., immunizations, tobacco and vaping prevention); engagements with screening sessions at school clinics.Peer-to-peer, school-based projects where students receive information and resources on a health topic (e.g. tobacco and vaping prevention, mental health) to engage their peers in incentivized educational activities.
Provider Newsletters	Monthly Medical Director Newsletter to Primary Clinician Leaders, as well as a quarterly publication by the Provider Relations Department (Provider Newsletter) with dedicated

Initiative Type	Definition
	space for Quality Improvement and Member Engagement articles for providers to consider applying to their patients.
Provider Education	Coaching, consultation, measure review, and in-depth guidance for providers on HEDIS/Quality Improvement Program (QIP) measures as part of the Partnership value-based payment program, improving communication between providers, and promoting appropriate specialty referrals. Regular training on health equity. -Webinars provide reminders on standards and best practices, including reminders about external policies, APLs and other regulatory/contractual guidance.
Provider Email & Fax Blast ~~(email or fax)~~	Communication to all network providers for important updates (e.g., a fax blast on new standards for using combined long-acting beta agonist/corticosteroid combinations in treating asthma).
Partnership Website	Changing banners to communicate health information to providers, community-based organizations, as well as to members.
Point of Service Interaction	I The Provider Relations Education team will collaborate with the Pharmacy and QI departments to ensure educational notices are created and sent to providers when there are changes or updates that impact them.
Media Campaign	Social media campaigns and county-level websites focused on improving member education and influencing member decision-making in preventive services/screenings. Websites include public service announcements from local providers and community members.

Informing Members About Available PHM Programs

Partnership shares information on programs and services available to the communities it serves in multiple ways, including Partnership's website (PartnershipHP.org), the Partnership Member Portal, member newsletters, program introductory letters, event attendance, and its provider network as appropriate, as well as~~and~~ telephonically

through Partnership's Care Coordination, Population Health, ~~and~~ Member Services departments. ~~.~~ Partnership also has the ability to inform providers of various programs through Partnership's website, various provider newsletters, in-person meetings, fax blasts, email, and flyer distribution. When a member requires a referral to a Population Health or Care Coordination program, the member is directed to the appropriate staff for assistance with enrollment to the program best matching the member's level of need, and providers are informed as appropriate to support referrals and coordination of member care.

Community Engagement and Coordination of PHM Programs

Partnership has committed to being an active partner in each of the communities it serves, through local presence, local knowledge, and consciously building productive and strong working relationships. The emphasis on Population Health is an exciting opportunity to expand community engagement activities and build on the strong partnerships developed over many years, and in some cases, decades.

Partnership is divided into six distinct geographic areas, with regional offices strategically located in each area. Regional offices and the regional staff are responsible for working closely with local providers of health care to Partnership members, county health and social services departments, local health improvement coalitions and a variety of community-based organizations addressing the social, economic and health needs of Plan members. Regional staff live and work in these communities and share their knowledge of the managed care program with the community, and just as importantly, share their knowledge of the community with Partnership.

Regional staff meet regularly with county health and social service leaders to share information and collaborate on projects with aligned goals, such as childhood immunization campaigns, local disaster response management or planning, CHA/CHIP activities, and more. These staff attend a variety of community organization meetings and collaboratives, and they participate in local initiatives aimed at improving health and quality of life for Partnership members and others in the community. All communities (including Partnership) have ~~came~~come together over the years to respond to various natural disasters and outbreaks such as the devastating wildfires in Northern California and the COVID pandemic. ~~the devastating wildfires in Northern California, forming strong working relationships. Regional staff were able to build on these working relationships as the COVID pandemic emerged to share information, communicate consistently, and build cohesive strategies in each community~~Given the success~~ful~~ of these joint efforts, ~~.~~ Partnership seeks to continue this type of collaboration for years to come.

Partnership has many different member programs/initiatives concurrently planned and executed. In order to prevent duplication of efforts, any department planning or implementing programs affecting our members has the ability to log their member-facing campaign in the Population Health Campaign Tracker within Partnership's internal SharePoint sites. This campaign tracker is a central location for anyone in the organization to ensure staff are aware of current interventions. Quarterly check-in meetings include all member-facing departments and provide updates on new initiatives and outreach campaigns. Member-facing departments also have read-only or edit access to Essette, Partnership's case-management software system. A move to a new system, JIVA, is planned ~~after mid-2025~~for 2026. Campaign documentation occurs within the case management platform, and departments with read-only access have the ability to read through outreach that has already been conducted on a mutual member.

Population Health department staff communicate with providers, multidisciplinary health agencies, community resources, community-based organizations, and workgroups to share and gather information about member-facing programs. This process facilitates identification, planning, and support of healthy initiatives in the community, and identifies community programs and resources that can improve member health and wellness.

Partnership's regional liaisons and leaders in various departments actively participate in both internal and external workgroups to share information and reduce duplication of efforts. Through collaborative meetings, these staff members identify community resources that may be of benefit to Partnership's members and share these resources with the organization to promote integration into program offerings and meet member needs. Programs within the community or offered through providers may include:

- Enhanced Care Management (ECM)
- Community Health Workers
- Doulas
- Community Supports
- Regional Center participation
- Behavioral Health and Wellness & Recovery services
- Eating Disorder treatment
- Outpatient palliative care
- Other community programs such as WIC, support groups, community collaboratives, etc.
- Partnerships with Local Health Jurisdiction
- And more

Partnership members enrolled in the above programs are tracked through Partnership's internal data platforms as appropriate. , along with Tthe cloud-based Point Click Care Platform is also used to facilitate real-time data sharing between Partnership and ECM or other community providers of services (see Partnership Policy MCACP20077002032). This allows members of Care Coordination or other member-facing teams to collaborate with community partners and external case management leads without duplicating services. In addition, Partnership has appropriate agreements in place with each lead entity to ensure HIPAA mandates are followed and member data is not shared inappropriately.

Per DHCS's California Advancing and Innovating Medi-Cal (CalAIM) effective January 1, 2022, members with exceptional clinical and non-clinical needs have access to a community-based benefit called Enhanced Care Management (ECM). ECM provides coordination of services and comprehensive care management through an interdisciplinary, high-touch, person-centered care plan. Members who qualify for ECM services are tracked through a shared data platform to promote communication between providers and reduce duplication of effort. Certain services may differ for a Medi-Cal Member compared to a Partnership Advantage Membermembers enrolled in a Dual Eligible Special Needs Plan (D-SNP) with Medicare.

In alignment with the most recent DHCS PHM Policy Guide, Partnership also makes a good faith effort to executes Memorandums of Understanding (MOUs) with the following Third Party Entities to ensure the delivery of services to Partnership members:

- County In-Home Supportive Services to coordinate between county and managed care plan (MCP) for members who may be eligible for and/or are receiving IHSS
- Regional Centers for the coordination of services between Regional Center and MCP for Members who are or may be served by Regional Center, including Intermediate Care Facilities for Developmentally Disabled Services
- Mental Health Plans (MHPs) to coordinate between MCP and MHP for Non-specialty and specialty Mental Health Services
- Substance Use Disorder Treatment Services to coordinate covered substance abuse services between DMC-ODS and MCPs
- Local Health Jurisdictions/Local Health Departments to coordinate between LHJ/LHD and MCP for the delivery of care and services for Members who reside in LHJ's jurisdiction and may be eligible for one or more services provided, made available, or arranged for by LHJ

- County Social Services for Child Welfare to coordinate between County and MCP for the delivery of care and services for Members who are receiving County Child Welfare Services
- Women, Infant, and Children (WIC) to coordinate services between WIC Agencies and MCP to ensure provision and delivery of MCP's Covered Services and WIC Services to Members
- Local Government Agency (LGA) County-Based Targeted Case Management (TCM) Program to coordinate services between LGA TCM Programs and the MCP to ensure the delivery of care and services for eligible Members.
- County Behavioral Health Departments to coordinate services for Specialty Mental Health Services in Medi-Cal Mental Health Plans and SUD Services in Drug Medi-Cal Organized Delivery System (ODS) Counties

~~Other MOUs with the following organizations became effective January 1, 2025:~~

- LGA/California Department of Corrections and Rehabilitation, County Jails, and Youth
- First 5 Programs
- Whole Child Model
- Local Education Agencies (LEAs) (effective in 2027)

~~By mid-2025,~~ Partnership ~~will~~ also makes a good faith effort to ~~work to~~ implement DHCS guidance regarding Closed Loop Referrals to applicable services, and in certain MOUs, as needed. Furthermore, Partnership ~~also~~ works to ensure services carried out by third party entities are delivered in a culturally and linguistically appropriate manner. Finally, Partnership supports warm handoffs with third party entities as appropriate. For more information on MOU requirements, see MCCP2036 Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities.

Informing Members on Interactive Content

Many of Partnership's programs and services are designed to be interactive, allowing members to select the extent to which they wish to engage in these opportunities. In all instances of interactive services, members have the ability to opt out of the program. Should the member express this wish – in writing, in a telephonic conversation, or through a face-to-face interaction – this preference is documented for each campaign or intervention. The annual PHM Work Plan details the interactive services offered, how members qualify for programs, and how to opt out of programs.

Program Evaluation

The Population Health department analyzes the impact of PHM programs annually through clinical, utilization, and member experience measures, in accordance with the PHM efforts of the year. Partnership's Health Analytics department takes the lead in performing quantitative analyses to monitor the ~~c,~~ utilization results in aggregate and by subpopulation, and data supporting the tracking measures identified in specific initiatives. Data gathered to perform this analysis may include advanced data sets described previously, as well as member demographics, annual medical/behavioral and pharmacy claims data, immunization data from California Immunization Registry, transportation claims data, health appraisal results, HEDIS data, and data specific to internal programs such as case management, pilot programs, and/or provider performance improvement activities, as appropriate, and member feedback survey results. The QIHEC reviews reports on PHM activities for potential areas of concern, opportunities for improvement, and evaluates the impact of existing programs. This allows Partnership's leadership to review and update PHM activities to meet the needs of the members, as well as identify staffing, education, system, and infrastructure changes/requirements needed to support the delivery of those services as needed. Partnership's Quality Improvement and Performance Improvement programs use HEDIS monthly and annual reporting and analysis to monitor the impact of the programs and select opportunities for future interventions. Data from Quality Incentive Programs is also used as a proxy while HEDIS data is tabulated. The PHM Work Plan tracks the progress of interventions according to the measures identified at the beginning of the year, while the Population Health Management Impact Analysis reports on select clinical and utilization measures, as well as member experiences with the population health interventions.

In addition, Partnership hosts quarterly committees to encourage members to engage directly with Partnership. One such committee is the Community Advisory Committee (CAC), made up of member representatives from each of the regions in which Partnership operates. This committee meets to review Partnership's programs and provide feedback on how Partnership meets the needs of its members and of its communities. A separate Family Advisory Committee (FAC) is comprised of members whose children have special needs. The Pediatric Quality Committee consists of public and private sector physicians who care for Partnership members; ~~the committee provides insight into challenges members may have in getting the care they need from a provider perspective~~. The committee provides input on pediatric members that are eligible for CCS services and helps shape policies and access for these members as well as provide input on pediatric concerns.

The Grievances & Appeals department gathers and analyzes trends in member-reported complaints to identify areas for program improvement in the coming year. Partnership also has a process for identifying and intervening where there may be Potential Quality Issues (PQIs) related to a provider or provider organization. Finally, Partnership participates in two NCQA-approved Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys; one assesses factors under Health Plan influence, the other focuses on factors managed by Primary Care sites.

Identifying Opportunities for Improvement

No less than annually, the QIHEC reviews the impact of PHM's programs, identifies opportunities for improvement, and may select at least one improvement opportunity to address in the coming year as appropriate.

Delivery-System Supports for Population Health Management

~~Through PHM, Partnership acts to support providers by working intentionally and collaboratively with the provider community. The Quality Improvement department outlines strategies for the coming year in the Quality Improvement Program Description (See Policy MPQD1001) and annual Work Plan, addressing how providers will be made aware of population needs, and how they will be supported in addressing them.~~
Through PHM, Partnership supports providers by working intentionally and collaboratively with the provider community to improve population health outcomes. The Quality and Performance Improvement ~~Trilogy~~ Program Description (Policy MPQD1001) outlines how Partnership identifies population health needs using performance monitoring, disparities analyses, community health assessments, member experience data, and other required evaluations. The annual Work Plan then translates those identified needs into targeted strategies and activities, including improvement initiatives, value-based programs, reporting tools, training, and technical assistance.

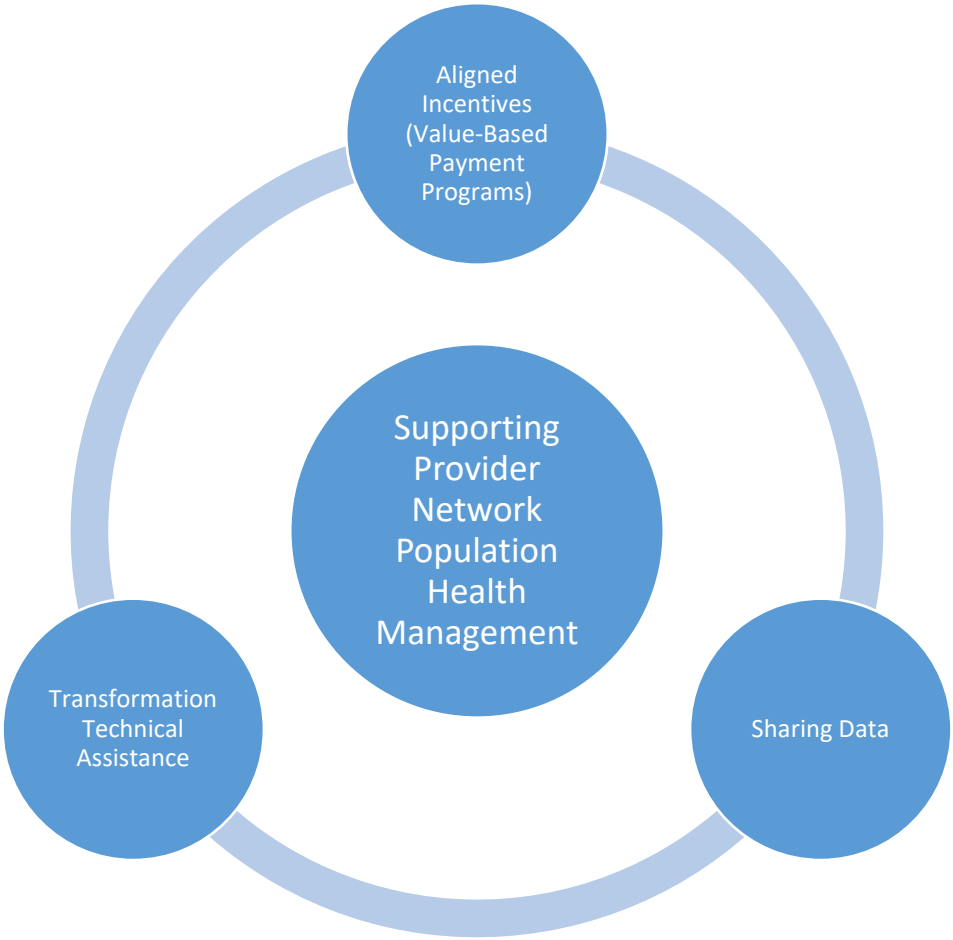
Value-Based Payment Programs

Partnership has a number of value-based payment programs through which contracted provider organizations can qualify for a financial incentives for quality-related performance. There are separate incentive programs for primary care providers, hospitals~~-~~, perinatal ~~providers, palliative~~providers, palliative care, ECM providers, extended care and ~~other~~more. Partnership's Primary Care Provider Quality Improvement Program (PCP-QIP) is Partnership's value-based payment program for

primary care providers. The PCP-QIP is largely focused on improving the quality of care members receive through a measure set reflecting Partnership's HEDIS measure score improvement priorities.

Incentivizing Patient-Centered Medical Home (PCMH) Recognition

Through our PCP-QIP, Partnership incentivizes contracted primary care practices to achieve and maintain Patient-Centered Medical Home recognition. This program is designed as an annual incentive, intended to encourage and recognize those provider practices that achieve excellent levels of service, care integration, and panel management, as recognized by established quality organizations.



Sharing Data

Partnership shares a variety of member data with our provider network in an effort to facilitate coordination of care and population health management. The two main

systems for data sharing are eReports and the Partnership Quality Dashboard (PQD). Partnership also shares a publicly available, annual data report with County Public Health Departments in alignment with DHCS's PHM requirements.[8]

eReports

eReports is a web-based platform that supports measurement and reporting for the clinical care domain of the Core Measurement set in Partnership's PCP-QIP. These preventive care and chronic disease management measures reflect DHCS's priority quality measures and are developed in-house by Partnership. The Core Measurement set is reviewed, modified, and approved annually by Partnership's Physician Advisory Committee (PAC) after considerable input from an internal technical workgroup, an external provider advisory group, and an open comment period involving all participating providers. eReports gives providers member-level data showing member eligibility and compliance for each clinical measure leveraging claims, lab, pharmacy, and immunization registry data. Providers may also upload medical record data to substantiate member compliance where representative administrative data is unavailable. eReports data ~~are~~ is refreshed twice per week, giving providers nearly real-time visibility to their measure-specific performance relative to performance targets. It also offers the ability to drill down into member lists by measure and view measure performance by site or organizational level (i.e. if multi-site provider). Once an organization is contracted with Partnership, ~~Healthplan~~ their PCP sites are loaded into the eReports platform and their Quality contact is notified via email by the QIP team with eReports registration and user access instructions.

Partnership Quality Dashboard (PQD)

This secure, online platform makes provider-site-level quality data available across quality improvement programs to help inform, prioritize, and evaluate quality improvement efforts. Specifically, PQD functionality includes:

Measure-Specific Data	PQD tracks provider performance on all Primary Care Provider Quality Improvement Program and HEDIS measures relevant to targets.
Trended Data	Providers can track their performance on the measures throughout the measurement periods (i.e. monthly rates).

[8] ~~DHCS Population Health Management Policy Guide, 2024~~DHCS Population Health Management Policy Guide, 2026

Comparative Data	PQD allows providers to compare their performance to blinded data of peer providers, including local averages and national benchmarks

Note: While the most currently available data for QIP Clinical measures is available on eReports, PQD serves as a visualization tool. PQD does not allow for any data entry. Instead, all clinical rates are calculated in eReports, and PQD takes the output of eReports, presenting the data longitudinally and comparatively. While eReports display performance at a given point in time, PQD shows performance data trending. In addition, the eReports interface compares performance against pre-defined thresholds, whereas PQD has multiple means of comparison including averages at regional, sub-regional, and county levels. PQD also includes data for non-clinical measures (e.g. 7 Day Follow-Up Visits, Avoidable ED Visits). Thisese data, which isare inclusive of measures involving follow-up visits after discharge from the emergency department, and ambulatory care sensitive admissions, are displayed in PQD allowing providers to view the number of members with admissions based on Preventive Quality Indicator diagnosis, date of admission and date of discharge. Other measures display members in a denominator based on number of acute inpatient discharge or observation visits in the measurement year and who received a follow-up visit within seven (7) days of hospital discharge. Thisese data isare all displayed at the member level and isare available for download into Excel format., readmissions, PCP Office Visits).

Transformation Technical Assistance

In addition to aligned incentives and data sharing, Partnership supports quality improvement and care delivery transformation in our network via the Partnership Improvement Academy and its component offerings. These opportunities are designed to prepare providers, including primary care providers, to optimize population health, enhance their patients' experiences of care, promote provider and care team satisfaction, and foster a culture of continuous quality improvement. The Improvement Academy offerings include the ABCs of Quality Improvement (QI) (QI basic methodology for the model for improvement)., the Improving Measure Outcome series that focuses on Partnership's Primary Care and Perinatal Quality Incentive Program (QIP) measures, offering practical strategies to close care gaps, and advance health equity; and improve clinical outcomes; and personalized services through Quality's Improvement Advisors, who work directly with provider sites to provide support, guidance, and tailored recommendations in support of practice transformation and the development of quality improvement subject matter expertise.. TtThe QI Project Training program to helps providers and community partners to plan and lead quality

improvement projects;~~, and personalized services through Quality's Improvement Advisors, who work directly with provider sites to provide support, guidance, and tailored recommendations in support of practice transformation and the development of quality improvement subject matter expertise~~.

Population Health and Health Education Delegation Oversight and Monitoring

Partnership may delegate Population Health, Health Education, and Cultural and Linguistics functions. Prior to assigning delegated responsibility, Partnership ensures the entity's capacity to perform. This is called a pre-delegation evaluation. Once confirmed, the parties enter into a formal agreement inclusive of all delegated responsibilities. Partnership conducts an audit of all delegated entities no less than annually to ensure that the delegate is performing consistent with the delegation agreement, applicable Partnership policies/procedures, and applicable regulatory obligations. Results from Oversight and Monitoring activities are presented to the Delegation Oversight Review Sub-Committee (DORS) for review and approval, as needed.

Population Health Department Structure

Population Health operations are supported by a leadership team and administrative staff. Partnership's Population Health department is responsible for developing, maintaining, and overseeing implementation of Partnership's overall PHM strategy, partnering with other departments to identify the health disparities and wellness needs of Partnership's members, implement DHCS's local planning requirements (previously known as the PNA requirement), and aligning organizational and community efforts to meet these needs in accordance with DHCS and NCQA requirements. In order to accomplish these objectives, Population Health departmental resources are leveraged to engage internal stakeholders, external stakeholders, and members aligning existing projects and efforts to promote health equity for Partnership's population. Population Health department staff are allocated to develop and share member education materials, ensure all member subpopulations have resources specific to their needs, engage with the community, educate community partners on Partnership programs and interventions, learn about resources available within communities, promote collaboration of effort, support each local LHJ's CHA/CHIP process, and reduce duplication of services.

Team Roles and Responsibilities

Chief Medical Officer:

As the principal manager of medical care, the Chief Medical Officer is responsible for the appropriateness and quality of medical care delivered through Partnership HealthPlan of California (Partnership) and for the cost-effectiveness of the utilization of services. ~~This position provides overall direction to multiple departments, including the Population Health Management Team and has the ultimate responsibility of ensuring that departmental programs and services are consistent and meet all regulatory requirements in every office location.~~ Required education includes an MD/DO degree from an accredited program, preferably in a primary care specialty required; minimum two (2) years' experience in a managed care plan preferred with duties comparable to those listed above, and experience administering medical programs. This role also requires board certification in a specialty and a minimum of seven (7) years clinical/medical practice experience.

Director of Population Health

The Director of Population Health is the key business leader who oversees the organization's Population Health Management strategy and is responsible for providing leadership, alignment, support, strategic development and implementation of associated activities and interventions. Provides clinical guidance and strategic direction for departmental activities by applying their understanding of population health management priorities, health care policy, financing, and regulations to promote optimal health outcomes for members. Works with the Chief Medical Officer, Chief Health Services Officer, Senior Director of Quality and Performance Improvement, Director of Health Equity, and other department leaders to meet organization and department goals and objectives while developing and tracking the measurable outcomes of department services. A Bachelor of Science Nursing or Doctorate in Public Health is required. At least 5 years of experience in a leadership/management role is also required. Experience in a managed care, health care provider network and/or working with Medi-Cal population is preferred.~~Provides oversight and direction of the Population Health strategy, programs and services to improve the health of Partnership members. Works with the Chief Medical Officer, Chief Health Services Officer, Senior Director of Quality and Performance Improvement, Director of Health Equity, and other department leaders to meet organization and department goals and objectives while developing and tracking the measurable outcomes of department services.~~

Associate Director of Population Health

~~Assists the Director of Population Health in the development, implementation and evaluation of Partnership's population health interventions and program oversight. The~~

~~Associate Director oversees the Managers of Population Health and the operational workings of the Population Health department. The Associate Director reviews and submits issues, updates, recommendations, and information to the HS Leadership when appropriate. Ensures ongoing audit readiness for Population Health deliverables.~~Under the leadership of the Director of Population Health, manages and provides direction to the Population Health team managers and supervisors to ensure key Basic Population Health Management activities are performed in compliance with DHCS and NCQA requirements. Participates in the development, implementation, and maintenance of Population Health programs and achievement of department goals and objectives in a fast paced, dynamic environment. This role ensures compliance with established operational criteria, NCQA, and DHCS Standards, and PHC policies and procedures. A bachelor's degree is required, but an RN license is preferred. A minimum of 5 years of relevant experience in health care operations, a minimum of 3 years of management experience with effective problem solving, or equivalent combination of education and experience is required.

Manager of Population Health

Gives day-to-day direction and has management responsibility for the implementation of member-facing outreach campaigns, member wellness coaching, CHA/CHIP activities, and other member and community-facing activities designed to keep members healthy and support them in managing their emerging health risks. The Manager provides day-to-day direction for supervisor~~ss,~~ and other key staff, manages escalated concerns, and ensures ongoing audit readiness for Population Health deliverables within the scope of their assigned unit.

Supervisor of Population Health

~~Provides supervisory oversight during daily department operations for assigned team members through sustained leadership and support. Using the best expertise and sound judgment (and in consultation with clinical leaders, providers, and staff), provides daily oversight, leadership, support, training, and direction of Population Health staff. S upports and assists the Manager and other Supervisors in developing and maintaining a cohesive team with a high level of productivity and accuracy to achieve the department's overall performance metrics.~~ Provides daily oversight, leadership, support, training, and direction of assigned Population Health staff. Supports and assists the Team Manager and other supervisors in developing and maintaining a cohesive team with a high level of productivity and accuracy to achieve the department's overall performance metrics. Bachelor's degree in business, Communication, Healthcare

Administration, or a related field, or 3-5 years of managed care experience, or equivalent combination of education and experience is required. General knowledge of managed care and principles of population health management is preferred.

Community Health Needs Liaison

In collaboration with departmental and organizational leadership, s~~S~~upports the coordination and implementation of Partnership's Local Planning process (Population Needs Assessment or (CHA/CHIP process) ~~activities~~requirements and activities through active and meaningful engagement in identified community workgroups and initiatives. On behalf of the health plan, identifies and supports key strategic activities and interventions that support alignment of collective agency efforts that promote and support efforts to encourage member health outcomes. Identifies community service programs available within our counties, outlining resources that are culturally and linguistically appropriate as needed and shares with appropriate stakeholders as needed. Supports the development of the key deliverables for DHCS and NCQA. ~~annual PHMSD and the NCQA annual Population Needs Assessment report.~~ Required education includes bachelor's degree in public health, Community Health or related field; A minimum of 2 years of experience in public health is preferred.

Senior Health Educator

The Senior Health Educator is a public health masters-prepared (or MCHES-certified) professional who maintains administrative and regulatory oversight of member facing materials (health education and member informing materials) and supports oversight of select cultural and linguistic services. This role also implements health education activities that promote member wellness, understanding of benefits, and access to care. More specifically, plans, implements and evaluates health education activities identified through gaps found in the PNA, CHA/CHIP work, HEDIS measures in conjunction with health promotion and equity programs; and supports cultural and linguistic services as appropriate. The Senior Health Educator also performs supervisor responsibilities for the Health Education team. This role requires a Master of Public Health (MPH) degree with a health education or health promotion emphasis, or master's degree in Community Health with a specialization in health education or health promotion, or Master Certified Health Education Specialist (MCHES) awarded by the National Commission for Health Education Credentialing, Inc. This role must have a minimum of 2 years' experience developing health education programs. Previous experience in a supervisory capacity, and/or experience or capacity to manage audit activities in our provider network, and experience or equivalent academic training on identifying health disparities within different cultures is preferred.

~~A masters-prepared (or MCHES-certified) professional who ensures the delivery of health education resources for both members and primary care providers. Also oversees the creation of member informing materials. Monitors and provides administrative oversight of all regulatory requirements related to Health Education and the Cultural & Linguistics programs. Provides assistance with regulatory requirements as needed.~~

Health Educator

Trained and competent to actively participate in the design and implementation of health education activities, including the creation of health education materials and classes and member informing materials. Leads on assigned member education projects, monitors health education materials, and performs literacy reviews to ensure appropriate readability and suitability levels. Supports and helps in delegate audits to ensure accuracy, compliance, and alignment with cultural and linguistic standards. Serves as a resource to internal staff and providers to ensure compliance with state requirements for educational member materials. Required education includes a bachelor's degree in health education, Public Health, Community Health or related field, experience in Public Health Education. A minimum of 2 years of health education experience is preferred.

Healthy Living Coach

Performs outbound call campaigns to members based on identified member needs using appropriate scripts. Administers post-campaign surveys. Helps members identify and access resources for their health and social support needs. Tracks outreach efforts in approved case management system per prescribed protocols. Engages Partnership members to identify barriers to care, member concerns, and resources needed. Lead member wellness campaigns and support members using Partnership's Healthy Living Tools. Participates in health fairs and other activities where Partnership members congregate; shares learnings with other Partnership departments who promote member engagement and wellness. When applicable, refers to culturally and linguistically appropriate community services.

Wellness Guide

~~Performs outbound call campaigns to members based on identified member needs for babies and young children, using appropriate scripts. Administers post-campaign surveys. Helps members identify and access resources for their health and social support needs. Tracks outreach efforts in approved case management system per prescribed protocols. When applicable, refers members to culturally and linguistically appropriate community services, and DHCS-approved health education materials.~~ This

position provides support and guidance to Partnership HealthPlan of California (Partnership) members for wellness services and incentive programs in a call-center environment. The Wellness Guide works closely with members and their families to encourage members to engage in healthy activities (including preventative care visits and chronic care management), remind members of available benefits, and connect members to available internal and external resources. Required education includes a high school diploma or equivalent combination of experience and education required; associate's or bachelor's degree is preferred. Two (2) years of experience working in a health care setting recommended, to include experience in health coaching, behavioral change, or any work experience, training or specialized education that would likely provide the ability to perform the essential functions of the position. Preference may be given to individuals certified and/or licensed in a health-related field

Project Manager

This position is r~~Responsible for managing timelines and deliverables in department projects. Develops agendas and leads meetings to advance departmental objectives. Provides routine and ad hoc reporting for key Population Health activities and initiatives. Works closely with designated department staff and leadership to gather, compile, and distribute reports, and facilitates structured file and record management. Supports ongoing audit readiness activities by maintaining structures around audit deliverables.~~ esponsible for effectively leading assigned projects, utilizing appropriate project management methodologies to drive the planning, implementation, and tracking of projects through all aspects of the project lifecycle. Project Managers are responsible for the planning, procurement, and execution of a project. This role also provides routine ad hoc reporting for key Population Health activities and initiatives and works closely with designated department staff and leadership to gather, compile, and distribute reports, and facilitates structured file and record management. Additional duties include s~~S~~upporting~~s~~ ongoing audit readiness activities by maintaining structures around audit deliverables. Required education includes a bachelor's degree and at least one (1) year of relevant project management experience required. In lieu of a degree, a minimum of three (3) years of relevant project management experience will be considered. Other requirements include experience managing multiple projects with medium to large teams. Experience in a health plan environment is preferred.

Project Coordinator

This role supports the planning, organization, management, and implementation of projects. The Project Coordinator also o~~O~~versees timelines and deliverables for

department projects, . pProvides routine and ad hoc reporting for key Population Health activities and initiatives, and w. Works closely with designated department staff and leadership to gather, compile, and distribute reports, and facilitates structured file and record management. Supports ongoing audit readiness activities by maintaining structures around audit deliverables, meeting minutes, and the file retrieval system. Required education includes a high school diploma or equivalent. A minimum of one (1) year project coordination or relevant experience is also required.

Coordinator

~~Provides coordination and administrative support to their manager and assigned unit. Performs a variety of general clerical duties, including data entry, help desk management, referral tracking, the distribution of non-monetary member incentives to members participating in incentive programs, organizing member packets and gifts, etc.~~ The Coordinator role provides coordination and administrative support to department teams and management. This role performs a variety of general clerical duties, including data entry, report generation, managing and responding to call inquiries, managing- internal Helpdesk inquiries, managing and assigning follow up inquiries from other departments, creates and revises desktop protocols, and develops forms and presentations. Other duties include referral tracking, the distribution of non-monetary member incentives to members participating in incentive programs, organizing member packets and gifts, etc. Required education includes a High School Diploma or equivalent. One (1) year of related experience in the medical/clerical field or equivalent combination of education and experience is also required. Experience in phone-based customer service may be preferred.~~Provides coordination and administrative support to their manager and assigned unit. Performs a variety of general clerical duties, including data entry, help desk management, referral tracking, the distribution of non-monetary member incentives to members participating in incentive programs, organizing member packets and gifts, etc.~~

Note: Staffing and staff job descriptions are subject to change based upon program needs and organizational growth.

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DHCS APL 2~~6~~2-00~~2~~6 Medi-Cal Managed Care Health Plan Responsibilities For Non-

Specialty Mental Health Services (04/08/2022)

DHCS APL 18-016 Readability and Suitability of Written Health Education Materials (10/05/2018)

Document A (APL 18-016): Review and Approval Guidance for Written Health Education and Member Information Materials

Document B (APL 18-016): -Readability and Suitability Checklist for Written Health Education materials

DHCS APL 16-005 *Revised* Requirements for Use of Non-Monetary Member Incentives for Incentive Programs, Focus Groups, and Member Surveys (11/23/2016)

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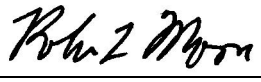
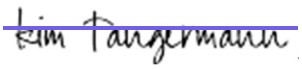
Population Health Management Strategy & Program Description Approval

	06/17~~XX18~~/2026~~5~~

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

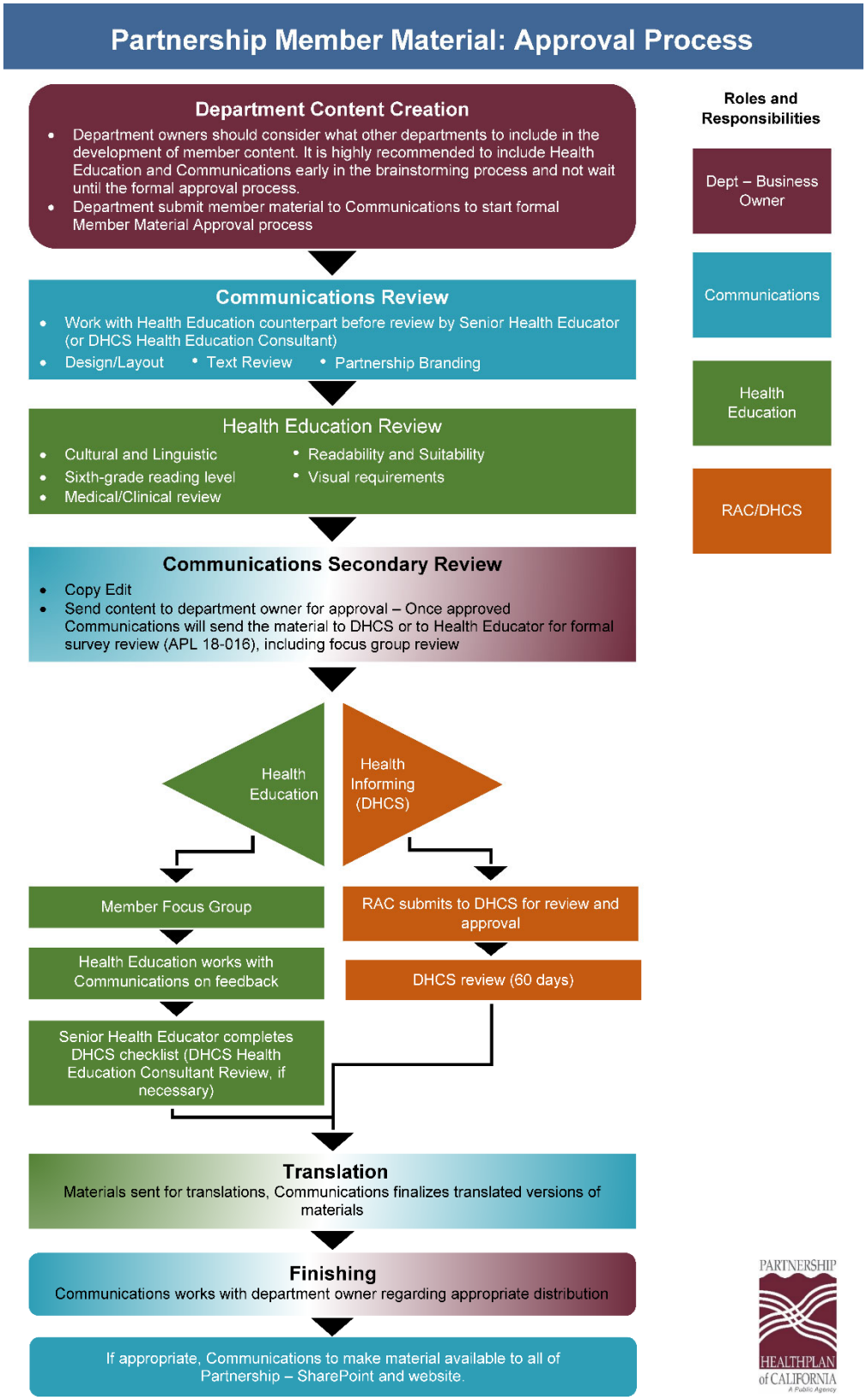
	08/12~~XX13~~/2026~~5~~

Angela Brennan, DO — *Date Approved*
Physician Advisory Committee Chairperson

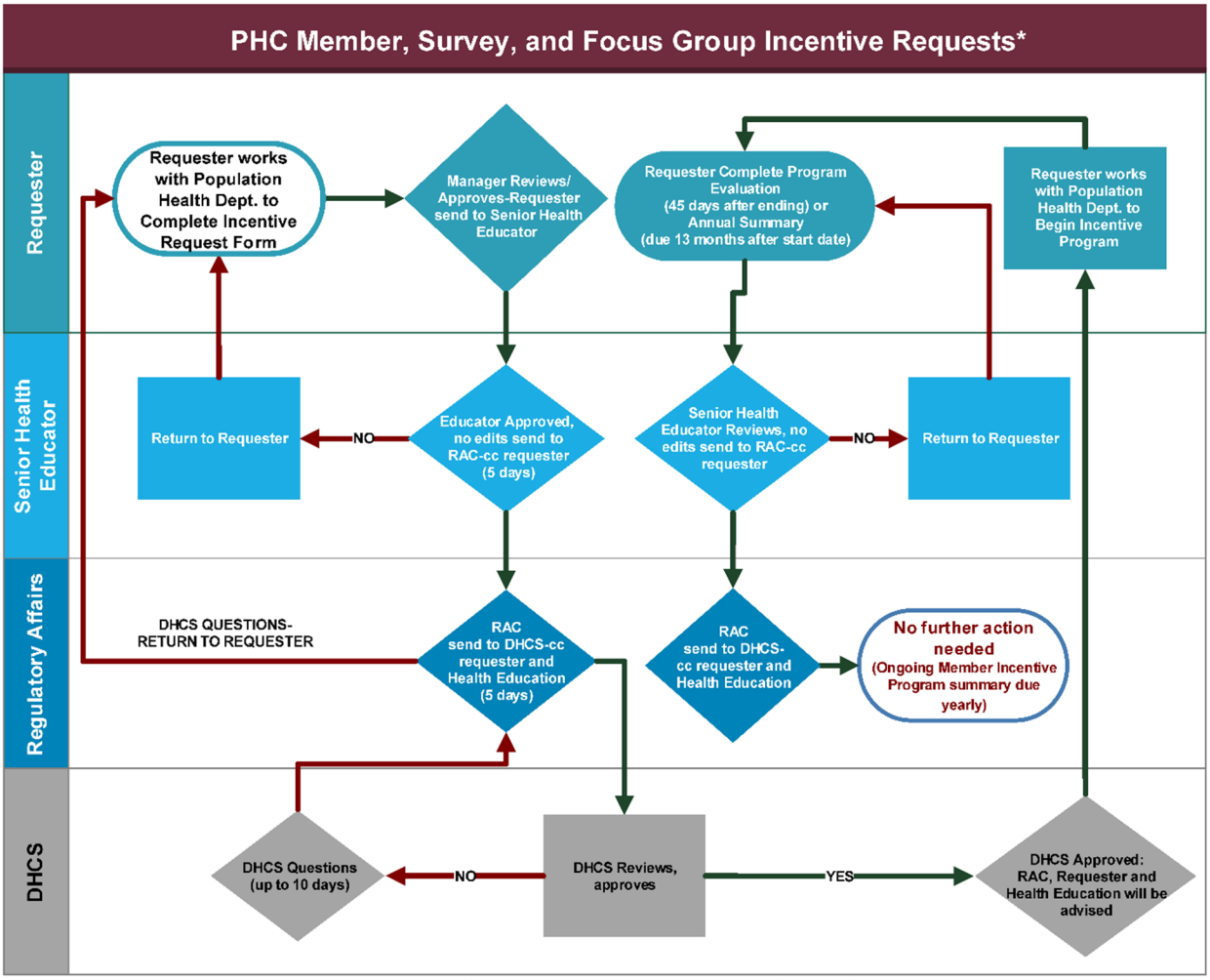
	08/26~~XX27~~/2026~~5~~

Dean Germano~~Kim Tangermann~~ — *Date*
Approved
Board of Commissioners Chairperson

Appendix A


Partnership Member Material: Approval Process
Department Content Creation
Department owners should consider what other departments to include in the development of member content. It is highly recommended to include Health Education and Communications early in the brainstorming process and not wait until the formal approval process.
Department submit member material to Communications to start formal Member Material Approval process
Communications Review
Work with Health Education counterpart before review by Senior Health Educator (or DHCS Health Education Consultant)
Design/Layout
Text Review
Partnership Branding
Health Education Review
Cultural and Linguistic
Sixth-grade reading level
Medical/Clinical review
Readability and Suitability
Visual requirements
Communications Secondary Review
Copy Edit
Send content to department owner for approval – Once approved Communications will send the material to DHCS or to Health Educator for formal survey review (APL 18-016), including focus group review
Health Education
Health Informing (DHCS)
Member Focus Group
Health Education works with Communications on feedback
Senior Health Educator completes DHCS checklist (DHCS Health Education Consultant Review, if necessary)
RAC submits to DHCS for review and approval
DHCS review (60 days)
Translation
Materials sent for translations, Communications finalizes translated versions of materials
Finishing
Communications works with department owner regarding appropriate distribution
If appropriate, Communications to make material available to all of Partnership – SharePoint and website.
Roles and Responsibilities
Dept – Business Owner
Communications
Health Education
RAC/DHCS

Appendix B



Email incentive requests to the Senior Health Educator at CLHE@partnershiphp.org

*As referenced by MMCD All Plan Letter (APL) 16-005 Revised

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Population Health Grand Analysis

DeLorean Ruffin, DrPH, MPH

June 2026

Data Sources for Report

Data Type	Data Source
Member demographics	Member demographics from Partnership data warehouse
Encounters	Encounters from Partnership claims system
Immunization data	California immunization registry (CAIR)
DHCS medical and pharmacy claims	DHCS claims data
Member experience survey results	Partnership case management system (Essette)
Member delivery report	Partnership claims system Hospital ADT data (PointClickCare) Authorization data
Case management	Partnership case management system (Essette)

Engagement Categories

Engaged

Declined

Left message

Unable to reach

Not referred

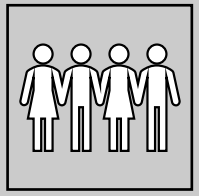
Growing Together Prenatal Program

Prenatal Program Goal Outcome - TDAP

Goal 1: 80% of engaged members would have a Tdap vaccine within 120 days (four months) prior to delivery

Goal ***not*** met (rate = 79%)

Engaged members were more likely to get a Tdap vaccine.



Note: The white engaged members had a statistically significantly lower rate of outcome completion compared to Hispanic members

Prenatal Program Engagement Results - TDAP

Campaign Outcome	Members (% of Total)	Members who had TDAP vaccination in the 4 months before delivery (% of outcome)
Engaged	922 (40%)	725 (79%)
Declined	297 (13%)	199 (67%)*
Left message	690 (30%)	482 (70%)*
Unable to reach	398 (17%)	277 (70%)*
Total	**2307**	**1683**
Not referred	6970	4813 (69%)*

** Indicates statistically significant result*

Growing Together Postpartum Program

Postpartum Program Goal Outcome – Postpartum Visits

Goal 1: 75% of moms engaged in the program will attend a postpartum visit within 60 days of delivery

- Goal **met** (Rate = 79%)
- Engaged members were more likely to attend a postpartum visit.

Note: The white population had a statistically significantly lower rate of members with postpartum visits when compared to other select races / ethnicities.

Postpartum Program Engagement Results – Postpartum Visits

Campaign Outcome	Members (% of Total)	Members who attended a post-partum visit within 60 days of delivery (% of outcome)
Engaged	2153 (33%)	1696 (79%)
Declined	999 (15%)	731 (73%)*
Left message	2167 (34%)	1459 (67%)*
Unable to reach	1139 (18%)	774 (68%)*
Total	**6458**	**4660**
Not referred	3298	1890 (57%)*

** Indicates statistically significant result*

Postpartum Program Goal Outcome – Well Child Visits

Goal 2: 70% of newborns linked to members engaged in the program will attend a well-child visit within 60 days of birth.

- Goal **met** (Rate = 76%)
- newborns linked to members engaged in the program were more likely to attend a well child visit.

Note: There was no statistically significant difference in the rate of well child visits between the white engaged members and all other races / ethnicities.

Postpartum Program Engagement Results – Well Child Visits

Campaign Outcome	Members (% of Total)	Newborns who attended a well child visit within 60 days of birth (% of linked newborns)
Engaged	2153 (33%)	1517 (76%)
Declined	999 (15%)	698 (77%)
Left message	2167 (34%)	1406 (73%)*
Unable to reach	1139 (18%)	768 (75%)
Total	**6458**	**4389**
Not referred	3298	1905 (68%) *

** Indicates statistically significant result*

Growing Together
Healthy Babies Program

Healthy Babies Goal Outcome – Vaccines

Goal 1: 80% of engaged members will complete 50% or more of their vaccinations during the program period (infants <24 months)

- Goal **met** (Rate = 83%)
- Engaged members were more likely to get a vaccine.

Note: Engaged members significantly outperformed all other groups. Large gaps observed vs declined (67%) and unable to reach (62%). The white engaged population had a statistically significant lower rate of completing vaccination compared to the Asian, Hispanic, and other / unknown populations.

Healthy Babies Goal Outcome – Well Child Visit (Some)

Goal 2: 65% of engaged members would be compliant with well-child visits (infants <24 months)

- Goal **met** (Rate = 89%)
- Strong performance across all groups, but engaged members still highest.

Note: The white engaged population had a statistically significant lower rate of completing well-child visits when compared to Hispanic and unknown / other populations.

Healthy Babies Goal Outcome – Well Child Visit (All)

Goal 3: 25% of engaged members would attend all the well-child visits (infants <24 months)

- Goal **exceeded** (Rate = 60%)
- Highest completion among engaged members.

Note: 26-point gap vs unreachable members (60% vs 34%). The white engaged population had a statistically significant lower rate of completing well-child visit rates compared to the Hispanic population.

Healthy Babies – Engagement Impact & Reach Opportunities

Engagement impact

- Engaged members had the **highest performance across all outcomes**
- Statistically significant differences vs all other groups
- Even **voicemail-only contact outperformed no contact**

Reach and scale opportunity

- Only **~32% engaged**, while 43% received only a message and 15% were unreachable

Healthy Babies Program - Equity Findings

Equity Findings

- **White engaged population had lower completion rates** across vaccinations and well-child visits (both all and some)
- Higher performance observed among **Hispanic, Asian, and other groups**
- These disparities were statistically significant across multiple outcome measures

Healthy Babies Engagement Results: Vaccines

Campaign Outcome	Members (% of Total)	July 2024 - June 2025 Members who completed vaccines (% of outcome)
Engaged	3106 (32%)	2589 (83%)
Declined	869 (9%)	581 (67%)
Left message	4163 (43%)	2917 (70%)
Unable to reach	1457 (15%)	910 (62%)
Total	9595	**6997**
Not referred	3612	2316 (64%)

** Indicates statistically significant result*

Healthy Babies Goal Outcome – Well child Visit (All)

- **Goal 2:** 25% of engaged members would attend **all** the well-child visits
  - Goal **met** (Rate = 60%).
  - Engaged members were more likely to attend well-chld visits.

Note: The white engaged population had a statistically significant lower rate of completing well-child visit rates compared to the Hispanics population.

Healthy Babies Engagement Results: Well child Visit (All)

Campaign Outcome	Members (% of Total)	Members who completed all recommended visits (% of outcome)
Engaged	3106 (32%)	1849 (60%)
Declined	869 (9%)	386 (44%)*
Left message	4163 (43%)	1820 (44%)*
Unable to reach	1457 (15%)	501 (34%)*
Total	**9595**	**4556**
Not referred	3612	1438 (40%)*

** Indicates statistically significant result*

Healthy Babies Goal Outcome – Well Child Visit (Some)

- **Goal 3:** 65% of members engaged in the program would be compliant with **some** of the recommended well-child visits was met
    - Goal **met** (Rate = 89%)
    - Engaged members were more likely of completing well-child visits

Note: The white engaged population had a statistically significant lower rate of completing well child visits when compared to Hispanics and unknown / other members.

Healthy Babies Engagement Results: Well Child Visit (Some)

Campaign Outcome	Members (% of Total)	Members who completed some of the recommended visits (% of outcome)
Engaged	3106 (32%)	2771 (89%)
Declined	869 (9%)	646 (74%)*
Left message	4163 (43%)	3084 (74%)*
Unable to reach	1457 (15%)	930 (64%)*
Total	**9595**	**7431**
Not referred	3612	2393 (66%)*

** Indicates statistically significant result*

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Growing Together Healthy Kids Program

Healthy Kids Goal Outcome – 120 Days After Call

- **Goal 1:** 50% of engaged members will have a well-child visit within 120 days of the phone call indicated "agreed to participation"
  - Goal ***not*** met (Rate = 41%).
  - Engaged members were more likely to attend a well-child visit 120 days after call.

Note: There was no statistically significant difference in the rate of well child visits between the white engaged members and other races / ethnicities.

Healthy Kids Engagement Results – 120 Days After Call

Campaign Outcome	Members (% of Total)	Members who completed well-child visits 120 days after the call (% of outcome)
Engaged	641 (25%)	262 (41%)
Declined	219 (9%)	53 (24%)*
Left message	1147 (45%)	317 (28%)*
Unable to reach	537 (21%)	125 (23%)*
Total	2544	757
Not referred	27950	N/A

Healthy Kids Goal Outcome – July 2024-June 2025

- **Goal 1:** 70% of engaged members will have a well-child visit between July 2024 – June 2025.
  - Goal was **met** (Rate = 80%)
  - Engaged members were more likely to attend a well-child visit between July 2024 – June 2025.

Note: The engaged white population had a statistically significantly lower rate of outcome completion compared to Hispanics.

Healthy Kids Engagement Results – July 2024-June 2025

Campaign Outcome	Members (% of Total)	Members who completed well-child visits July 2024 – June 2025 (% of outcome)
Engaged	641 (25%)	511 (80%)
Declined	219 (9%)	128 (58%)*
Left message	1147 (45%)	691 (60%)*
Unable to reach	537 (21%)	289 (54%)*
Total	2544	1619
Not referred	27950	17627 (63%)*

Transitional Care Services

(Previously Transitions of Care)

Transitional Care Services (TCS)

Adult members (age > 20) **and**:

- Discharging home from an inpatient admission with any length of stay, and
- Meet the criteria for high-risk transitioning members

Pediatric members (under age 21) **and**:

- Discharging home from an inpatient stay with an admission date > 60 days from their date of birth and having any length of stay.

Transitional Care Services: Member Experience Results

- **Goal 1:** 75% of members surveyed agree with each statement of the **Adult** TOC or TCS satisfaction survey
  - Goal was **met**.
    - Average score ranged from 2.77 to 2.99, exceeding the goal average of 2.5
- **Goal 2:** 75% of members surveyed agree with each statement of the **Pediatric** TCS satisfaction survey
  - Goal was **met.**
    - Average score ranged from 2.80 to 3.00, exceeding the goal average of 2.5

Transitional Care Services: Member Experience Results
Adults

Survey Question	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my health issues.	2.98	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager).	2.99	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.94	Yes
After working with the case management team, I feel my ability to manage my health care needs is better.	2.92	Yes
My health has improved since working with my case management team.	2.77	Yes
I was able to safely transition between providers with the help of my care team.	2.87	Yes
The relationship that I have with the PCP and/or specialist offices has improved since working with my case management team.	2.82	Yes
I was provided the available equipment, medication and/or services that were needed.	2.94	Yes

Transitional Care Services: Member Experience Results
Pediatrics

Survey Question	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my child's health issues.	3.00	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager).	3.00	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.90	Yes
After working with the case management team, I feel my ability to manage my child's health care needs is better.	2.93	Yes
My child's health has improved since working with our case management team.	2.83	Yes
I was able to safely transition my child between providers with the help of my care team.	2.83	Yes
The relationship that my child and I have with the PCP and/or specialist offices has improved since working with our case management team.	2.90	Yes
My child and I were provided with the available equipment, medication and/or services that were needed.	2.80	Yes

Complex Case Management

Complex Case Management Program Criteria

- Provides support for members who have:
  - Multiple chronic conditions
  - Social determinants of health barriers and/or
  - Difficulty navigating the healthcare system
  - CCS condition

Complex Case Management: Member Experience Results

- **Goal 1:** 75% of members surveyed agree with each statement of the **Adult** CCM satisfaction survey
  - Goal was **met.**
    - Average score ranged from 2.60 to 3.00, which is above the goal average of 2.5
- **Goal 2:** 75% of members surveyed agree with each statement of the **Pediatric** CCM satisfaction survey
  - Goal was **met.**
    - Average score ranged from 2.60 to 3.00, which is above the goal average of 2.5

CCM Member Experience Results
Adults

Survey Question	Average Response	Goal Met
The CM program helped me manage my health issues.	3.00	Yes
I am happy with the number of calls I received from our case management team.	3.00	Yes
I am confident in the abilities of the team members who contacted me.	3.00	Yes
My team referred me to medical and community resources that were valuable and helped me.	3.00	Yes
I feel my ability to manage my health care needs is better after working with CM.	2.60	Yes
I have a better understanding of my health conditions and/or diagnosis after working with CM.	2.80	Yes
I have a better understanding of my medications after working with CM.	2.60	Yes
My health has improved since working with our case management team.	2.60	Yes
The relationship that I have with the PCP and/or specialist offices has improved since working with our case management team.	3.00	Yes
I feel like my providers and I work together better to help me since working with our case management team.	2.80	Yes
I have had more success reaching our health goals since working with the case management team.	2.80	Yes

CCM Member Experience Results
Pediatrics

Survey Question	Average Response	Goal Met
The CM program helped me manage my child's health issues.	3	Yes
I am happy with the number of calls I received from our case management team.	3	Yes
I am confident in the abilities of the team members who contacted me.	3	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.80	Yes
I feel my ability to manage my child's health care needs is better after working with CM.	2.60	Yes
I have a better understanding of my child's health conditions and/or diagnosis after working with CM.	2.80	Yes
I have a better understanding of my child's medications after working with CM.	2.60	Yes
My child's health has improved since working with our case management team.	2.60	Yes
The relationship that my child and I have with the PCP and/or specialist offices has improved since working with our case management team.	2.60	No
I feel like my providers and I work together better to help my child since working with our case management team.	2.80	Yes
My child and I have had more success reaching our health goals since working with our case management team.	2.60	Yes

Summary of Findings

Program Enhancements	Clinical & Utilization Goals Met	Member Experience Outcomes	Equity & Stratified Outcomes	Summary & Opportunities
• Refined offerings based on lessons learned from prior years lessons learned • **Multi-modal outreach** (mail, calls, incentives) proved most effective for member engagement	• Achieved **pediatric vaccination** goals *(Healthy Babies)* • Met goals for **newborn well-child visits** (*linked to prenatal/postpartum engagement)* • **Postpartum visit goals** met (*postpartum program participants)* • **Well-child visit goals met** for *Healthy Babies* and **partially met for *Healthy Kids*** participants	• **All experience goals met** in *Transitional Care Services and Complex Case Management* • Ongoing challenge: limited provider availability for timely well-child visit scheduling	• **White members had lower rates of well-child and postpartum visits** vs. other groups • No significant difference in linked newborn visits under the Prenatal Program in white population vs. other groups • Opportunity to enhance analytics **by stratifying data by geographic location (county and ZIP code)**	• **PHM participants showed improved outcomes for select goals** vs. non-participants • Opportunities exist to strengthen PHM design and address systemic care barriers • Partnership to explore CalAIM resources to enhance member support and outcomes

Population Health Management 2025 Program Impact Analysis

June 2026

Production Date: June 9, 2026

Table of Contents

I. Objective

The purpose of this report is to evaluate the Population Health Management (PHM) interventions performed during 2025 through clinical, utilization, and member experience measures in accordance with the PHM efforts of the year.

II. Methodology

Partnership's Health Analytics team provided performance data related to clinical and utilization measures for individuals engaged in Population Health outreach campaigns. In addition, Partnership staff invited members to complete post-intervention satisfaction surveys for selected campaigns. Partnership uses the following data sources to evaluate the PHM programs:

Data Type	Data Source
Member Demographics from Partnership Data warehouse	Member Demographics from Partnership Data warehouse
Encounters from Partnership Claims System	Encounters from Partnership Claims System
Immunization Data	California Immunization Registry (CAIR)
DHCS Medical and Pharmacy Claims	DHCS Claims Data
Member Experience Survey Results	Partnership Case Management System (Essette)
Member Delivery Report	Partnership Claims System Hospital ADT Data (PointClickCare) Authorization data
Case Management	Partnership Case Management System (Essette)

Population Health staff completed the quantitative and qualitative analyses and made the decisions included in the report, with cross-departmental input and approval solicited as needed. Below is a list of staff involved in program execution and qualitative analysis, by title and department name:

Position Title	Department
Director	Population Health
Manager	Population Health
Community Health Needs Liaison	Population Health

A. Statistical Significance

The statistical significance of association in contact outcome and the various measures were calculated using either the chi-square test for association when all expected cell frequencies were > 5 or the Fisher's exact test when any one of the expected cell frequencies were < 5.

The association is found to be significant when the p-value is < 0.05. Race disparities are identified by comparing the white population with other ethnic groups.

III. Definitions and Explanations

A. Clinical Measures

Vaccinations are the primary intervention for maintaining health and protecting individuals from illness and even death. They are administered at various stages of life, including during pregnancy (to safeguard newborns), in the first six years of life, and again during adolescence. The PHM Program clinical measures evaluated this year focused on campaigns that promoted vaccinations, specifically:

- Growing Together Prenatal Program
- Healthy Babies Growing Together

B. Utilization Measures

Partnership continued to implement targeted outreach campaigns aimed at improving well-care visits for pregnant members and children through adolescence. Early well-child visits enable providers to educate parents about their child's developmental milestones, and to teach parents how to build healthy habits with their children. Early visits also give providers the opportunity for early intervention when a child has developmental delays. Well care visits also help foster a strong relationship between parents and providers, which is essential for effective care in the event of illness or injury. The following programs reinforce well-care visits in the PHM Work Plan:

- Growing Together Prenatal Program
- Growing Together Postpartum Program
- Healthy Babies Growing Together
- Healthy Kids Growing Together

C. Member Experience/Satisfaction Measures

At the close of each select campaign or service, a Partnership Coordinator or staff member contacts the members by phone to complete a Likert-scale member experience survey. Scores assigned are Agree (3 points) Neutral (2 points) Disagree (1) or No Response. In addition to weighed responses, members are given the opportunity to provide comments. Partnership compiles and reviews these responses at least annually to assess whether select, implemented interventions are effectively addressing member needs. For each satisfaction measure, the goal is for a minimum of 75% of members surveyed to indicate

agreement with the statement, corresponding to an average score of 2.5 or greater for each response.

The programs that emphasize and track member satisfaction in the PHM Work Plan include:

- Transitional Care Services (formerly Transitions of Care Services - TOC) for Adult and Pediatric Members
- Complex Case Management (CCM) for Adult and Pediatric Members

D. Reporting Categories

Partnership staff reached out to all members who met qualifying criteria, defined below for each individual measure. Members who were successfully contacted were given the opportunity to opt in or out of the campaign. Outcomes reflect the members' level of engagement with the campaign as follows:

- Engaged – members who qualified for the program, reached by phone, and opted in to program participation
- Declined – members who qualified for the program, reached by phone, and opted against program participation
- Left Message – members who qualified for the program, did not answer the phone, and were left a voice message encouraging a behavior
- Unable to Reach – members who qualified for the program but were not able to be reached via phone
- Not Referred – members who qualified for the program retrospectively, but were not identified prospectively for campaign inclusion
- Completion - indicates that staff has completed all of the attempted outreach, and the member is not being worked on by any staff member

IV. Growing Together Prenatal Program

Partnership offers the Growing Together Prenatal outreach campaign, enrolling members identified as pregnant to receive targeted program outreach and support. PHM staff contacts these members and offers engagement in a campaign that supports prenatal care, reinforces the importance of Tdap vaccinations during pregnancy, and reminds them of the importance of post-partum care, as well as well-child visits and vaccinations in the first months following delivery. There are incentives provided for members who comply with program recommendations both before and after delivery.

A. Clinical Measure

1. Tdap Vaccination before delivery

The goal of this intervention was to ensure that 80% of members who engaged in the program between September 1, 2024, and December 31, 2025, receive the Tdap vaccinations within 120 days (four months) prior to delivery, at a higher rate when compared to those who did not engage or who declined to participate in the program.

Methodology

Measure Description:	Members who engaged in the Growing Together Prenatal Program would have a greater rate of Tdap vaccination before delivery than those not engaged or declined engagement.
Denominator:	Partnership members who had at least one prenatal care visit and delivered a baby between January-December 2025.
Numerator:	Of denominator, those who had a Tdap September 2024-December 2025.
Measurement Period:	September 2024 through December 2025 for numerator. January 2025 through December 2025 for denominator.
Exclusion Criteria:	Individuals who were not Partnership members when they delivered a baby.

Results

Campaign Outcome	*Members (% of Total)*	*Members who had Tdap vaccination in the 4 months before delivery (% of outcome)*
Engaged	922 (40%)	725 (79%)
Declined	297 (13%)	199 (67%)*
Left Message	690 (30%)	482 (70%)*
Unable to Reach	398 (17%)	277 (70%)*
Total	**2307**	**1683**
Not Referred	6970	4813 (69%)*

* Indicates statistically significant result

Analysis

Measure	*Test*	*Statistic*	*P-value*	*Significance*
Engaged Vs Declined	Chi-Square	16.5638	<.0001	Yes*
Engaged Vs Left Message	Chi-Square	16.1662	<.0001	Yes*
Engaged Vs Unable to Reach	Chi-Square	12.4105	0.0004	Yes*
Engaged Vs Not Referred	Chi-Square	35.7068	<.0001	Yes*

* Indicates statistically significant result

The goal for this intervention was for 80% of members engaged in the program in 2025 to have a higher percentage of Tdap vaccinations within 120 days (four months) prior to delivery. While close, the goal was not met (Rate = 79%). However, engaged members had a

statistically significantly higher rate of outcome completion (Rate = 79%) compared to members who:

- Declined (Rate = 67%, Chi-Square = 16.56, p <.0001)
- Were left a message (Rate = 70%, Chi-Square = 16.17, p = 0.0001)
- Were unable to be reached (Rate = 70%, Chi-Square = 12.41, p = 0.0004)
- Were not referred (Rate = 69%, Chi-Square = 35.71, p <.0001)

While the data shows statistical significance in the engaged category compared to other campaign categories, we did not meet our goal. As such, this data seems to suggest that this program is only somewhat making a difference in vaccination rates among our eligible member population.

Analysis by Race and Ethnicity

Ethnicity Group	*Members in Campaign*	*Engaged*	*Members with Tdap*				
			N(%)	*Test*	*Statistic*	*P-value*	*Sig*
WHITE	736	249 (34%)	175 (70%)	Reference			
AMERICAN INDIAN	49	13 (27%)	9 (69%)	Fishers Exact	0.2395	1.000	No
ASIAN	128	47 (37%)	34 (72%)	Chi-Square	0.0808	0.7762	No
BLACK	61	27 (44%)	21 (78%)	Chi-Square	0.6651	0.4148	No
HISPANIC	1096	486 (44%)	420 (86%)	Chi-Square	27.8107	<.0001	Yes*
UNKNOWN/ OTHER	235	100 (43%)	66 (66%)	Chi-Square	0.6119	0.4341	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	2	0 (0%)	0 (%)	N/A	N/A	N/A	N/A

* Indicates statistically significant result

There was no statistically significant difference in the rate of outcome completion between the White Engaged members and American Indian engaged members, Asian engaged members, Black engaged members, and Unknown/Other engaged members. However, the White Engaged members had a statistically significantly lower rate of outcome completion (Rate = 70%) compared to Hispanic members (Rate = 86%, Chi-Square = 27.81, p <.0001). The full results for other groups are displayed in the table above. This data shows our current campaign seems to be making a measurable difference in the lives of our Hispanic populations. Further analysis may be warranted due to the small sample size for some groups.

B. Utilization Measures

1. Post-Partum Visits

The goal for this intervention is that 80% of members engaged in the program will attend a post-partum visit within 60 days of delivery.

Methodology

Measure Description:	Members who engaged in the Growing Together Prenatal program will attend a post-partum visit in the 60 days following delivery.
Denominator:	Partnership members who had at least one prenatal care visit and delivered a baby January 2025-November 2025.
Numerator:	Of denominator, those who attended a post-partum visit within 60 days of delivery between January 2025-January 2026.
Measurement Period:	Denominator is January 2025 through November 2025. (Adjusted measurement period to account for claims lag). Numerator is January 2025-January 2026.
Exclusion Criteria:	Individuals who were not Partnership members when they delivered a baby.

Results

Campaign Outcome	*Members (% of Total)*	*Members who attended a post-partum visit within 60 days of delivery (% of outcome)*
Engaged	808 (41%)	618 (76%)
Declined	262 (13%)	194 (74%)
Left Message	590 (30%)	403 (68%)*
Unable to Reach	334 (17%)	234 (70%)*
Total	**1994**	**1449**
Not Referred	6478	4818 (74%)

* Indicates statistically significant result

Analysis

Measure	*Test*	*Statistic*	*P-value*	*Significance*
Engaged Vs Declined	Chi-Square	0.6434	0.4225	No
Engaged Vs Left Message	Chi-Square	11.5856	0.0007	Yes*
Engaged Vs Unable to Reach	Chi-Square	5.1495	0.0233	Yes*
Engaged Vs Not Referred	Chi-Square	1.6889	0.1938	No

* Indicates statistically significant result

The Growing Together Prenatal Program did not meet the goal of 80% attendance at post-partum visits (Rate = 76%). Furthermore, there was no statistically significant difference in the rate of outcome completion between the Engaged members and Declined members and between Engaged members and Not Referred members. However, engaged members had a statistically significantly higher rate of outcome completion (Rate = 76%) compared to Left

Message members (Rate = 68%, Chi-Square = 11.59, p = 0.0007). Engaged members also had a statistically significantly higher rate of outcome completion (Rate = 76%) compared to Unable to Reach members (Rate = 70%, Chi-Square = 5.15, p = 0.0233). This data seems to suggest that this program is making a slight difference in postpartum visit rates among our eligible population compared to select campaign categories.

Analysis by Race and Ethnicity

Ethnicity Group	*Members in Campaign*	*Engaged*	*Members with postpartum visits*				
			N (%)	*Test*	*Statistic*	*P-value*	*Sig*
WHITE	736	249 (34%)	154 (71%)	Reference			
AMERICAN INDIAN	49	13 (27%)	9 (82%)	Fishers Exact	0.2151	0.5184	No
ASIAN	128	47 (37%)	32 (82%)	Chi-Square	2.1537	0.1422	No
BLACK	61	27 (44%)	13 (65%)	Chi-Square	0.2786	0.5976	No
HISPANIC	1096	486 (44%)	344 (80%)	Chi-Square	7.7448	0.0054	Yes*
UNKNOWN/ OTHER	235	100 (43%)	66 (72%)	Chi-Square	0.0378	0.8459	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	2	0 (0%)	0 (0%)	N/A	N/A	N/A	N/A

* Indicates statistically significant result

There was no statistically significant difference in the rate of outcome completion between the White Engaged members and America Indian engaged members, Asian engaged members, Black engaged members, and Unknow/Other engaged members. However, the White engaged members had a statistically significantly lower rate of outcome completion (Rate = 71%) compared to Hispanic members (Rate = 80%, Chi-Square = 7.74, p = 0.0054). This data shows our current campaign may not be making any measurable difference in the lives of some of our non-white population. Further analysis may be warranted due to the small sample size for some groups.

2. Linked Newborns Well-Child Visits

A secondary goal of this intervention is that 70% of newborns linked to members engaged in the program will attend a well-child visit within 60 days of birth.

Methodology

Measure Description:	Newborns linked to members who engaged in the Growing Together Prenatal program will attend a well-baby visit in the 60 days following birth
Denominator:	Members who had at least one prenatal care visit and delivered baby January-November 2025 and baby is linked to birth mom.
Numerator:	Of denominator, the percentage of linked babies who attended a well-child visit within 60 days of birth between January 2025-January 2026
Measurement Period:	The denominator is January 2025 through November 2025 for denominator. (Adjusted measurement period to account for claims lag). The numerator is January 2025-January 2026.
Exclusion Criteria:	Individuals who were not Partnership members when they delivered a baby

Results

Campaign Outcome	*Members (% of Total)*	*Members who were linked to a Newborn (% of Outcome)*	*Newborns who attended a well-child visit within 60 days of birth (% of linked Newborns)*
Engaged	808 (41%)	738 (91%)	522 (71%)
Declined	262 (13%)	237 (90%)	181 (76%)
Left Message	590 (30%)	530 (90%)	384 (72%)
Unable to Reach	334 (17%)	304 (91%)	229 (75%)
Total	**1994**	**1809**	**1316**
Not Referred	6478	5861	4400 (75%)*

* Indicates statistically significant result

Analysis of Newborns who attended a well-child visit within 60 days of birth

Measure	*Test*	*Statistic*	*P-value*	*Significance*
Engaged Vs Declined	Chi-Square	2.8365	0.0921	No
Engaged Vs Left Message	Chi-Square	0.4480	0.5033	No
Engaged Vs Unable to Reach	Chi-Square	2.2608	0.1327	No
Engaged Vs Not Referred	Chi-Square	6.4757	0.0109	Yes*

* Indicates statistically significant result

The program goal that 70% of newborns linked to members engaged in the program will attend a well-child visit within 60 days of birth was met (Rate = 71%). However, there was no statistically significant difference in the rate of outcome completion between the Engaged members and Declined members, Left Message members, and Unable to Reach members. Comparatively, engaged members had a statistically significantly lower rate of outcome completion (Rate = 71%) compared to Not Referred members (Rate = 75%, Chi-Square = 6.48, p = 0.0109). As such, while the goal was met, this data seems to suggest that this program is not making much of a difference among our eligible member population.

Analysis by Race and Ethnicity

Ethnicity Group	*Members in Campaign*	*Engaged*	*Newborns with well-child visits*				
			N (%)	*Test*	*Statistic*	*P-value*	*Sig*
WHITE	736	249 (34%)	137 (73%)	Reference			
AMERICAN INDIAN	49	13 (27%)	8 (73%)	Fishers Exact	0.2695	1.0000	No
ASIAN	128	47 (37%)	25 (66%)	Chi-Square	0.7812	0.3768	No
BLACK	61	27 (44%)	14 (70%)	Chi-Square	0.0750	0.7842	No
HISPANIC	1096	486 (44%)	283 (70%)	Chi-Square	0.3823	0.5364	No
UNKNOWN/ OTHER	235	100 (43%)	55 (70%)	Chi-Square	0.2912	0.5894	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	2	0 (0%)	0 (0%)	N/A	N/A	N/A	N/A

There was no statistically significant difference in the rate of outcome completion between the White Engaged members and American Indian engaged members, Asian engaged members, Black engaged members, Hispanic engaged members, and Unknown/Other engaged members. This data seems to show our current campaign is not making any measurable difference in the lives of our non-white population. Further analysis may be warranted due to the small sample size for some groups.

Year-Over-Year Analysis of the Prenatal Program

In 2025, the PHM team continued to identify an opportunity to increase the numbers of members offered enrollment in the prenatal program along with the percentage of members reached. Year-over-year analysis shows the following:

Campaign Outcome	*2025 Members (% of Total)*	*2025 Post-Partum Visits (% of outcome)*	*2024 Members (% of Total)*	*2024 Post-Partum Visits (% of outcome)*
Engaged	808 (41%)	618 (76%)	385 (32%)	290 (75%)
Declined	262 (13%)	194 (74%)	193 (16%)	140 (73%)
Left Message	590 (30%)	403 (68%)	300 (25%)	213 (71%)
Unable to Reach	334 (17%)	234 (70%)	126 (10%)	88 (70%)
Total	**1994**	**1449**	**1004**	**731**
Not Referred	6478	4818 (74%)	7408	5380 (73%)

In 2025, Partnership continued to explore additional strategies to increase engagement among pregnant members in the Growing Together Prenatal Program. One such strategy was hosting several events for the prenatal population in hopes of engaging more members into the Growing Together Prenatal Program. Between 2024 and 2025, there was an increase of members identified, from 1,004 in 2024 to 1,994 in 2025. We anticipate increased identification of pregnant members in 2026. The overall number of members engaged who agreed to participate increased from 2024 (385) to 2025 (808), meaning we were able to have higher program participation.

C. Opportunities

Partnership recognizes the importance of promoting prenatal care to support maternal health and establish a strong foundation for healthy behaviors for both the parent and baby. As the foundation for other post-partum and well-baby interventions, this program will remain with Partnership continuing to monitor and evaluate program engagement outcomes. However, due to lack of meeting several program goals, there are clear opportunities to improve the impact of this program.

1. Improving Tdap vaccinations and postpartum visits

While the goal that a higher percentage of babies linked to moms engaged in the program will attend a well-child visit within 60 days of birth was met, Partnership did not meet its other goals for this program. Partnership did not meet the goal that a higher percentage of members engaged in the program will have a Tdap vaccination in the 120 days (4 months) prior to delivery. Additionally, the goal of increasing the percentage of members attending a postpartum visit within 60 days of delivery was not met. Furthermore, the engaged white population had a statistically significant lower rate or no statistically significant difference in completing a Tdap vaccination before delivery compared to certain race/ethnic groups among Partnership's membership. The engaged white population also had a statistically significant lower rate or no statistically significant difference of attending a post-partum visit within 60

days of delivery when compared to certain race/ethnic groups among Partnership's membership. Partnership's Population Health staff conduct member satisfaction surveys over the phone at the end of the program to gather and analyze qualitative feedback. While not directly asked for in the survey, results of this qualitative feedback from Partnership members often reveal significant barriers to achieving these goals. Themes primarily include challenges with childcare, competing priorities, long appointment wait times which can be due to lack of provider availability, and not feeling the need to be seen for a postpartum checkup. Disinterest (or possible hesitancy) in receiving the vaccine also plays a role in not meeting the vaccination goals.

The prenatal program engagement rate for Tdap vaccines has increased from 340 (73%) in 2024 to 725 (79%) in 2025. The prenatal program engagement rates for postpartum visits within 60 days of delivery has increased from 290 (75%) in 2024 to 618 (76%) in 2025. Current efforts to continue improving program engagement rates for both program components include assisting members with scheduling appointments via warm handoffs by directly contacting providers on their behalf as needed. Members are also offered the option to switch to a new provider if challenges to access continue. Members are offered the option to file a grievance with Partnership's grievance department as additional support. The upward trend in results may be due in part to effective program efforts.

Because not all program goals were met, there is also an opportunity to improve the percentage of members receiving Tdap vaccines and attending a postpartum visit within 60 days of delivery by raising awareness of our programs among providers, members, and internal staff. Efforts to increase program awareness include circulating program flyers to community partners and providers. Partnership will continue to promote this program through a multipronged approach with members, providers, and community-based organizations. Furthermore, Partnership also looks forward to implementing texting campaigns to promote this program.

At a systems level, Partnership has and will continue to make efforts to address some of these barriers through ongoing efforts to expand our provider network in hopes of improving engagement rates. Ongoing provider network expansion efforts include offering the Provider Retention Initiative Pilot and Provider Recruitment program which support contracted providers in using incentives to recruit and retain high-quality health professionals in the region. These efforts aim to strengthen access to care for Partnership members.

2. Identifying and referring high-risk pregnant members

In 2025, Partnership continued to act on an identified opportunity to assign a high-risk level to pregnant members who meet certain criteria as part of new program efforts referred to as Transitional Care Services (previously Transitions of Care). Since April 2025, high-risk

pregnant members identified to have higher levels of clinical needs, other support needs or barriers to care are referred to Care Coordination and educated on available resources such as Community Health Worker or doula benefits to strengthen engagement during their pregnancy and post-partum period. This program will continue to evolve in 2026. By conducting these activities, the hope is for these interventions to serve as an opportunity to improve the percentage of members who complete a postpartum visit within 60 days of delivery. Future analysis is warranted to measure the effectiveness of these interventions; these methods could include, but are not limited to, evaluating the number of members enrolled into TCS and cross checking with the number of TCS members who successfully accessed CHW or doula services.

V. Growing Together Post-Partum Program

In addition to Partnership's Growing Together Prenatal outreach campaign, Population Health offers a campaign for members after delivery to encourage them to attend post-partum care visits as well as encouraging early entrance to care by bringing their child to well-baby visits.

A. Utilization Measures

1. Post-Partum Visits

The goal for this measure was that 75% of members engaged in the program will attend a post-partum visit within 60 days of delivery.

Methodology

Measure Description:	Members who are engaged in the Growing Together Post-Partum Program will attend a post-partum visit in the 60 days following delivery.
Denominator:	Partnership members who delivered a baby January-November 2025.
Numerator:	Of denominator, the percentage of members who attended a post-partum visit within 60 days of delivery between January 2025-January 2026.
Measurement Period:	The denominator is January 2025 through November 2025. (Adjusted measurement period to account for claims lag). The numerator is January 2025-January 2026.
Exclusion Criteria:	Individuals who were not Partnership members when they delivered a baby.

Results

Campaign Outcome	*Members (% of Total)*	*Members who attended a post-partum visit within 60 days of delivery (% of outcome)*
Engaged	2153 (33%)	1696 (79%)
Declined	999 (15%)	731 (73%)*
Left Message	2167 (34%)	1459 (67%)*
Unable to Reach	1139 (18%)	774 (68%)*
Total	**6458**	**4660**
Engaged in Prenatal	335	261 (78%)
Not Referred	3298	1890 (57%)*

* Indicates statistically significant result

Analysis of Members who attended a post-partum visit within 60 days of delivery

Measure	*Test*	*Statistic*	*P-value*	*Significance*
Engaged Vs Declined	Chi-Square	12.0854	0.0005	Yes*
Engaged Vs Left Message	Chi-Square	71.8367	<.0001	Yes*
Engaged Vs Unable to Reach	Chi-Square	46.5447	<.0001	Yes*
Engaged only in Postpartum Vs Not Engaged in Prenatal	Chi-Square	0.1769	0.6741	No
Engaged Vs Not Referred	Chi-Square	266.6846	<.0001	Yes*

* Indicates statistically significant result

This intervention met the goal that 75% of members engaged in the program will attend a post-partum visit within 60 days of delivery (Rate = 79%). Engaged members had a statistically significantly higher rate of outcome completion (Rate = 79%) compared to:

- Declined members (Rate = 73%, Chi-Square = 12.09, p = 0.0005))
- Left Message members (Rate = 67%, Chi-Square = 71.84, p <.0001)
- Unable to Reach members (Rate = 68%, Chi-Square = 46.54, p <.0001)
- Not Referred members (Rate = 57%, Chi-Square = 266.68, p <.0001)

Comparatively, there was no statistically significant difference in the rate of outcome completion between members who were engaged only in Postpartum (Rate = 79%) and members who were engaged in both postpartum and prenatal program (Rate = 78%). This data seems to demonstrate the program is improving rates of postpartum visits among the eligible population.

Analysis by Race and Ethnicity

Ethnicity Group	Members in Campaign	Engaged	Members with postpartum visits				
			N (%)	Test	Statistic	P-value	Sig
WHITE	2048	513 (25%)	357 (70%)	Reference			
AMERICAN INDIAN	133	33 (25%)	24 (73%)	Chi-Square	0.1447	0.7037	No
ASIAN	297	91 (31%)	74 (81%)	Chi-Square	5.2014	0.0226	Yes*
BLACK	175	48 (27%)	31 (65%)	Chi-Square	0.5160	0.4726	No
HISPANIC	3109	1224 (39%)	1028 (84%)	Chi-Square	46.3668	<.0001	Yes*
UNKNOWN/OTHER	684	241 (35%)	180 (75%)	Chi-Square	2.0792	0.1493	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	12	3 (25%)	2 (67%)	Fishers Exact	0.4432	1.0000	No

* Indicates statistically significant result

The White Engaged members had a statistically significantly lower rate of outcome completion (Rate = 70%) compared to Asian members (Rate = 81%, Chi-Square = 5.20, p = 0.0226). White Engaged members also had a statistically significantly lower rate of outcome completion (Rate = 70%) compared to Hispanic members (Rate = 84%, Chi-Square = 46.37, p <.0001). However, there was no statistically significant difference in the rate of outcome completion between the White Engaged members and American Indian engaged members, Black engaged members, Unknown/Other engaged members, and Native Hawaiian or Other Pacific Islander engaged members. This data seems to demonstrate that our current campaign is making a measurable difference in the lives of certain non-white population groups in the table above. Further analysis may be warranted due to the small sample size for some groups.

2. Linked Newborn Well-Child Visits

A secondary goal for this intervention is that 70% of newborns linked to members engaged in the program will attend a well-child visit within 60 days of birth.

Methodology

Measure Description:	Babies born to members who engaged in the Growing Together Post-Partum program will attend a well-child visit in the 60 days following birth
Denominator:	Partnership Members who delivered a baby January-November 2025 and baby is linked to birth mom
Numerator:	Of denominator, the percentage of linked babies who attended a well-child visit within 60 days of birth between January 2025-January 2026.
Measurement Period:	The denominator is January 2025 through November 2025 (Adjusted measurement period to account for claims lag and other logistics). The numerator is January 2025-January 2026.
Exclusion Criteria:	Individuals who were not Partnership members when they delivered a baby.

Results

Campaign Outcome	*Members (% of Total)*	*Members who were linked to a Newborn (% of Outcome)*	*Newborns who attended a well-child visit within 60 days of birth (% of linked Newborns)*
Engaged	2153 (33%)	2008 (93%)	1517 (76%)
Declined	999 (15%)	905 (91%)	698 (77%)
Left Message	2167 (34%)	1935 (89%)	1406 (73%)*
Unable to Reach	1139 (18%)	1021 (90%)	768 (75%)
Total	**6458**	**5868**	**4389**
Engaged in Prenatal and Postpartum	335	313 (93%)	229 (73%)
Not Referred	3298	2812	1905 (68%)*

* Indicates statistically significant result

Analysis of newborns who attended a well-child visit within 60 days of birth

Measure	*Test*	*Statistic*	*P-value*	*Significance*
Engaged Vs Declined	Chi-Square	0.8946	0.3442	No
Engaged Vs Left Message	Chi-Square	4.1691	0.0412	Yes*
Engaged Vs Unable to Reach	Chi-Square	0.0307	0.8610	No
Engaged only in Postpartum Vs Not Engaged in Prenatal	Chi-Square	1.1047	0.2932	No
Engaged Vs Not Referred	Chi-Square	34.3003	<.0001	Yes*

* Indicates statistically significant result

This intervention did meet the goal that 70% of newborns linked to members engaged in the program will attend a well-child visit within 60 days of birth (Rate = 76%). In addition, engaged members had a statistically significantly higher rate of outcome completion (Rate = 76%) compared to Left Message members (Rate = 73%, Chi-Square = 4.17, p = 0.0412). Engaged members also had a statistically significantly higher rate of outcome completion (Rate = 76%) compared to Not Referred members (Rate = 68%, Chi-Square = 34.30, p <.0001).

In contrast, there was no statistically significant difference in the rate of outcome completion between the Engaged members and Declined members, and between Engaged members and Unable to Reach members. There was also no statistically significant difference in the rate of outcome completion between members who were engaged only in Postpartum (Rate = 76%) and members who were engaged in both postpartum and prenatal program (Rate = 73%). This data seems to demonstrate the program is improving rates of postpartum visits among some of the eligible population.

Analysis by Race and Ethnicity

Ethnicity Group	Members in Campaign	Engaged	Newborns with well-child visits				
			N (%)	Test	Statistic	P-value	Sig
WHITE	2048	513 (25%)	365 (78%)	Reference			
AMERICAN INDIAN	133	33 (25%)	24 (77%)	Chi-Square	0.0199	0.8879	No
ASIAN	297	91 (31%)	62 (73%)	Chi-Square	1.2765	0.2585	No
BLACK	175	48 (27%)	31 (66%)	Chi-Square	3.8288	0.0504	No
HISPANIC	3109	1224 (39%)	869 (75%)	Chi-Square	2.4948	0.1142	No
UNKNOWN/ OTHER	684	241 (35%)	164 (76%)	Chi-Square	0.7243	0.3947	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	12	3 (25%)	2 (100%)	Fishers Exact	0.6172	1.0000	No

* Indicates statistically significant result

There was no statistically significant difference in the rate of outcome completion between the White Engaged members and American Indian engaged members, Asian engaged members, Black engaged members, Hispanic engaged members, Unknown/Other engaged members, or Native Hawaiian or Other Pacific Islander engaged members. This data shows our current campaign may not be making a measurable difference in the lives of many of our non-white populations. Further analysis may be warranted due to the small sample size for some groups.

B. Opportunities

Partnership recognizes the importance of postpartum care to promote the health of the mother and to establish an important foundation for wellness behaviors for the mother and the baby. Because this program is the basis for other well-baby and well-child interventions, Partnership will continue this intervention and will evaluate results of program engagement. Although both program goals were met, there are opportunities to improve the impact of this program.

1. Improving Post-partum and Well Child Visit Rates

This program's outcome measures for increasing postpartum visit attendance and increasing the number of well child visits among newborns linked to engaged members showed statistical significance in at least two campaign categories for both measures. In addition, both program goals were met. However, the engaged white population had a statistically significantly lower rate of members with postpartum visits compared to several other race/ethnicities. Furthermore, for well-child visits, there was no statistically significant difference between the white population when compared to other race/ethnic groups among Partnership's membership. Partnership's Population Health staff conduct member satisfaction

surveys over the phone at the end of the program to gather and analyze qualitative feedback. While not directly asked on the survey, emerging barriers based on this qualitative feedback from Partnership members tend to include challenges with childcare, competing priorities, long appointment wait times which can be due to lack of provider availability, and not feeling the need to be seen for a postpartum checkup.

The postpartum program engagement rates for postpartum visits within 60 days of delivery increased from 1,342 (75%) in 2024 to 1696 (79%) in 2025. The postpartum program engagement rates for newborns linked to care has also increased from 1,158 (71%) in 2024 to 1517 (76%) in 2025. Current efforts to continue improving program engagement rates for both program components include assisting with scheduling appointments by directly calling the provider on their behalf or warm handoffs connecting member to provider as needed. Participants are also given the option to switch to a new provider if access is a problem. If participants continue to experience difficulties scheduling an appointment, they are offered the option to file a grievance with Partnership's grievance department. Furthermore, if members experience significant barriers, they are provided a referral to the Care Coordination department for more in-depth support.

To help address identified logistical challenges faced by program participants, the Population Health Team also provides additional efforts to assist parents of newborns. Efforts include mailing postpartum packets to program enrollees which include a Medi-Cal enrollment form along with the address and fax number needed to submit the form and answering member questions. This additional support helps ensure newborns are enrolled in Medi-Cal, with the aim of improving the rate of well-child visits among newborns linked to members. While goals for post-partum visit attendance were met, there is an opportunity to improve the percentage of members who attend a post-partum visit within 60 days of delivery by raising awareness of our program via flyers to providers, members, and community partners to enhance visibility of available services. Partnership will continue to promote this program through a multipronged approach with members, providers, and community-based organization. Partnership also continues to offer incentives for members to attend 2 post-partum visits in hopes of continuing to improve engagement rates. Finally, Partnership also looks forward to implementing texting campaigns to promote this program.

At a systems level, Partnership continues to address several identified barriers by expanding our provider network, with the goal of improving engagement rates. Such efforts include the continuation of the Provider Retention Initiative Pilot and the Provider Recruitment program, both designed to strengthen provider capacity and ensure increase access to care for members. These programs help our contracted network use incentives to recruit and retain high-quality health professionals in our region to improve access to care for Partnership members.

VI. Healthy Babies Growing Together Program

Population Health enrolls infants under 24 months of age in the Healthy Babies Growing Together Program the month they become Partnership members. The program provides health education and promotion of well-child visits and the importance of timely vaccinations to support the child's lifetime of immunity. Incentives are also offered for completing well-care visits with immunizations throughout the duration of the program.

A. Clinical Measure

1. Well Child Vaccinations

The goal for this measure was that of the members who agreed to participate in the program, 80% of members engaged in the program would be compliant with 50% or more of their vaccinations during the program period.

Methodology

Measure Description:	Of the members who were reached and engaged for at least 12 months in the Healthy Babies Growing Together Program, those who had at least 50% of the recommended vaccinations completed within 12 months of engagement." • Age at enrollment 0 - 11 months – 9+ vaccines • Age at enrollment 12 - 23 months – 3+ vaccines
Denominator:	Members newly enrolled with Partnership at less than 24 months of age and who were enrolled with Partnership for at least 12 months as of report run date.
Numerator:	Of denominator, those who completed immunizations by age at enrollment and within 12 months of engagement: * 0 - 11 months - 9+ vaccinations * 12 – 23 months - 3+ vaccinations
Measurement Period:	Denominator is July 2024 through June 2025 (Adjusted measurement period to account for a delay in provider billing of services and to include recent Partnership enrolled members). Numerator is July 2024 to run date, or 12 months after initial engagement.
Exclusion Criteria:	Members who enrolled less than 12 total months during the reporting period; members identified as California Children's Services (CCS).

Results

Members who completed vaccines by age at campaign enrollment and year over year comparison

Campaign Outcome	*Members (% of Total)*	***July 2024-June 2025** Members who completed vaccines (% of outcome)*	*Members (% of Total)*	***July 2023-June 2024** Members who completed vaccines (% of outcome)*
Engaged	3106 (32%)	2589 (83%)	1254	866 (69%)
Declined	869 (9%)	581 (67%)	862	483 (56%)
Left Message	4163 (43%)	2917 (70%)	2189	1304 (60%)
Unable to Reach	1457 (15%)	910 (62%)	1110	621 (56%)
Total	9595	**6997**	5415	**3274**
Not Referred	3612	2316 (64%)	10804	6046 (56%)

* Indicates statistically significant result

Analysis

Measure	*Test*	*Statistic*	*P-value*	*Significance*
Engaged Vs Declined	Chi-Square	114.4138	<.0001	Yes*
Engaged Vs Left Message	Chi-Square	170.8937	<.0001	Yes*
Engaged Vs Unable to Reach	Chi-Square	242.2270	<.0001	Yes*
Engaged Vs Not Referred	Chi-Square	313.5780	<.0001	Yes*

* Indicates statistically significant result

The goal for 80% of members engaged in the program to be compliant with 50% or more of their vaccinations during the program period was met (Rate = 83%). Engaged members had a statistically significantly higher rate outcome completion (Rate = 83%) compared to the following outcomes among members:

- Declined (Rate = 67%, Chi-Square = 114.41, p <.0001)
- Left Message (Rate = 70%, Chi-Square = 170.89, p <.0001)
- Unable to Reach members (Rate = 62%, Chi-Square = 242.23, p <.0001)
- Not Referred members (Rate = 64%, Chi-Square = 313.58, p <.0001)

In addition, significantly more engaged members completed vaccines in July 2024-June 2025 than in July 2023-June 2024 (2,589 compared to 866, respectively). This may be due in part to adjustments to the measurement period.

Analysis by Race and Ethnicity

Ethnicity Group	*Members in Campaign*	*Engaged*	*Members completing recommended vaccinations*				
			N (%)	*Test*	*Statistic*	*P-value*	*Sig*
WHITE	1473	336 (23%)	241 (72%)	Reference			
AMERICAN INDIAN	70	22 (31%)	14 (64%)	Chi-Square	0.6594	0.4168	No
ASIAN	269	99 (37%)	89 (90%)	Chi-Square	13.7913	0.0002	Yes*
BLACK	197	52 (26%)	41 (79%)			0.2836	No
HISPANIC	2939	1176 (40%)	1030 (88%)	Chi-Square	49.0545	<.0001	Yes*
UNKNOWN/ OTHER	4640	1418 (31%)	1171 (83%)	Chi-Square	20.3909	<.0001	Yes*
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	7	3 (43%)	3 (100%)	Fishers	0.3716	0.5624	No

* Indicates statistically significant result

There was no statistically significant difference in the rate of outcome completion between the White Engaged members and American Indian engaged members, Black engaged members, and the Native Hawaiian or Other Pacific Islander. The White Engaged members had a statistically significantly lower rate of outcome completion (Rate = 72%) compared to

- Asian members (Rate = 90%, Chi-Square = 13.79, p = 0.0002)
- Hispanic members (Rate = 88%, Chi-Square = 49.05, p <.0001)
- Unknown/Other members (Rate = 83%, Chi-Square = 20.39, p <.0001)

This data shows our current campaign may be making a measurable difference in the lives of some of our non-white populations. Further analysis may be warranted due to the small sample size for some groups.

B. Utilization Measure

1. Well Child Visits

This program also had a secondary and tertiary goal to support member engagement and adherence to recommended care. The secondary goal is that of the members who agreed to participate in the Healthy Babies Growing Together Program, 25% of members will be compliant with all recommended well-child visits within 24 months of engagement (5+ visits for members enrolled between ages 0 – 6 months, 4+ visits for members enrolled between 7 – 12 months, and 2+ visits for members enrolled between 13-23 months). The tertiary goal aims for 65% of members engaged in the program to be compliant with at least some of the recommended well-child visits within 24 months of engagement (3+ visits for members

enrolled between 0 – 6 months of age, 2+ visits for members enrolled between 7 – 12 months of age, and 1+ visits for members enrolled between 13 – 23 months).

Methodology

Measure Description:	The percentage of members who were reached in the first twenty-four months of life, and engaged in the Growing Together Healthy Babies campaign, and who were enrolled for at least 12 months and completed all or some of the recommended child visits for their enrollment time period.
Denominator:	Members newly enrolled with Partnership at less than 24 months of age and who were enrolled with Partnership for at least 12 months as of report run date.
Numerator:	Of denominator, those who had completed all well-care visits by age at enrollment and within 12 months of enrollment. • Age at enrollment 0 - 6 months – all (5+ visits) or some (3+ visits) • Age at enrollment 7 - 12 months – all (4+ visits) or some (2+ visits) • Age at enrollment 13 - 23 months – all (2+ visits) or some (1+ visits)
Measurement Period:	Denominator is July 2024 through June 2025 (Adjusted measurement period to account for a delay in provider billing of services and to include recent Partnership enrolled members). Numerator is July 2024-run date, or 12 months after initial engagement.
Exclusion Criteria:	Members enrolled less than 12 total months; members identified as California Children's Services (CCS).

Results

Members who completed all or some well-child visits by age at campaign enrollment

Campaign Outcome	*Members (% of Total)*	*Members who completed **all** recommended visits (% of outcome)*	*Members who completed **some** of the recommended visits (% of outcome)*
Engaged	3106 (32%)	1849 (60%)	2771 (89%)
Declined	869 (9%)	386 (44%)*	646 (74%)*
Left Message	4163 (43%)	1820 (44%)*	3084 (74%)*
Unable to Reach	1457 (15%)	501 (34%)*	930 (64%)*
Total	**9595**	**4556**	**7431**
Not Referred	3612	1438 (40%)*	2393 (66%)*

* Indicates statistically significant result

Analysis

Members who completed all the recommended well-child visits by age at campaign enrollment

Measure	*Test*	*Statistic*	*P-value*	*Significance*
Engaged Vs Declined	Chi-Square	62.9973	<.0001	Yes*
Engaged Vs Left Message	Chi-Square	177.9004	<.0001	Yes*
Engaged Vs Unable to Reach	Chi-Square	251.0374	<.0001	Yes*
Engaged Vs Not Referred	Chi-Square	259.8385	<.0001	Yes*

* Indicates statistically significant result

These results indicate that the goal of 25% of engaged members will attend all the well-child visits was met (Rate = 60%). Engaged members had a statistically significantly higher rate of outcome completion (Rate = 60%) compared to members who

- Declined (Rate = 44%, Chi-Square = 63.00, p <.0001)
- Were left a message (Rate = 44%, Chi-Square = 177.90, p <.0001)
- Unable to Reach (Rate = 34%, Chi-Square = 251.04, p <.0001)
- Not Referred (Rate = 40%, Chi-Square = 259.84, p <.0001)

This data seems to suggest that the program is making an impact among the eligible population.

Members who completed some of the recommended well-child visits by age at campaign enrollment

Measure	*Test*	*Statistic*	*P-value*	*Significance*
Engaged Vs Declined	Chi-Square	124.5253	<.0001	Yes*
Engaged Vs Left Message	Chi-Square	259.9978	<.0001	Yes*
Engaged Vs Unable to Reach	Chi-Square	417.0873	<.0001	Yes*
Engaged Vs Not Referred	Chi-Square	495.2343	<.0001	Yes*

*Indicates statistically significant result

These results indicate that the goal of 65% of members engaged in the program will be compliant with at least some of the recommended well-child visits was met (Rate = 89%). Engaged members had a statistically significantly higher rate of outcome completion (Rate = 89%) compared to members who:

- Declined (Rate = 74%, Chi-Square = 124.53, p <.00001)
- Were left a message (Rate = 74%, Chi-Square = 260.00,p <.0001)
- Were unable to reach (Rate = 64%, Chi-Square = 417.09, p <.0001)
- Were not Referred (Rate = 66%, Chi-Square = 495.23, p <.0001)

This data seems to suggest that the program is making an impact among the eligible population.

Analysis by Race and Ethnicity

Members attending all recommended well-child visits

Ethnicity Group	Members in Campaign	Engaged	Members attending all recommended visits				
			N (%)	Test	Statistic	P-value	Sig
WHITE	1473	336 (23%)	175 (52%)	Reference			
AMERICAN INDIAN	70	22 (31%)	8 (36%)	Chi-Square	2.0419	0.1530	No
ASIAN	269	99 (37%)	63 (64%)	Chi-Square	4.1192	0.0424	Yes*
BLACK	197	52 (26%)	20 (38%)	Chi-Square	3.3423	0.0675	No
HISPANIC	2939	1176 (40%)	721 (61%)	Chi-Square	9.2141	0.0024	Yes*
UNKNOWN/ OTHER	4640	1418 (31%)	860 (61%)	Chi-Square	8.2391	0.0041	Yes*
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	7	3 (43%)	2 (67%)	Fishers Exact	0.3921	1.0000	No

* Indicates statistically significant result

There was no statistically significant difference in the rate of outcome completion between the White Engaged members and American Indian engaged members, Black engaged members, and Native Hawaiian or Other Pacific Islander engaged members. White Engaged members had a statistically significantly lower rate of outcome completion (Rate = 52%) compared to

- Asian members (Rate = 64%, Chi-Square = 4.12, p = 0.0424)
- Hispanic members (Rate = 61%, Chi-Square = 9.21, p = 0.0024)
- Unknown/Other members (Rate = 61%, Chi-Square = 8.24, p = 0.0041)

Analysis by Race and Ethnicity

Members attending some of the recommended visits

Ethnicity Group	Members in Campaign	Engaged	Members attending some of the recommended visits				
			N (%)	Test	Statistic	P-value	Sig
WHITE	1473	336 (23%)	286 (85%)	Reference			
AMERICAN INDIAN	70	22 (31%)	15 (68%)	Fishers Exact	0.0303	0.0629	No
ASIAN	269	99 (37%)	90 (91%)	Chi-Square	2.1867	0.1392	No
BLACK	197	52 (26%)	38 (73%)	Chi-Square	4.7408	0.0295	Yes*
HISPANIC	2939	1176 (40%)	1067 (91%)	Chi-Square	8.7474	0.0031	Yes*
UNKNOWN/ OTHER	4640	1418 (31%)	1272 (90%)	Chi-Square	5.7525	0.0165	Yes*
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	7	3 (43%)	3 (100%)	Fishers Exact	0.6186	1.0000	No

* Indicates statistically significant result

There was no statistically significant difference in the rate of outcome completion between the White engaged members and American Indian engaged members, Asian engaged members, and Native Hawaiian or Other Pacific Islander engaged members.

The White engaged members had a statistically significantly higher rate of outcome completion (Rate = 85%) compared to Black members (Rate = 73%, Chi-Square = 4.74, p = 0.0295). Furthermore, the White Engaged members had a statistically significantly lower rate of outcome completion (Rate = 85%) compared to Hispanic members (Rate = 91%, Chi-Square = 8.75, p = 0.0031) and when compared to Unknown/Other members (Rate = 90%, Chi-Square = 5.75, p = 0.0165). This data shows our current campaign is making a measurable difference in the lives of some of our non-white populations.

C. Opportunity

The Healthy Babies Growing Together Program plays a vital role in helping infants and their parents establish lifelong wellness patterns and strong immunities. From July 2024-June 2025, of the 13,207 Partnership members ages 0 – 24 months, only 9,595 were identified as potential program participants. In 2026, the Population Health team will continue outreach efforts by sending letters to members who could not be reached, inviting them to contact Partnership and enroll in the program. These efforts aim to increase well-child visit attendance and improve adherence to recommended vaccination schedules. Notably, engaged members were more likely to receive vaccinations from July 2024-June 2025 than they were in July 2023-June 2024 (2,589 compared to 866, respectively). Furthermore, engaged members were more likely to attend all or some of their well child visits from July 2024-June 2025 than they were in July 2023-June 2024 (1,849 compared to 619 and 2,771 compared to 1,076, respectively).

1. Improving Vaccination and Well Child Visit Rates

While all goals for the Healthy Babies Growing Together Program were met, there are opportunities for improving engagement rates. Partnership's Population Health staff conduct member satisfaction surveys over the phone at the end of the program to gather and analyze qualitative feedback. A significant barrier to care is the ongoing national shortage of providers, particularly pediatric care specialists, which is a reoccurring theme in Partnership's qualitative feedback. While not explicitly asked during satisfaction surveys, members frequently report challenges with transportation and challenges in scheduling timely well-child visits, including clinic cancellations and appointments being pushed out for several months. As noted above, multiple measures under this program saw an increase in rates. Furthermore, all programmatic goals were met. These results may be due in part to additional outreach and support efforts. Current strategies to continue improving program engagement rates includes assisting participants with scheduling an appointment by directly calling the provider on their behalf, warm handoffs connecting member to providers as needed, and if scheduling challenges persist, offering the option to switch to a new provider, and finally, providing the option to file a grievance with Partnership's grievance department.

Although the goal for well child vaccine rates was met, members feedback has indicated ongoing concerns and hesitancy regarding immunizations. Thus, there remains an opportunity for Population Health staff to enhance educational efforts by continuing to apply motivational interviewing skills during outreach call campaigns by reinforcing the importance of timely immunizations. Additionally, there is an opportunity to continue promoting vaccine compliance by offering incentives to all members who receive recommended vaccinations. Partnership will continue to promote this program through a multipronged approach with members, providers, and community-based organizations. Finally, Partnership also looks forward to implementing texting campaigns to promote this program.

At a systems level, Partnership has adopted and will continue to pursue a multi-year collaborative approach to improving provider availability. As a part of this effort, staff will continue collecting data on member experiences with their providers to gain insight into access barriers in order to identify provider or location-specific actions to improve access. Furthermore, Partnership will continue its efforts to expand the provider network with the goal of improving engagement and access to care rates. Provider network expansion efforts include offering the Provider Retention Initiative Pilot and Provider Recruitment program. These programs support our contracted network and use incentives to recruit and retain high-quality health professionals in our region to improve access to care for Partnership members.

VII. Healthy Kids Growing Together

The Healthy Kids program aims to reach all children between the ages 3 through 6 that have not had a well-child visit in the last 11 months or longer. Once identified, these members are offered an incentive to encourage the completion of their annual well-child visits prior to their next birthday.

A. Utilization Measure

1. Well Child Visits

The first goal for this intervention is for 50% of members engaged in the program to have a well-child visit within 120 days of the phone call outcome referred to as “Agreed to Participation.” The second goal for this intervention is for 70% of members engaged will have a well-child visit between July 2024-June 2025.

Methodology

Measure Description:	The percentage of members who were engaged in the Growing Together Healthy Kids campaign who were between 3-6 years old at the time of enrollment and completed the recommended well-child visits for that age range.
Denominator:	Partnership members between ages 3 and 6 years during reporting period and enrolled with Partnership for at least 12 months as of report run date and did not have a well-child visit during 11 months prior to their first eligibility month.
Numerator:	Of denominator, those who completed a well-child visit during the: • 120 days after the call • The measurement period (July 2024 through June 2025)
Measurement Period:	The denominator is July 2024 through June 2025 (Adjusted measurement period to include more eligible participants). The numerator is July 2024 - October 2025.
Exclusion Criteria:	Members enrolled less than 12 total months and members identified as California Children's Services (CCS).

Results

Members who completed a well-child visit 120 days after the call

Campaign Outcome	*Members (% of Total)*	*Members who completed a well-child visits 120 days after the call (% of outcome)*
Engaged	641 (25%)	262 (41%)
Declined	219 (9%)	53 (24%)*
Left Message	1147 (45%)	317 (28%)*
Unable to Reach	537 (21%)	125 (23%)*
Total	2544	757
Not Referred	27950	N/A

* Indicates statistically significant result

Analysis

Members who completed a well-child visits 120 days after the call

Measure	*Test*	*Statistic*	*P-value*	*Significance*
Engaged Vs Declined	Chi-Square	19.5482	<.0001	Yes*
Engaged Vs Left Message	Chi-Square	39.9017	<.0001	Yes*
Engaged Vs Unable to Reach	Chi-Square	41.0135	<.0001	Yes*

* Indicates statistically significant result

The goal that 50% of members engaged in the program will have a well-child visit within 120 days of the phone call outcome referred to as “Agreed to Participation was not met (Rate =

41%). However, Engaged members had a statistically significant higher rate of outcome completion (Rate = 41%) when compared to the following outcomes:

- Members who declined (Rate = 24%, Chi-Square = 19.55, p <.0001)
- Members who were left message (Rate = 28%, Chi-Square = 32.90, p <.0001)
- Members who were unable to reach (Rate = 23%, Chi-Square = 41.01, p <.0001)

While the goal was not met, the higher statistical significance found among the engaged members compared to other campaign categories seems to suggest that the program is making an impact among the eligible member population.

Results

Members who completed a well-child visit between July 2024-June 2025

Campaign Outcome	*Members (% of Total)*	*Members who completed well-child visits between July 2024-June 2025 (% of outcome)*
Engaged	641 (25%)	511 (80%)
Declined	219 (9%)	128 (58%)*
Left Message	1147 (45%)	691 (60%)*
Unable to Reach	537 (21%)	289 (54%)*
Total	2544	1619
Not Referred	27950	17627 (63%)*

* Indicates statistically significant result

Analysis

Members who completed well-child visits between July 2024-June 2025

Measure	*Test*	*Statistic*	*P-value*	*Significance*
Engaged Vs Declined	Chi-Square	38.6823	<.0001	Yes*
Engaged Vs Left Message	Chi-Square	70.7856	<.0001	Yes*
Engaged Vs Unable to Reach	Chi-Square	89.9605	<.0001	Yes*
Engaged Vs Not Referred	Chi-Square	74.9245	<.0001	Yes*

* Indicates statistically significant result

The goal that 70% of engaged members will have a well-child visit between July 2024 and June 2025 was met (Rate = 80%). Engaged members had a statistically significantly higher rate of completing well-child visit (Rate = 80%) when compared to the following outcomes:

- Members who Declined (Rate = 58%, Chi-Square = 38.68, p <0.0001),
- Members who were left message (Rate = 60%, Chi-Square = 70.79, p <0.0001),
- Members who were unable to reach (Rate = 54%, Chi-Square = 89.96, p <0.0001), and
- Members who were not referred (Rate = 63%, Chi-Square = 74.92, p <0.0001)

This data seems to suggest that the program is making an impact among the eligible population.

Analysis by Race and Ethnicity

Members who completed a well-child visits 120 days after the call

Ethnicity Group	*Members in Campaign*	*Engaged*	*Members attending a well-child visit 120 days after the call*				
			N (%)	*Test*	*Statistic*	*P-value*	*Sig*
WHITE	578	102 (18%)	41 (40%)	Reference			
AMERICAN INDIAN	39	12 (31%)	5 (42%)	Fishers Exact	0.2406	1.0000	No
ASIAN	111	32 (29%)	17 (53%)	Chi-Square	1.6586	0.1978	No
BLACK	101	26 (26%)	9 (35%)	Chi-Square	0.2711	0.6026	No
HISPANIC	869	285 (33%)	111 (39%)	Chi-Square	0.0491	0.8246	No
UNKNOWN/ OTHER	844	184 (22%)	79 (43%)	Chi-Square	0.2021	0.6530	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	2	0 (0%)	0 (0%)	N/A			

* Indicates statistically significant result

There was no statistically significant difference in the rate of outcome completion between the White Engaged members and American Indian engaged members, Asian engaged members, Black engaged members, Hispanic engaged members, and Unknown/Other engaged members. This data seems to suggest that the program is not making much of an impact among all ethnicities. Further analysis may be warranted due to the small sample size for some groups.

Members who completed a well-child visit between July 2024-June 2025

Ethnicity Group	*Members in Campaign*	*Engaged*	*Members attending a well-child visit between July 2024-June 2025*				
			N (%)	*Test*	*Statistic*	*P-value*	*Sig*
WHITE	578	102 (18%)	75 (74%)	Reference			
AMERICAN INDIAN	39	12 (31%)	8 (67%)	Fishers Exact	0.2247	0.7325	No
ASIAN	111	32 (29%)	28 (88%)	Chi-Square	2.6735	0.1020	No
BLACK	101	26 (26%)	16 (62%)	Chi-Square	1.4496	0.2286	No
HISPANIC	869	285 (33%)	243 (85%)	Chi-Square	7.0592	0.0079	Yes*
UNKNOWN/ OTHER	844	184 (22%)	141 (77%)	Chi-Square	0.3414	0.5590	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	2	0 (0%)	0 (0%)	N/A			

* Indicates statistically significant result

There was no statistically significant difference in the rate of outcome completion between the White engaged members and American Indian engaged members, Asian engaged members, Black engaged members, and Unknown/Other engaged members. However, the engaged White population had a statistically significantly lower rate of outcome completion (Rate = 74%) compared to Hispanics (Rate = 85%, Chi-Square = 7.06, p = 0.0079). This data seems to demonstrate that our current campaign are making a measurable difference in the lives of our Hispanic members.

B. Opportunity

The Healthy Kids Growing Together Program plays a critical role in helping children and their parents establish wellness patterns and immunities that will protect them for life. As the basis for other well-child interventions, Partnership will continue implementing this program and will evaluate engagement outcomes. However, there are opportunities to improve the impact of this program, such as through program promotion. In 2025, the Population Health team continued mailing outreach materials to eligible members, encouraging them to contact Partnership to participate in the program with the goal of increasing well-child visit rates.

1. Improve Well Child Visits

The goal to attend well child visits between July 2024 and June 2025 was met (Rate = 80%). However, the goal to attend well child visits within 120 days of the phone call outcome referred to as “Agreed to Participation” was not met (Rate = 41%). Partnership’s Population Health staff conduct member satisfaction surveys over the phone at the end of the program to gather and analyze qualitative feedback. While not directly asked on the survey, qualitative feedback from Partnership members often reveals barriers to achieving programmatic goals which may include concerns of long appointment wait times, limited provider availability, transportation to appointments, and the belief that kids do not need to see the doctor when they are not actively sick. Given these findings, there are opportunities for improvement. Partnership will continue to work on improving some of these barriers through ongoing initiatives to expand our provider network. Efforts to improve program engagement rates include assisting participants with scheduling an appointment by directly calling the provider on their behalf or warm handoffs connecting member and provider as needed. Participants who continue to experience difficulties scheduling appointments are offered the option to switch to a new provider if needed and the option to file a grievance through Partnership’s grievance department.

Partnership also looks forward to implementing texting campaigns to encourage well child visits. Additionally, Partnership is engaged in ongoing efforts to expand its provider network. These expansion efforts include the continuation of the Provider Retention Initiative Pilot and Provider Recruitment program, both of which are designed to support provider capacity and

improve access to care for members. These programs help our contracted network use incentives to recruit and retain high-quality health professionals in our region to improve access to care for Partnership members.

VIII. Transitional Care Services

Transitional Care Services (TCS) focuses on members who are transitioning across settings or benefit structures with high-risk of poor outcomes. Partnership's Care Coordination (CC) team provides TCS to this vulnerable population to ensure implementation of the discharging facility's transition plan and connects members to medical care and community resources that support health and wellness following a transition of care. The current TCS criteria for the members identified include the following:

Adult members (age > 20) **and**:

- Discharging home from an inpatient admission with any length of stay, and
- Meet the criteria for high-risk transitioning members

Of note, TCS replaced Transitions of Care program in April of 2025, which has broader criteria than TOC as defined in the Population Health Management (PHM) Policy Guide.[1] TOC only included acute care hospital length of stays longer than four days, out-of-county hospitals with any length of stay, more than one admission in 10 days, and excluded members in Long Term Care or in a Long- Term Care Psychiatric facility.

Pediatric members (under age 21) **and**:

- Discharging home from an inpatient stay with an admission date > 60 days from his/her date of birth and having any length of stay.

A. Member Experience/Satisfaction Measures

At the close of TCS, a Partnership designee contacts the members by phone to complete a member-experience survey. Response options are Agree (3 points), Neutral (2 points), Disagree (1 point), or No Response. In addition to weighted responses, members have an opportunity to provide comments. Since the TOC program was still performed during the first quarter of 2025, its data is also included.

1. Adult Member Experience

There were 255 adult members who were assigned to the TOC or TCS survey intervention after completion of the program, and 224 provided responses to the Adult TOC or TCS Satisfaction Surveys between January 1 and December 31, 2025; a survey completion rate of

[1] Population Health Policy Guide, 2026

88%. The goal is at least 75% of members surveyed agree with the statement below, which translates to an average score of 2.5 or greater for each response. Average scores for each of the questions were as follows:

Survey Question	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my health issues.	2.98	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager).	2.99	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.94	Yes
After working with the case management team, I feel my ability to manage my healthcare needs is better.	2.92	Yes
My health has improved since working with my case management team.	2.77	Yes
I was able to safely transition between Providers with the help of my Care Team	2.87	Yes
The relationship that I have with the PCP and/or Specialist offices has improved since working with my case management team.	2.82	Yes
I was provided the available equipment, medication and/or services that were needed.	2.94	Yes

Analysis

The average score for each satisfaction measure exceeded the goal of at least 75% of members surveyed agreeing with each statement of the Adult TOC or TCS Satisfaction Survey. The average score ranged from the lowest at 2.77 to the highest at 2.99, which exceeds the goal average of 2.5. The results of the Adult TOC and TCS surveys and the positive comments left reveal a high satisfaction rate among the members surveyed. Our adult members report good outcomes with this program and we will continue providing this benefit.

2. Pediatric Experience Member

There were 38 pediatric members who were assigned to the TOC or TCS survey intervention after completion of the program, and 30 of them provided responses to the Pediatric TOC or TCS Satisfaction Surveys between January 1 and December 31, 2025; a response rate of 79%. The goal is at least 75% of members surveyed agree with the statements below, which translates to an average score of 2.5 or greater for each response. The average responses were as follows:

Survey Question	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my child's health issues.	3.00	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager).	3.00	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.90	Yes
After working with the case management team, I feel my ability to manage my child's healthcare needs is better	2.93	Yes
My child's health has improved since working with our case management team	2.83	Yes
I was able to safely transition my child between Providers with the help of my Care Team.	2.83	Yes
The relationship that my child and I have with the PCP and/or Specialist offices has improved since working with our case management team.	2.90	Yes
My child and I were provided with the available equipment, medication and/or services that were needed.	2.80	Yes

Analysis

The average score for each satisfaction measure exceeded the goal of at least 75% of members surveyed agreeing with each statement of the Pediatric TOC or TCS Satisfaction Survey. The average score ranged from the lowest at 2.80 to the highest at 3.00, which exceeds the goal average of 2.5. The results of the Pediatric TOC or TCS surveys and the many positive comments left reveal a high satisfaction rate among the members surveyed. Families report good outcomes with this program for our Pediatric members, and we will continue providing this benefit.

IX. Complex Case Management (CCM)

Complex Case Management is a support for members who have multiple chronic conditions, social determinants of health barriers and/or have difficulty navigating the healthcare system without the intensive support of a care coordinator and an individualized care plan. Care Coordination licensed staff engage the member or caregiver to perform a comprehensive assessment, clarify member/caregiver's goals and desired level of involvement, and develop an individualized care plan to overcome barriers to care and to support the member/caregiver in reaching his/her wellness goals. Individual goals are time-bound; however, a member may

remain in complex case management for an extended period of time to ensure they receive appropriate care.

A. Member Experience/Satisfaction Measures

Member satisfaction with the complex case management program is ascertained via telephonic survey by a Partnership designee either annually (for multi-year interventions) or upon case closure, if the case is active for less than one year. Response options are Agree (3 points), Neutral (2 points), Disagree (1), or No Response. In addition to weighted responses, members have an opportunity to provide comments.

1. Adult Experience Measure

The number of Adult CCM Satisfaction Surveys completed was low because many of the adult members enrolled in the CCM program with open cases were closed after becoming unable to reach or had insufficient time within the program per NCQA standards to qualify for a satisfaction survey in 2025.

There were 6 adult members assigned to the Adult CCM Survey intervention after completion of the program and 5 members provided responses between January 1 and December 31, 2025, a response rate of 83%. The goal is at least 75% of members surveyed agree with the statements below, which translates to an average score of 2.5 or greater for each response. The average responses were as follows:

Survey Question	Average Response	Goal Met
The CM program helped me manage my health issues.	3.00	Yes
I am happy with the number of calls I received from our case management team	3.00	Yes
I am confident in the abilities of the team members who contacted me	3.00	Yes
My team referred me to medical and community resources that were valuable and helped me.	3.00	Yes
I feel my ability to manage my healthcare needs are better after working with CM	2.60	Yes
I have a better understanding of my health conditions and/or diagnosis after working with CM	2.80	Yes
I have a better understanding of my medications after working with CM.	2.60	Yes
My health has improved since working with our case management team.	2.60	Yes
The relationship that I have with the PCP and/or Specialist offices has improved since working with our case management team.	3.00	Yes
I feel like my providers and I work together better to help me since working with our case management team.	2.80	Yes
I have had more success reaching our health goals since working with the case management team.	2.80	Yes

Analysis

With five respondents, the average score for each satisfaction measure met the goal of at least 75% of members surveyed agreeing with each statement of the Adult CCM Satisfaction Survey. The average score ranged from the lowest at 2.60 and 3.00, which is above the goal average of 2.5. The number of members eligible to complete the survey is low; nevertheless, with the average scores meeting the goal along with the positive responses, Partnership will continue providing this benefit.

2. Pediatric Experience Measure

In addition to the above program criteria, Partnership's Clinical CC staff outreach to all newly identified CCS members and members currently eligible for CCS who develop an additional CCS condition to complete a comprehensive assessment, determine acuity, and to offer enrollment into CCM if they meet criteria. The final activity upon completion of the program for these CCS members along with other enrolled Pediatric CCM cases is the satisfaction survey. For each satisfaction measure, the goal is at least 75% of members surveyed agree

with the statement below, which translates to an average score of 2.5 or greater for each response.

There were five pediatric members assigned to the Pediatric CCM Survey intervention after completion of the program and all five members completed a Pediatric CCM Satisfaction Survey between January 1 and December 31, 2025, a response rate of 100%. The goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response. The average responses were as follows:

Survey Question	Average Response	Goal Met
The CM program helped me manage my child's health issues.	3	Yes
I am happy with the number of calls I received from our case management team	3	Yes
I am confident in the abilities of the team members who contacted me	3	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.80	Yes
I feel my ability to manage my child's healthcare needs is better after working with CM	2.60	Yes
I have a better understanding of my child's health conditions and/or diagnosis after working with CM	2.80	Yes
I have a better understanding of my child's medications after working with CM.	2.60	Yes
My child's health has improved since working with our case management team.	2.60	Yes
The relationship that my child and I have with the PCP and/or Specialist offices has improved since working with our case management team.	2.60	No
I feel like my providers and I work together better to help my child since working with our case management team.	2.80	Yes
My child and I have had more success reaching our health goals since working with our case management team.	2.60	Yes

Analysis

With five respondents, the average score for each satisfaction measure exceeded the goal of at least 75% of members surveyed agreeing with each statement of the Pediatric CCM Satisfaction Survey. The average score ranged from 2.60 to 3.00, which is above the goal of 2.5. The number of members eligible to complete the survey is low; nevertheless, with the average scores meeting the goal along with the positive responses, Partnership will continue providing this benefit.

X. Overall Program Effectiveness

Partnership continues to look for opportunities to refine its program offerings based on insights and successes from previous years. Lessons learned have shown that the most effective programs utilize multiple modalities of reaching members, such as combining mailings with phone calls and with incentives to maximize engagement. Among the clinical measures, program goals were met for vaccination rates among infants enrolled in the Healthy Babies program. For utilization measures, we met our goal of newborns attending well child visits who are linked to members engaged in the prenatal and postpartum program. We also met the goal for members to attend postpartum visits among members enrolled in the postpartum program. Furthermore we met the goal for members to attend well child visits who were enrolled in the Healthy Babies program and one of the goals for kids to attend well child visits who were enrolled in the Healthy Kid's program. As for member experience measures, we met all goals under both the Transitions of Care / Transitional Care Services and Complex Case Management programs.

A significant finding that has carried on through 2025 is feedback from members about the ongoing challenges around scheduling well child visits due to the lack of provider availability to serve the member population in a timely manner. This finding highlights the greatest areas of need for innovative solutions and will inform multidisciplinary efforts to support providers in delivering this essential service. Member experience measures highlighted the significant value that Partnership's programs provide to members. Partnership continues to integrate member experience questions into a broader range of member interactions to gain deeper insight into member barriers to care and to promote the overall experience members have with Partnership. In 2025, Partnership also conducted analyses of program outcomes stratified by race and ethnicity. An interesting finding was the white population had statistically significant lower rates for certain well-child attendance visit goals, and postpartum visits when compared to other racial groups. Under the Prenatal Program, there was no statistical significance between the white population and other non-white populations for the linked newborns to well child visits measure.

Finally, results of member experience questions indicate a high level of satisfaction as reported by Partnership members surveyed, exceeding the goal of at least 75% of members agreeing with each statement of the Adult and Pediatric TOC or TCS Satisfaction Surveys, as well as Adult and Pediatric CCM Satisfaction Surveys. Despite small numbers of enrolled members in the CCM program, our adult members, as well as families of our Pediatric members, report good outcomes with these programs and we will continue providing this benefit..

A. Summary

In conclusion multiple interventions demonstrated improved outcomes among Partnership members enrolled in Population Health Management (PHM) programs compared to those who were not engaged or not referred to the programs. There are some opportunities that exist to improve the design of PHM interventions, along with broader systemic factors addressing the environment of care. Partnership will explore means to leverage new benefits and resources offered through the CalAIM initiative to bolster member support and improve the overall health outcomes of the population.

Works Cited

1. Department of Health Care Services (April 2026). *Population Health Management Policy Guide*. Retrieved from https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf

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Population Segmentation

Production Date: June 2026

Eligible Partnership Members as of April 2026: 862,138

Data presented in this report reflects distinct members as of April 2026; Activities are presented for 2026/2027 fiscal year. This report is a point in time count for the month of April 2026.

Keeping Members Healthy				
Population Subset	**Data Source(s) Used for Identification**	**Interventions for which Members are Eligible**	**Number of Qualifying Members**	**% of Membership**
Members new to Partnership and less than 24 months	• **Partnership Member Enrollment Data** • **Partnership Integrated Claims and Encounter Data**	**Healthy Babies Growing Together** – Reminds parent/guardian to take baby for recommended well baby check-ups, immunizations, and blood lead testing; periodic assessments of child and family care needs, and provides incentives for attending well child visits.	1,311	0.152%
Partnership members 3 to 6 years of age and have not been seen for a well-child visit in the last 12 months	• **Partnership Member Enrollment Data** • **Partnership Integrated Claims and Encounter Data**	**Healthy Kids Growing Together** Reminds parent/guardian of the well-child visit benefit, reinforces the importance of immunizations, and make-up blood lead testing; periodic developmental screenings and assessments of child and family care needs, and offers an incentive for members who complete a well-care visit following outreach.	1,714	0.198%
Partnership members ages 11 – 12	• **Partnership Member Enrollment Data**	**Health Care Transitions** – Informational mailers to parents / guardians of 11 & 12 year old Partnership members about their changing relationship with their PCP, teen issues, and teen vaccinations. Option to call in for more information.	1,329	0.154%

Keeping Members Healthy				
Population Subset	**Data Source(s) Used for Identification**	**Interventions for which Members are Eligible**	**Number of Qualifying Members**	**% of Membership**
Partnership members between 0 – 20 years old (up to 21st birthday)	• **Partnership Member Enrollment Data**	**Medi-Cal for Kids and Teens (EPSDT) Awareness Campaign** – Notice about DHCS approved materials sent to parents/guardians of all Partnership members under the age of 21 outlining their benefits and rights, and how to access care. Members can request material online, by phone, or by mail.	330,727 (sent in December 2025)	38.361%
All Member Households	• **Partnership Member Enrollment Data**	**Routine Member Newsletters** – Includes general preventive and wellness material and provides contact information for Member Services, Care Coordination, and to Partnership's website for more information about preventive health and chronic care services. Letters are sent to households rather than individual members.	414,834 (households as of February 2026)	100.00%
Partnership members seeking local resources available and accessible to Medi-Cal recipients	• **Partnership Member Enrollment Data** • **Partnership Community Resources Pages**	**Community Resource Connections** – Part of the outbound call service to provide resources for members, track resources provided, and perform follow-up (closed loop referrals) to ensure resource(s) met member needs.	722	0.083%
Partnership members living in areas lacking local imaging services	• **Partnership Member Enrollment Data** • **Partnership Primary Care Provider Quality Incentive Program (PCP QIP) data**	**Mobile Mammography Clinics** – Mobile mammography clinic days in locations known to have poor access to brick-and-mortar mammography services.	70,447	8.171%

Keeping Members Healthy				
Population Subset	**Data Source(s) Used for Identification**	**Interventions for which Members are Eligible**	**Number of Qualifying Members**	**% of Membership**
Partnership members attending middle-school within Partnership's region where a high percentage of Partnership members are enrolled	• **Partnership Member Enrollment Data** • **California Immunization Registry (CAIR) Data**	**School-Based Vaccination Education & Clinics** – in-classroom education about the importance of adolescent vaccinations, incentivized activity, with a vaccination clinic offered during event.	60 (estimate)	0.006%
Partnership members attending middle-school within Partnership's region where a high percentage of Partnership members are enrolled	• **Partnership Member Enrollment Data**	**School-Based Tobacco Prevention** – In-classroom education about the importance of not vaping followed up with an incentivized, interactive, activity.	60 (estimate)	0.006%
Partnership members of any age attending events in their communities	• **Partnership Community Events Summary data from Population Health staff**	**Community Outreach / Engagement Events -** Offer benefit education, resource referrals, and member surveys to gain insight into barriers and member priorities. Attend at least 1-2 events per county per year, weather permitting (approximately 150+ total events per year). Number of Qualifying Members reflects the number of Partnership members who visited the resource table at a community event for March 2026.	755 (estimate)	0.087%

Keeping Members Healthy				
Population Subset	**Data Source(s) Used for Identification**	**Interventions for which Members are Eligible**	**Number of Qualifying Members**	**% of Membership**
Pregnant Partnership members who self-identify as African American, Native American/Alaska Native, or Native Hawaiian/Pacific Islander and who attend the event	• **Partnership Member Enrollment Data**	**Health Equity Community Outreach Events: Maternity photo shoot** – Intervention to address disparities in Solano County among Black, Alaska Native/American, and/or Hispanic pregnant individuals at about 20-30 weeks gestation. Aim to increase supportive community interactions and social support and promote various Partnership member benefits including Doula services, and Partnership's Growing Together Program through the provision of professional photography, makeup, and gifts.	217 (eligible for April event)	0.025%

Managing Members with Emerging Risks				
Population Subset	**Data Source(s) Used for Identification**	**Interventions for which Members are Eligible**	**Number of Qualifying Members**	**% of Membership**
Partnership members who are pregnant and who have had a prenatal care visit in the past 12 months and	• **Partnership Member Enrollment Data** • **Referral Data** • **Utilization Data** • **Partnership Integrated Claims & Encounter Data** • **Collective Medical**	**Growing Together Prenatal Program** – welcome call when pregnancy is identified, reinforcement of prenatal care, educational materials, pre- and post-partum depression screening, reminders for post-partum care and re-establishment with a PCP; incentives provided.	1,494	0.173%

Managing Members with Emerging Risks				
Population Subset	**Data Source(s) Used for Identification**	**Interventions for which Members are Eligible**	**Number of Qualifying Members**	**% of Membership**
Partnership members who have delivered babies during the calendar year	• **Partnership Member Enrollment Data** • **Referral Data** • **Utilization Data** • **ADT Data** • **Partnership Integrated Claims & Encounter Data** • **Collective Medical**	**Growing Together Post-Partum Program** – Welcome call when member has delivered, educational materials, post-partum depression screening, reminders for post-partum care and re-establishment with a PCP, initiating well-child visits for their babies; incentives provided.	810	0.093%
Any Partnership member	• **All partnership members with internet access**	**Disaster Preparedness** – Booklets posted online describing how to prepare for emergencies with local resources supporting the vulnerable community. Option to call in for further information and local links.	556,784 (estimate of eligible adult population)	64.581%
PHC members 5-65 who have a recent (<7 days) ED event with a primary diagnosis of asthma	• **Partnership Integrated Claims & Encounter Data**	**BPHM Asthma Control / Improvement Program** – If a member calls in after receiving the program flyer, then a pharmacist will consult member/member's guardian on priorities of asthma self-management.	421	0.048%
Partnership members 18-85 with a new diagnosis of hypertension AND self-identify as African American and/or Native American/Alaskan Native and/or Pacific Islander	• **Partnership Member Enrollment Data** • **Partnership Integrated Claims & Encounter Data** • **Utilization Data**	**BPHM Hypertension Lifestyle Control Program Management** – Population Health staff will reach out to members and offer Healthy Living Tools and lifestyle coaching to promote wellness and disease management using the hypertension action plan.	276	0.032%
Partnership members between the ages of 21-44 who either have a new	• **Partnership Member Enrollment Data**	**BPHM Diabetes Management Program** – Population Health staff will reach out to members and offer Healthy Living Tools	123	0.014%

Managing Members with Emerging Risks				
Population Subset	**Data Source(s) Used for Identification**	**Interventions for which Members are Eligible**	**Number of Qualifying Members**	**% of Membership**
diagnosis of diabetes or an A1C of >8.0 or who have not received an A1C test in the last year AND self-identify as African American and/or Native American/Alaskan Native and/or Pacific Islander	• **Partnership Integrated Claims & Encounter Data** • **Laboratory Results**	and lifestyle coaching to promote wellness and disease management using the diabetes action plan.		
Partnership members ages 21 years and older that have had a recent diagnosis of stroke or myocardial infarction within the past 90 days and who may be experiencing symptoms of depression	• **Partnership Member Enrollment Data** • **Partnership Integrated Claims & Encounter Data** • **Utilization Data**	**BPHM Depression Management Program** – Population Health staff will reach out to members and offer Healthy Living Tools and lifestyle coaching to promote wellness and lifestyle management using the depression management action plan.	235	0.027%

Outcomes Across Settings				
Population Subset	**Data Source(s) Used for Identification**	**Interventions for which Members are Eligible**	**Number of Qualifying Members**	**% of Membership**
High-risk PHC members who are discharged from one setting or level of care to another identified using a variety of criteria	• **Partnership Member Enrollment Data** • **Partnership Case Management Flag(s)** • **ADT Data** • **Partnership Utilization Data**	**Transitional Care Services** – Care Coordination staff contact members discharging home after a hospital stay within 7 days of discharge.	2,054	0.238%

Managing Members with Multiple Chronic Conditions				
Population Subset	**Data Source(s) Used for Identification**	**Interventions for which Members are Eligible**	**Number of Qualifying Members**	**% of Membership**
Members (adult or pediatric) who fall into at least one of the following criteria: Has a California Children's Services (CCS)-eligible conditions; has multiple unmanaged chronic conditions; has barriers to managing their care without the support of an individualized care plan, are high risk seniors or persons with SPD; or has had at least one hospitalization and has a mental or behavioral health component that requires stabilization	• **Partnership Member Enrollment Data** • **ADT Data** • **Partnership Utilization Data** • **Partnership Integrated Claims & Encounter Data** • **Partnership Risk Score Level** • **Screening and Assessment data** • **Social Needs data** • **Behavioral Health data**	**Complex Case Management** – Care Coordination licensed staff engage member to perform a comprehensive assessment, clarify member/caregiver's goals and desired level of involvement, and develop an individualized care plan to overcome barriers to care and to support the member/caregiver in reaching his/her wellness goals.	9,234	1.071%
Partnership members who have a high-risk (high intensity) pregnancy diagnosis and self-identify as Native American/Alaska Native	• **Partnership Member Enrollment Data** • **Partnership Integrated Claims and Encounter Data**	**High Risk (High Intensity) Pregnancies** – Care Coordination staff engage member to perform an assessment, clarify member's goals and desired level of involvement, and develop an individualized care plan to overcome barriers to care and to support the member through pregnancy and delivery. If clinical needs are identified at any point while working with the member, a nurse consult can be requested.	34	0.003%

*** Engaged = Agreed to Participation**
*** Declined = Declined Participation**
*** Not Engaged = Unable to Reach**
*** Not Referred = in campaign demographic but not referred to the campaign**

Note: programs are measured for effectiveness as appropriate

2026/2027 Population Health Management Work Plan **Produced June 2026**		
NCQA/DHCS Risk Tier	**Project/ Program**	**Target Population / Inclusion / Exclusion**
Keeping Members Healthy / Low Risk	**Healthy Babies Growing Together**	INCLUDE: * PHC members ***new to the plan*** AND < 24 months old at age of enrollment EXCLUDE: * Members enrolled in the plan less than 12 total months * Members identified as California Children's Services (CCS)

2026/2027 Population Health Manageme Produced June 2026				
NCQA/DHCS Risk Tier	**Project/ Program**	**Service Description**	**Member Notification**	**Interactive (Y/N)**
Keeping Members Healthy / Low Risk	**Healthy Babies Growing Together**	Reminds parent/guardian to take baby for recommended well baby check-ups, immunizations, and blood lead testing; periodic assessments of child and family care needs, and provides incentives for attending well child visits.	Outbound telephone calls, mailed incentives, text messages	Y

2026/2027 Population Health Manageme Produced June 2026			
NCQA/DHCS Risk Tier	**Project/ Program**	**How to Opt Out**	**Measure Goals**
Keeping Members Healthy / Low Risk	**Healthy Babies Growing Together**	When member is called or texted, they will be given the opportunity to Opt Out of further contact	* **50%** of members **engaged** in the Healthy Babies GTP program will be compliant with well child visits within 12 months of engagement Target per age at enrollment: * 0 - 6 months - 5+ visits * 7 - 12 months - 4+ visits * 13-23 months - 2+ visits
			* **75%** of **members engaged** in the Healthy Babies GTP program will be compliant with well child visit scheduled within 12 months of engagement Target per age at enrollment: * 0 - 6 months - 3+ visits * 7 - 12 months - 2+ visits * 13-23 months - 1+ visits

2026/2027 Population Health Manageme Produced June 2026				
NCQA/DHCS Risk Tier	**Project/ Program**	**Denominator**	**Numerator**	**Measurement Period**
Keeping Members Healthy / Low Risk	**Healthy Babies Growing Together**	Members enrolled with PHC at less than 24 months of age and who were enrolled with PHC for at least 12 months as of report run date	Of denominator, those who completed well child visits by age at enrollment: * 0 - 6 months - 5+ visits * 7 - 12 months - 4+ visits * 13-23 months - 2+ visits	Campaigns: July 2025 - June 2026 Claims: July 2025-Run Date
		Members enrolled with PHC at less than 24 months of age and who were enrolled with PHC for at least 12 months as of report run date	Of denominator, those who completed well child visits by age at enrollment: * 0 - 6 months - 3+ visits * 7 - 12 months - 2+ visits * 13-23 months - 1+ visits	Campaigns: July 2025 - June 2026 Claims: July 2025-Run Date

2026/2027 Population Health Management Work Plan
Produced June 2026

NCQA/DHCS Risk Tier	Project/ Program	Target Population / Inclusion / Exclusion
Keeping Members Healthy / Low Risk	**Healthy Kids Growing Together**	INCLUDE: * PHC members between 3 years and 6 years of age (up to age 7) and * Enrolled with PHC for at least 12 months and have never had a well-child visit coded while enrolled with PHC. EXCLUDE: * Members enrolled less than 12 total months * Members identified as California Children's Services (CCS)
Keeping Members Healthy / Low Risk	**Health Care Transitions**	* PHC members ages 11 & 12 years old

2026/2027 Population Health Manageme
Produced June 2026

NCQA/DHCS Risk Tier	Project/ Program	Service Description	Member Notification	Interactive (Y/N)
Keeping Members Healthy / Low Risk	**Healthy Kids Growing Together**	Reminds parent/guardian of the well-child visit benefit, reinforces the importance of immunizations, dental visits, and make-up blood lead testing; periodic developmental screenings and assessments of child and family care needs, and offers an incentive for members who complete a well-care visit following outreach.	Telephone, informational mailer, mailed incentives	Y
Keeping Members Healthy / Low Risk	**Health Care Transitions**	Informational mailer to parents/ guardians of 11 & 12 year old PHC members about their relationship with their PCP, teen issues, and teen vaccinations. Option to call in for more information.	Informational mailer	N

2026/2027 Population Health Manageme Produced June 2026			
NCQA/DHCS Risk Tier	**Project/ Program**	**How to Opt Out**	**Measure Goals**
			* **80%** of **members engaged** in the Healthy Babies GTP program will be compliant with 50% of recommended immunizations within 12 months of engagement Target per age at enrollment: * 0-11 months - 9+ vaccines *12-23 months - 3+ vaccines
Keeping Members Healthy / Low Risk	**Healthy Kids Growing Together**	When member is called, they will be given the opportunity to Opt Out of further calls	*** 50 %** of members **engaged** will have a well-child visit within 90 days of call outcome "Agreed to Participation"
			* **70%** of members **engaged** will have a well-child visit by the end of the measurement period
Keeping Members Healthy / Low Risk	**Health Care Transitions**	N/A	N/A

2026/2027 Population Health Manageme Produced June 2026				
NCQA/DHCS Risk Tier	**Project/ Program**	**Denominator**	**Numerator**	**Measurement Period**
		Members enrolled with PHC at less than 24 months of age and who were enrolled with PHC for at least 12 months as of report run date	Of denominator, those who completed immunizations by age at enrollment: * 0-11 months - 9+ vaccines *12-23 months - 3+ vaccines	Campaigns: July 2025 - June 2026 Claims: July 2025-Run Date
Keeping Members Healthy / Low Risk	**Healthy Kids Growing Together**	PHC members between ages 3 and 6 years during reporting period, and enrolled with PHC for at least 12 months as of report run date, and have never had a well-child visit coded while enrolled with PHC	Of denominator, those who completed a well-child visit within 90 days of the call	Campaigns: July 2025 - June 2026 Claims: July 2025-Run Date
		PHC members between ages 3 and 6 years during reporting period, and enrolled with PHC for at least 12 months as of report run date, and have never had a well-child visit coded while enrolled with PHC	Of denominator, those who completed a well-child visit during the measurement period	Campaigns: July 2025 - June 2026 Claims: July 2025-Run Date
Keeping Members Healthy / Low Risk	**Health Care Transitions**	N/A	N/A	January 2026 -December 2026

2026/2027 Population Health Management Work Plan Produced June 2026		
NCQA/DHCS Risk Tier	**Project/ Program**	**Target Population / Inclusion / Exclusion**
Keeping Members Healthy / Low Risk	**Medi-Cal for Kids and Teens (EPSDT) Awareness campaign**	* PHC members under the age of 21 and their families
Keeping Members Healthy / Low Risk	**Routine Member Newsletters**	* Any PHC member * Known mailing address
Keeping Members Healthy / Low Risk	**Community Resource Connections**	* PHC members seeking local resources available to Medi-Cal recipients
Keeping Members Healthy / Low Risk / Equity	**Mobile Mammography Clinics**	* Partnership members living in areas lacking local imaging service providers for mammography screening

2026/2027 Population Health Manageme
Produced June 2026

NCQA/DHCS Risk Tier	Project/ Program	Service Description	Member Notification	Interactive (Y/N)
Keeping Members Healthy / Low Risk	**Medi-Cal for Kids and Teens (EPSDT) Awareness campaign**	Flyer informing members about DHCS approved materials sent to parents/guardians of all PHC members under the age of 21 outlining their benefits and rights, and how to access care. Can request materials by mail, phone, or access online.	Mailed information packet / Partnership Website	N
Keeping Members Healthy / Low Risk	**Routine Member Newsletters**	Includes general preventive and wellness material, benefit information, and provides contact information for Member Services, Care Coordination, and directs members to PHC's website for more information about preventive health and chronic care services.	USPS Mailing and email	N
Keeping Members Healthy / Low Risk	**Community Resource Connections**	Provide members with resources, track resources provided as applicable, and perform follow up outreach (closed loop referrals) to ensure resource(s) met member needs as applicable.	N/A	N
Keeping Members Healthy / Low Risk / Equity	**Mobile Mammography Clinics**	40+ clinic days in locations with poor access to mammography services.	clinic-based outreach	N

2026/2027 Population Health Manageme Produced June 2026			
NCQA/DHCS Risk Tier	**Project/ Program**	**How to Opt Out**	**Measure Goals**
Keeping Members Healthy / Low Risk	**Medi-Cal for Kids and Teens (EPSDT) Awareness campaign**	N/A	N/A
Keeping Members Healthy / Low Risk	**Routine Member Newsletters**	N/A	Newsletters are sent out **2 times per year**.
Keeping Members Healthy / Low Risk	**Community Resource Connections**	N/A	N/A
Keeping Members Healthy / Low Risk / Equity	**Mobile Mammography Clinics**	N/A	N/A

2026/2027 Population Health Manageme Produced June 2026				
NCQA/DHCS Risk Tier	**Project/ Program**	**Denominator**	**Numerator**	**Measurement Period**
Keeping Members Healthy / Low Risk	**Medi-Cal for Kids and Teens (EPSDT) Awareness campaign**	N/A	N/A	May 2023 and distributed annually in December thereafter
Keeping Members Healthy / Low Risk	**Routine Member Newsletters**	N/A	N/A	January 2026 - December 2026
Keeping Members Healthy / Low Risk	**Community Resource Connections**	N/A	N/A	January 2026 - December 2026
Keeping Members Healthy / Low Risk / Equity	**Mobile Mammography Clinics**	N/A	N/A	July 2026 - June 2027

2026/2027 Population Health Management Work Plan Produced June 2026		
NCQA/DHCS Risk Tier	**Project/ Program**	**Target Population / Inclusion / Exclusion**
Keeping Members Healthy / Low Risk	**School-Based Vaccination Education & Clinics**	* Middle-school event(s) in at least one middle-school with a high percentage of PHC members enrolled
Keeping Members Healthy / Low Risk	**School-Based Tobacco Prevention**	* Middle-school event(s) in at least two middle-schools with a high percentage of PHC members enrolled
Keeping Members Healthy / Low Risk	**Community Outreach / Engagement Events**	* Onsite presence of Partnership staff at community events where PHC members are likely to gather.

2026/2027 Population Health Manageme
Produced June 2026

NCQA/DHCS Risk Tier	Project/ Program	Service Description	Member Notification	Interactive (Y/N)
Keeping Members Healthy / Low Risk	**School-Based Vaccination Education & Clinics**	In-classroom education about the importance of adolescent vaccinations, an incentivized, interactive, activity, with some vaccination clinics offered during event.	N/A	N
Keeping Members Healthy / Low Risk	**School-Based Tobacco Prevention**	In-classroom education about the importance of not vaping followed up with an incentivized, interactive, activity.	N/A	N
Keeping Members Healthy / Low Risk	**Community Outreach / Engagement Events**	Partnership staff offer benefit education, resource referrals, and member surveys to gain insight into barriers and member priorities. Partnership staff attend at least 1-2 events per county per year weather permitting (approximately 150+ total events per year).	N/A	N

2026/2027 Population Health Manageme
Produced June 2026

NCQA/DHCS Risk Tier	Project/ Program	How to Opt Out	Measure Goals
Keeping Members Healthy / Low Risk	**School-Based Vaccination Education & Clinics**	N/A	Conduct 1 school-based health education sessions on vaccines.
Keeping Members Healthy / Low Risk	**School-Based Tobacco Prevention**	N/A	Conduct 3 school-based health education sessions on vaping.
Keeping Members Healthy / Low Risk	**Community Outreach / Engagement Events**	N/A	N/A

2026/2027 Population Health Manageme Produced June 2026				
NCQA/DHCS Risk Tier	**Project/ Program**	**Denominator**	**Numerator**	**Measurement Period**
Keeping Members Healthy / Low Risk	**School-Based Vaccination Education & Clinics**	Number of schools in which school based education for vaccines was conducted	Number of students who conducted pre and post test knowledge survey to measure knowledge increase	January 2026 - December 2026 (once on an annual basis)
Keeping Members Healthy / Low Risk	**School-Based Tobacco Prevention**	Number of schools in which school based education on vaping was conducted	Number of students who conducted pre and post test knowledge survey to measure knowledge increase	January 2026 - December 2026
Keeping Members Healthy / Low Risk	**Community Outreach / Engagement Events**	N/A	N/A	January 2026 - December 2026 (ongoing)

2026/2027 Population Health Management Work Plan Produced June 2026		
NCQA/DHCS Risk Tier	**Project/ Program**	**Target Population / Inclusion / Exclusion**
Keeping Members Healthy / Low Risk	**Health Equity/Disparity Community Events**	Pregnant members who self-identify as African American, Native American/Alaska Native, or Native Hawaiian/Pacific Islander
Moderate/ Rising Risk/ Emerging Risk (Moderate-Intensity Pregnancy)	**Perinatal Growing Together - Prenatal**	INCLUDE: * PHC members who have had a prenatal care visit in the past 12 months and * Delivered a baby at least 90 days prior to report run date EXCLUDE: * Individuals who were not PHC members when they delivered a baby

2026/2027 Population Health Manageme
Produced June 2026

NCQA/DHCS Risk Tier	Project/ Program	Service Description	Member Notification	Interactive (Y/N)
Keeping Members Healthy / Low Risk	**Health Equity/Disparity Community Events**	Maternity photo shoot: Intervention to address disparities in Solano County among Black, Alaska Native/Native American, and/or Hispanic pregnant individuals at about 20-30 weeks gestation. Aim to increase supportive community interactions and social support and promote various Partnership member benefits including Doula services, and Partnership's Growing Together Program through the provision of professional photography, makeup, and gifts.	Phone outreach to invite specific members	N
Moderate/ Rising Risk/ Emerging Risk (Moderate-Intensity Pregnancy)	**Perinatal Growing Together - Prenatal**	Welcome call when pregnancy is identified, reinforcement of prenatal care, educational materials, pre and post-partum depression screening, reminders for post-partum care and re-establishment with a PCP; incentives provided. Modified to include: * Reminders to attend all scheduled visits - if unable to attend, please work with	Telephone, informational mailers, mailed incentives, texting campaigns	Y

2026/2027 Population Health Manageme Produced June 2026			
NCQA/DHCS Risk Tier	**Project/ Program**	**How to Opt Out**	**Measure Goals**
Keeping Members Healthy / Low Risk	**Health Equity/Disparity Community Events**	Decline invitation	**1. Participation & Engagement.** **2. Access & Education.** # of referrals made to doula services or other maternal health services Surveys measuring maternal care experience **3. Satisfaction & Experience.** Photos captured and shared with consent (number of families photographed and received portraits) **4. Community Partnership & Visibility.** Press/media coverage (if applicable) **5. Equity & Inclusion. Demographic reach: were attendees reflective of the county's diverse populations?**
Moderate/ Rising Risk/ Emerging Risk (Moderate-Intensity Pregnancy)	**Perinatal Growing Together - Prenatal**	When member is called or texted, they will be given the opportunity to Opt Out of further contact	*** 80%** of members **engaged** in the program will have a Tdap vaccination in the 120 days prior to delivery * **35%** of **members engaged** in the program will have a flu vaccination at point during the pregnancy.

2026/2027 Population Health Manageme Produced June 2026				
NCQA/DHCS Risk Tier	**Project/ Program**	**Denominator**	**Numerator**	**Measurement Period**
Keeping Members Healthy / Low Risk	**Health Equity/Disparity Community Events**	* Number of invited members * Number of attendees total * Number of attendees who expressed a need or interest in services * Number of members who enrolled in GTP * Number of Surveys measuring maternal care experience administered * Number of surveys measuring event satisfaction administered	# of attendees (pregnant Medi-Cal members) # of attendees who received doula benefit information # of referrals made to doula services or other maternal health services # Surveys measuring maternal care experience completed % of participants reporting satisfaction with the event # of new or strengthened partnerships with local CBOs, doula collectives, clinics Social media reach (if photos/stories shared with consent): impressions, likes, shares	January 2026 - December 2026 (approximately 3 events per year)
Moderate/ Rising Risk/ Emerging Risk (Moderate-Intensity Pregnancy)	**Perinatal Growing Together - Prenatal**	PHC members who had at least one prenatal care visit and delivered a baby during the measurment period.	Of denominator, those who had a Tdap during the measurement period.	Deliveries Jan 2026 - Dec 2026 Tdap Sept 2025-Dec 2026
		PHC members who had at least one prenatal care visit and delivered a baby during the measurement period.	Of denominator, those who had a Flu shot during the measurement period.	Deliveries Jan 2026 - Dec 2026 Flu Vaccine Aug 2025-Dec 2026

2026/2027 Population Health Management Work Plan Produced June 2026		
NCQA/DHCS Risk Tier	**Project/ Program**	**Target Population / Inclusion / Exclusion**
Moderate / Rising Risk/ Emerging Risk (Moderate-Intensity Pregnancy)	**Perinatal Growing Together - Post-Partum**	INCLUDE: *PHC members who delivered a baby in the 2026 Calendar year EXCLUDE: * Individuals who were not PHC members when they delivered a baby

NCQA/DHCS Risk Tier	Project/ Program	Service Description	Member Notification	Interactive (Y/N)
		provider to reschedule		
Moderate / Rising Risk/ Emerging Risk (Moderate-Intensity Pregnancy)	**Perinatal Growing Together - Post-Partum**	Welcome call when member has delivered and been identified, educational materials, post-partum depression screening, reminders for post-partum care and re-establishment with a PCP, initiating well-child visits for their babies; incentives provided. Modified to include: * Reminders to attend all scheduled visits - if unable to attend, please work with provider to reschedule	Telephone, informational mailers, mailed incentives, texting campaigns	Y

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NCQA/DHCS Risk Tier	**Project/ Program**	**How to Opt Out**	**Measure Goals**
			* **80%** of **moms engaged** in the program will attend a post-partum visit within 60 days of delivery
			* **70% of babies linked to moms** engaged in the program will attend a well-child visit within 60 days of birth
Moderate / Rising Risk/ Emerging Risk (Moderate-Intensity Pregnancy)	**Perinatal Growing Together - Post-Partum**	When member is called or texted, they will be given the opportunity to Opt Out of further contact	*** 35%** of members **referred** to the program will be **engaged** in the post-partum program
			* **75%** of moms **engaged** in the program will attend a post-partum visit within 60 days of delivery
			* **70%** of **babies linked to moms** engaged in the program will attend a well-child visit within 60 days of birth

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NCQA/DHCS Risk Tier	**Project/ Program**	**Denominator**	**Numerator**	**Measurement Period**
		PHC members who had at least one prenatal care visit and delivered a baby during the measurement period.	Of denominator, the percentage of moms who attended a post-partum visit within 60 days of delivery	Deliveries Jan 2026 - Nov 2026
		PHC members who had at least one prenatal care visit and delivered a baby during the measurement period and baby is linked to birth mom	Of denominator, the percentage of linked babies who attended a well-child visit within 60 days of birth	Deliveries Jan 2026 - Nov 2026
Moderate / Rising Risk/ Emerging Risk (Moderate-Intensity Pregnancy)	**Perinatal Growing Together - Post-Partum**	PHC members who delivered a baby during the measurement period.	Of denominator, those who were engaged in the program	Deliveries Jan 2026 - Nov 2026
		PHC members who delivered a baby during the measurement period.	Of denominator, the percentage of moms who attended a post-partum visit within 60 days of delivery	Deliveries Jan 2026 - Nov 2026
		PHC members who delivered a baby during the measurement period **and** baby is linked to birth mom	Of denominator, the percentage of linked babies who attended a well-child visit within 60 days of birth	Deliveries Jan 2026 - Nov 2026

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NCQA/DHCS Risk Tier	Project/ Program	Target Population / Inclusion / Exclusion
Moderate / Rising Risk/ Emerging Risk	**Disaster Preparedness**	INCLUDE: * Any Partnership member
Moderate / Rising Risk/ Emerging Risk	**BPHM - Asthma Control / Improvement Program**	* PHC members 5-65 who have a recent (<7 days) ED event with a primary diagnosis of asthma
Moderate / Rising Risk/ Emerging Risk	**BPHM - Hypertension Lifestyle Control Program Management**	* PHC members 18-85 with a new diagnosis of hypertension AND self-identify as African American and/or Native American/Alaskan Native and/or Pacific Islander

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NCQA/DHCS Risk Tier	**Project/ Program**	**Service Description**	**Member Notification**	**Interactive (Y/N)**
Moderate / Rising Risk/ Emerging Risk	**Disaster Preparedness**	Booklets posted online as part of distributing information on how to prepare for emergencies with local resources available to support the vulnerable community. Option to call in for further information and local links.	Posted to website	N
Moderate / Rising Risk/ Emerging Risk	**BPHM - Asthma Control / Improvement Program**	If a member calls in after receiving the program flyer, then a pharmacists will consult member/member's guardian on priorities of asthma self-management. • Educate member of different roles of asthma medications and inhaler technique • Educate member to identify asthma triggers and how to avoid asthma flare ups • Educate member to work with their PCP to develop an asthma action plan	Mailed letter, mailed information upon request	N
Moderate / Rising Risk/ Emerging Risk	**BPHM - Hypertension Lifestyle Control Program Management**	If a member calls in after receiving a text, PHM staff -offer Healthy Living Tools and lifestyle coaching to promote wellness and disease management using the hypertension action plan.	Texting campaigns	N

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NCQA/DHCS Risk Tier	**Project/ Program**	**How to Opt Out**	**Measure Goals**
Moderate / Rising Risk/ Emerging Risk	**Disaster Preparedness**	N/A	N/A
Moderate / Rising Risk/ Emerging Risk	**BPHM - Asthma Control / Improvement Program**	N/A	N/A
Moderate / Rising Risk/ Emerging Risk	**BPHM - Hypertension Lifestyle Control Program Management**	When member is texted, they will be given the opportunity to Opt Out of further contact	N/A

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NCQA/DHCS Risk Tier	**Project/ Program**	**Denominator**	**Numerator**	**Measurement Period**
Moderate / Rising Risk/ Emerging Risk	**Disaster Preparedness**	N/A	N/A	January 2026 - December 2026
Moderate / Rising Risk/ Emerging Risk	**BPHM - Asthma Control / Improvement Program**	N/A	N/A	January 2026 - December 2026
Moderate / Rising Risk/ Emerging Risk	**BPHM - Hypertension Lifestyle Control Program Management**	N/A	N/A	January 2026 - December 2026

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NCQA/DHCS Risk Tier	Project/ Program	Target Population / Inclusion / Exclusion
Moderate / Rising Risk/ / Emerging Risk	**BPHM - Diabetes Management Program**	* PHC members between the ages of 21-44 who either have a new diagnosis of diabetes or an A1C of >8.0 or who have not received an A1C test in the last year AND self-identify as African American and/or Native American/Alaskan Native and/or Pacific Islander
Moderate / Rising Risk/ Emerging Risk	**BPHM Depression Management Program**	* PHC members ages 21 years and older that have had a recent diagnosis of stroke or myocardial infraction within the past 90 days and who may be experiencing symptoms of depression

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NCQA/DHCS Risk Tier	Project/ Program	Service Description	Member Notification	Interactive (Y/N)
Moderate / Rising Risk/ / Emerging Risk	**BPHM - Diabetes Management Program**	If a member calls in after receiving a text, PHM staff offer Healthy Living Tools and lifestyle coaching to promote wellness and disease management using the diabetes action plan.	Texting campaigns	N
Moderate / Rising Risk/ Emerging Risk	**BPHM Depression Management Program**	PHM staff will reach out to members and offer Healthy Living Tools and lifestyle coaching to promote wellness and lifestyle management using the depression management action plan.	Telephone, mailed letter, mailed information upon request	Y

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NCQA/DHCS Risk Tier	**Project/ Program**	**How to Opt Out**	**Measure Goals**
Moderate / Rising Risk/ / Emerging Risk	**BPHM - Diabetes Management Program**	When member is texted, they will be given the opportunity to Opt Out of further contact	N/A
Moderate / Rising Risk/ Emerging Risk	**BPHM Depression Management Program**	When member is called, they will be given the opportunity to Opt Out of further calls	50% of members engaged in the program *and who stay engaged for at least 60 days and* complete a chronic disease survey will give a score of 3 on a Likert scale in response to the following statement “After working with the PHC staff member, I have a better understanding of how to manage my condition" (1 = Disagree; 2 = Neutral; 3 = Agree).

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NCQA/DHCS Risk Tier	**Project/ Program**	**Denominator**	**Numerator**	**Measurement Period**
Moderate / Rising Risk/ / Emerging Risk	**BPHM - Diabetes Management Program**	N/A	N/A	January 2026 - December 2026
Moderate / Rising Risk/ Emerging Risk	**BPHM Depression Management Program**	Members **engaged** in the Depression Management program and responded to survey	Members who respond to post-intervention survey questions and responded with agreed or strongly agreed	January 2026 - December 2026

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NCQA/DHCS Risk Tier	Project/ Program	Target Population / Inclusion / Exclusion
Outcomes Across Settings / Transitions of Care	**Transitional Care Services (not pregnant or postpartum)**	• High-risk PHC members who are discharged from one setting or level of care to another identified as: • Those with LTSS needs • Children with Special Health Care Needs (CSHCN) • Pregnant individuals, including discharges related to the delivery. • Seniors and persons with disabilities who meet the definitions of “high-risk” established in existing APL requirements • Members who have been authorized to receive: * IHSS greater than, or equal to, 195 hours per month; * Community-Based Adult Services (CBAS), and/or * Multipurpose Senior Services Program (MSSP) Services. • Those that have been on oxygen within the past 90 days • Those residing in an acute hospital setting • Those that have been hospitalized within the last 90 days or have had three or more hospitalizations within the past year • Have had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g., multiple prescriptions consistent with the diagnosis of chronic diseases • Members assessed as high-risk by Partnership's RSST • Any member who has been served by the county 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 the MCP or discharging facility. • Any member transitioning to or from a SNF • 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.

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NCQA/DHCS Risk Tier	Project/ Program	Service Description	Member Notification	Interactive (Y/N)
Outcomes Across Settings / Transitions of Care	**Transitional Care Services (not pregnant or postpartum)**	Care Coordination staff contact members discharging home after a hospital stay within 7 days of discharge in order to: • Ensure discharge planning services have been rendered and are in receipt of the discharging facility's discharge summary, • Ensure any new medications have been obtained and medication reconciliation have been conducted • Coordinate referrals/authorizations for appropriate services/providers (including transitioning from non-capitated into capitated services), including eligibility and referral to ECM/CS or CCM, • Ensure member obtains and attends a follow-up appointment following discharge from hospital, and • Ensure member received and understands discharge instructions Telephone and Letter by USPS.	Telephone & USPS Letter	Y

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NCQA/DHCS Risk Tier	**Project/ Program**	**How to Opt Out**	**Measure Goals**
Outcomes Across Settings / Transitions of Care	**Transitional Care Services (not pregnant or postpartum)**	After program purpose is explained, member may decline to participate, and this choice is documented in the case management system. TCS services that do not require member participation will continue even after member declines.	Adult member satisfaction with Transition of Care services per annual Transitions of Care satisfaction survey summary will be at least **75% positive / average score of 2.5** on survey responses.

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NCQA/DHCS Risk Tier	**Project/ Program**	**Denominator**	**Numerator**	**Measurement Period**
Outcomes Across Settings / Transitions of Care	**Transitional Care Services (not pregnant or postpartum)**			January 2026 - December 2026

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NCQA/DHCS Risk Tier	Project/ Program	Target Population / Inclusion / Exclusion
Multiple Chronic Conditions / High Risk	**Complex Case Management**	PHC Members of any age who meet one of the following criteria for enrollment: 1. Having barriers to managing their care without the support of CCM, (e.g., poor support systems, fragmented care, health literacy barriers), **or** 2. Having one (1) or more California Children's Services (CCS)-eligible conditions and requiring the support of an individualized care plan; **or** 3. High-risk members new to PHC who are identified as Seniors and Persons with Disability (SPD) , according to the parameters outlined in policy MCCP 2019 Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services **or** 4. Having two (2) or more chronic medical conditions (e.g. CKD, COPD, CHF, DM, HTN, hyperlipidemia), or an unmanaged chronic condition like asthma or diabetes, and requiring the support of an individualized care plan; **or** 5. Having at least one hospitalization and have a mental or behavioral health component that requires urgent stabilization and/or collaboration with County Mental Health Services to support the member's overall wellness. Examples include members who have eating disorders or substance use disorders.
Multiple Chronic Conditions / High Risk	**High Risk (High Intensity) Pregnancies**	INCLUDE: *PHC members who have a high-risk pregnancy diagnosis and self-identify as Native American/Alaska Native

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NCQA/DHCS Risk Tier	Project/ Program	Service Description	Member Notification	Interactive (Y/N)
Multiple Chronic Conditions / High Risk	**Complex Case Management**	CC licensed staff engage member to perform a comprehensive assessment, clarify member/caregiver's goals and desired level of involvement, and develop an individualized care plan to overcome barriers to care and to support the member/caregiver in reaching his/her wellness goals. Individual goals are time-bound; however, a member may remain in complex case management for an extended period of time to ensure the member gets the care he/she needs. Telephone and Letter by USPS.	Telephone & USPS Letter	Y
Multiple Chronic Conditions / High Risk	**High Risk (High Intensity) Pregnancies**	CC staff engage member to perform an assessment, clarify member's goals and desired level of involvement, and develop an individualized care plan to overcome barriers to care and to support the member through pregnancy and delivery. If clinical needs are identified at any point while working with the member, a nurse consult can be requested.	Telephone & USPS Letter	Y

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NCQA/DHCS Risk Tier	**Project/ Program**	**How to Opt Out**	**Measure Goals**
Multiple Chronic Conditions / High Risk	**Complex Case Management**	After program purpose is explained, member may decline to participate, and this choice is documented in the case management system. CC staff may begin coordination of services for a member while he/she is hospitalized/ unable to participate in a full CCM assessment; however, once the member is stabilized, CC staff will contact the member to perform the assessment, and he/she will be given the option of participation in ongoing case management. The member may opt out at any time and this choice is documented in the case management system.	Pediatric member satisfaction with Complex Case Management services per annual Complex Case Management satisfaction survey summary will be at least **75% positive / average score of 2.5** on survey responses.
			Adult member satisfaction with Complex Case Management services per annual Complex Case Management satisfaction survey summary will be at least **75% positive / average score of 2.5** on survey responses.
Multiple Chronic Conditions / High Risk	**High Risk (High Intensity) Pregnancies**	When member is called, they will be given the opportunity to Opt Out of further calls	* **80%** of moms **engaged** in the program will attend 2 post-partum visits within 60 days of delivery

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NCQA/DHCS Risk Tier	**Project/ Program**	**Denominator**	**Numerator**	**Measurement Period**
Multiple Chronic Conditions / High Risk	**Complex Case Management**			January 2026 - December 2026
				January 1, 2026 - December 31, 2026
Multiple Chronic Conditions / High Risk	**High Risk (High Intensity) Pregnancies**	PHC members who had at least one prenatal care visit in the 12 months prior to report run date **and** who delivered a baby at least 90 days prior to report run date	Of denominator, the percentage of moms who attended two post-partum visit within 60 days of delivery	January 1, 2026 - December 31, 2026