



PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE MEETING NOTICE

FROM: Leslie Erickson, Program Coordinator II, Quality Improvement
DATE: June 13, 2025
SUBJECT: Quality/Utilization Advisory Committee (Q/UAC) Meeting

The California Public Health Emergency has ended and Q/UAC has now returned to in-person meetings per Brown Act guidelines. Meeting locations (and call-in information for Partnership staff only) are below and 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 – 8:55 a.m., Wednesday, June 18, 2025

Meeting Locations:

Partnership HealthPlan of California

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

Other Locations:

Open Door Community Health Center, 3770 Janes Road, Arcata
Chapa-de Indian Health: 11670 Atwood Road, Auburn

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

Partnership Offices: Please use the QUAC Partnership HealthPlan's Personal Room in WebEx

<https://partnershiphp.webex.com/meet/quac> | 809114256 (Need assistance? Contact IT at least one (1) day prior to the meeting.)

Voting Members:

Choudhry, Sara, MD
Gwiazdowski, Steven, MD, FAAP
Hackett, Emma, MD, FACOG
Lane, Brandy, PHC Consumer Member

Luu, Phuong, MD
Montenegro, Brian, MD
Mulligan, Meagan, FNP-BC
Murphy, John, MD
Quon, Robert, MD, FACP

Strain, Michael, PHC Consumer Member
Swales, Chris, MD
Thomas, Randolph, MD
Wilson, Jennifer, MD, MPH

PHC Staff (Ex-Officio) Members:

Barresi, Katherine, RN, BSN, PHN, NE-BC, Chief Health Equity Officer
Bides, Robert, RN, BSN, Mgr, Member Safety-Quality Investigations, QI
Bontrager, Mark, Sr. Director of Behavioral Health, Behavioral Health
Cotter, James, MD, Associate Medical Director
Cox, Bradley, DO, Regional Medical Director, Northeast
DeVido, Jeffrey, MD, Behavioral Health Clinical Director
Esget, Heather, BSN, ACM-RN, Director of Utilization Management
Frankovich, Terry, MD, Associate Medical Director
Gast, Brigid, MSN, BS, RN, NEA-BC, Sr. Director of Care Management
Glickstein, Mark, MD, Associate Medical Director
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
Moore, Robert, MD, MPH, MBA, Chief Medical Officer (Chair)
Netherda, Mark, MD, Medical Director for Quality (Vice Chair)
Newman, Rachel, RN, BSN, Manager, Clinical Compliance - Inspections
O'Connell, Lisa, MHA, Director, Enhanced Health Services
Randhawa, Manleen, Senior Health Educator, Population Health
Ribordy, Jeff, MD, MPH, FAAP, Regional Medical Director, Northwest
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Spiller, Bettina, MD, Associate Medical Director
Steffen, Nancy, Senior Dir. of Quality and Performance Improvement
Thornton, Aaron, MD, Associate Medical Director
Townsend, Colleen, MD, Regional Medical Director, Southeast
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
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, MHA/MBA, Director of Quality Management, QI
Brunkal, Monika, RPh, Associate Director of Population Health
Campbell, Anna, Policy Analyst, Utilization Management
Davis, Wendi, Chief Operations Officer
Devan, James, Manager of Performance Improvement, QI (NR)
Durst, Jennifer, Sr Mgr of Performance Improvement, QI (SE/SW)
Escobar, Nicole, S, Mgr of Behavioral Health, Behavioral Health
Friedman, Greg Allen, Project Coordinator II, Pop Health
Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
Gual, Kristine, Director of Quality Measurement, QI
Harrell, Briia, Project Manager I, Configuration

Innes, Latrice, Manager of Grievance & Appeals Compliance
Isola, Brandy, Mgt of Performance Improvement, QI (Chico/Auburn)
Jarrett-Lee, Kevin, RN, Associate Director, UM
Kerlin, Mary, Senior Director of Provider Relations
Klakken, Vicki, Regional Director, Northwest
Kubota, Marshall, MD, Associate Medical Director
McCune, Amy, MPH, MS, Manager of Quality Incentive Programs, QI
Morris, Matthew, MD, Regional Medical Director, Auburn
Nakatani-Phipps, Stephanie, Manager of Provider Relations Reps
Payumo, Desiree, RM, Manager of UM
Power, Kathryn, Regional Director, Southeast
Quichocho, Sue, Manager of Quality Improvement, QI
Sharp, Tim, Regional Director, Northeast
Smith, Christine, Community Health Needs Liaison, Pop Health
Stark, Rebecca, Regional Director, Chico

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

Date: June 18, 2025

Time: 7:30 – 8:55 a.m.

Locations: Partnership HealthPlan of California

4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano Room
2525 Airpark Drive, Redding, CA 96002 | Trinity Alps Conference Room
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Partnership Staff only may join by Web-ex:

<https://partnershiphp.webex.com/meet/quac> Meeting # 809 114 256

Partnership Staff only may join by Telephone:

1-844-621-3956 Access Code: 809 114 256

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

Welcome / Introductions / Public welcome at cited locations

	Item	Lead	Time	Page #
I.	Call to Order – Welcome/Introductions/Announcements/Approval/Acceptance of Minutes			
1	Approval of May 21 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD, MPH, MBA	7:30	5 – 18
2	Acknowledgment and acceptance of draft minutes of the - May 13 Internal Quality Improvement (IQI) Committee - May 22 Member Grievance Review Committee (MGRC) - April 30 Over/Under Utilization Workgroup			19 – 44
II.	Standing Updates			
1	Quality and Performance Improvement Program Update	Nancy Steffen	7:35	45 – 55
2	HealthPlan Update	Robert Moore, MD	7:40	57 – 59
III.	Old Business – None			
IV.	New Business – Consent Calendar			
	Consent Calendar	All	7:45	61
	G&A PULSE Report / Issue 17 / June 2025			63 – 73
Health Services Departments	Care Coordination			
	MCCP2024 – Whole Child Model for California Children’s Services (CCS)			75 – 95
	MPCP2014 – Continuity of Care – <i>new policy number and title change (“Medi-Cal” dropped) as policy will now apply to Medicare too. The policy is bundled here without Attachment C (400 pages of codes).</i>			97 – 136
	Population Health			
	MCNP9004 – Regulatory Required Notices (NEW Title)			137 – 151
	MPNP9007 – Lactation Policy and Guidelines – <i>the former MCCP2020 in CC is archived on p. 161</i>			153 – 160
	MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program – <i>the former MCCP2021 in CC in archived on p. 173</i>			169 – 172

	Item	Lead	Time	Page #
Health Services Departments	Quality Improvement			
	MPQP1004 – Internal Quality Improvement Committee			177 – 180
	MPQP1008 – Conflict of Interest Policy for QI Activities			181 – 183
	MPXG5009 – Lactation Clinical Practice Guideline			184 – 188
	Utilization Management			
	MCUG3134 – Hospital Bed/Specialty Mattress Guidelines			189 – 193
	MCUP3044 – Urgent Care Services			195 – 197
	MPUG3010 – Chiropractic Services – <i>previously MCUG3010</i>			198 – 200
	MPUP3014 – Emergency Services			201 – 208
	MPUP3039 – Direct Members – <i>previously MCUP3039</i>			209 – 221
	MPUP3111 – Pulmonary Rehabilitation – <i>previously MCUP3111</i>			223 – 228
	V.			New Business – Discussion Policies
	Synopsis of Changes		--	229 – 233
CC	MCCP2036 – Memorandum of Understanding (MOU) Requirements for Medi-Cal Managed Care Plans and Third-Party Entities – NEW POLICY – <i>the 12 attachments are not included in this packet. All executed MOUs are available on the Partnership website at: https://www.partnershiphp.org/About/Pages/MOU-Documents.aspx</i>	Shannon Boyle, RN	7:50	235 – 239
UM	MCUP3041 – Treatment Authorization Request (TAR) Review Process	Tony Hightower, CPhT	7:54	241 – 260
	MPUP3139 – Criteria and Guidelines for Utilization Management – <i>previously MCUP3139</i>		7:58	261 – 265
PHM	MPND9001 – Population Health Management Strategy & Program Description – <i>previously MCND9001 – clean copy begins on p. 323</i>	Greg Allen Friedman	8:02	267 – 322
	MPND9002 – Cultural & Linguistic Program Description – <i>previously MCND9002 – clean copy begins on p. 417</i>	Christine Smith	8:06	371 – 416
VI.	Presentations			
1	Population Health Management Grand Analysis – <i>PowerPoint presentation begins on p. 445</i> • Population Health Management 2024 Program Impact Analysis (<i>pp. 471 – 510</i>) • Population Segmentation (<i>pp. 511 – 519</i>)	DeLorean Ruffin, DrPH	8:10	445 – 519
2	Annual Review of UM and InterQual® Criteria – <i>demonstration by Desiree Payumo, RN, Manager of UM</i>	Tony Hightower Anna Campbell	8:28	521 – 558
3	Grievance & Appeals Department Annual Report CY 2024	Kory Watkins, MBA-HM	8:45	559 – 576
VII.	PHM Work Plan Final Update			577 – 579
FYI	Adjournment scheduled for 8:55 a.m. Q/UAC next meets 7:30 a.m. Wednesday, Aug. 20, 2025 – NO MEETING IN JULY			

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES**

Quality and Utilization Advisory Committee (Q/UAC) Meeting
Wednesday, May 21, 2025 / 7:34 a.m. – 8:55 a.m. Napa/Solano Room, 1st Floor

May is Mental Health Month

<u>Voting Members Present:</u>		
Sara Choudhry, MD	Brian Montenegro, MD	Michael Strain, PHC Consumer Member
Emma Hackett, MD, FACOG	Meagan Mulligan, FNP-BC	Chris Swales, MD
	John Murphy, MD	Randolph Thomas, MD
	Robert Quon, MD, FACP	Jennifer Wilson, MD
<u>Voting Members Absent:</u> Steven Gwiazdowski, MD, FAAP; Brandy Lane, PHC Consumer Member; Phuong Luu, MD		
<u>Partnership Ex-Officio Members Present:</u>		
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	
Cotter, James, MD, Associate Medical Director	Netherda, Mark, MD, Medical Director for Quality – Vice Chair	
Cox, Bradley, DO, Regional Medical Director (Northeast)	Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections	
DeVido, Jeff, MD, Behavioral Health Clinical Director	O’Connell, Lisa, Director, Enhanced Health Services	
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management	Randhawa, Manleen, Senior Health Educator, Population Health	
Glickstein, Mark, MD, Associate Medical Director	Ribordy, Jeff, MD, Regional Medical Director (Northwest)	
Hightower, Tony, CPhT, Associate Director, UM Regulations	Ruffin, DeLorean, DrPH, Director of Population Health	
Jalloh, Mohamed “Moe”, Pharm.D, Dir. of Health Equity (Health Equity Officer)	Spiller, Bettina, MD, Associate Medical Director	
Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination	Steffen, Nancy, Senior Director of Quality and Performance Improvement	
Jones, Kermit, MD, JD, Medical Director for Medicare Services	Thornton, Aaron, MD, Associate Medical Director	
Katz, Dave, 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	
<u>Partnership Ex-Officio Members Absent:</u>		
Esget, Heather, RN, BSN, ACM, Director of Utilization Management	Guillory, Ledra, Senior Manager of Provider Relations Representatives	
Frankovich, Terry, MD, Associate Medical Director	Kerlin, Mary, Senior Director of Provider Relations	
<u>Guests:</u>		
Bontrager, Mark, Senior Director, Behavioral Health	Escobar, Renee, Senior Manager of Behavioral Health	
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance	Gaul, Kristine, PMO, CPHQ, Director of Quality Measurement, QI	
Brown, Isaac, MBA/MHA, Director of Quality Management, QI	Hooper, Jacques’	
Brunkal, Monika, Associate Director, Population Health	Jarrett-Lee, Kevin, RN, Associate Director of UM	
Campbell, Anna, Health Policy Analyst, Utilization Management	Matthews, Richard “Doug,” MD, Regional Medical Director, Chico	
Chebolu, Radha, Senior Health Data Analyst II, Finance	Morris, Matthew, MD, Regional Medical Director, Auburn	
Devan, James, Manager of Performance Improvement (Redding)	Nakatani-Phipps, Stephanie, Lead Senior Provider Relations Rep, PR	
Durst, Jennifer, Senior Manager of Performance Improvement, QI	Robertello, Kimberly, Senior Medicare QI Program Manager, QI	
Erickson, Leslie, Program Coordinator II, QI (scribe)	Romero, Liz, Improvement Advisor, QI	
	Smith, Christine, Community Health Needs Liaison, Population Health	
	Stone, Kelly, RN, Director of Care Coordination	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – <i>none made</i> Introductions – <i>none made</i> Approval of Minutes	Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 7:34 a.m. The April 16, 2025 Q/UAC Minutes were approved as presented without comment. <i>Acknowledgment and acceptance of draft meeting minutes of the</i> April 8 Internal Quality Improvement (IQI) Committee	Motion to approve the Q/UAC minutes: Robert Quon, MD Second: Jennifer Wilson, MD <i>Approved unanimously</i> Motion to accept IQI minutes: Robert Quon, MD Second: Meagan Mulligan, FNP <i>Approved unanimously</i>
II. Standing Updates		
1. Quality Improvement (QI) Department Update <i>Nancy Steffen, Senior Director of Quality and Performance Improvement, QI</i>	- In light of this being Behavioral Health month, I want to update our State work we refer to as PIPs or Performance Improvement projects that are typically run over an 18-month to two-year cycle. We’ve been working with Open Door to help improve follow-up after ED visits for mental health (FUM) and follow-up after ED visits for substance use abuse (FUA). This is proving to be a good learning in terms of making sure the primary care site can see the discharge on the ED side and then do timely follow-up with our members, and the data collection process is proving out nicely. Open Door has agreed to continue working directly with this pilot over the next year. We aim to spread these learnings as they take shape to our Federally Qualified Health Center- (FQHC) based primary care network. - We also continue to work closely with the Behavioral Health team, who is presenting today on other efforts under our Behavioral Health Focus Quality Measure Score Improvement (QMSI) work group. I’ll leave them to speak to those in more detail. - We have been providing updates for the last year, year-and-one-half, around the Equity and Practice Transformation project. We have had great participation from the 27 provider organizations invited by the Department of Health Care Services (DHCS) to continue to participate even after some budget refinements occurred about a year ago. By May 1, they each had completed another round of six deliverables that were due from practices as of day one. We are really pleased to see this ongoing commitment and participation. It’s helping us learn in partnership with them on opportunities to drive improvements, particularly in preventative care and chronic disease measure sets, and data infrastructure opportunities to improve capacity. - As you will recall from previous reports, the small, short (about four weeks with four primary care organizations of varying size) locum tenens pilot last fiscal year was a success, both in increasing capacity and giving our members access to the provider of their choice. We have received approval to continue this, now referring to it as the “Preventative Care Bridge Project,” wherein we will continue on a broader scale for a longer cycle of three months. We are working with some new provider organizations, and our goal is to further our learnings from pilot one. We want to refine the strategies we are seeing as potential improvement around preventative care screenings that otherwise often are not the focus of local providers when they are brought into an organization. We saw some good returns when we	<i>For information only: no formal action required.</i> There were no questions.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	asked our pilot participants to focus on well child visits, especially in the adolescent range, and in cervical cancer screenings. I conclude with an update of the nomenclature in our Member Safety team, particularly our Inspections team focused on site reviews. Back in July 2024, Partnership took on managed care program responsibilities (i.e., specific trainings that had been the responsibility of the counties) for the Child Health and Disability Prevention Program, often referred to as CHDP. As a Managed Care Plan (MCP) Partnership has rebranded these for the future as a Comprehensive Health Intervention for Lifelong Development (CHILD), focused on children and adolescent populations. This is coupling nicely with our periodic site review process so providers would see these trainings come forward every three years.	
2. HealthPlan Update <i>Robert Moore, MD Chief Medical Officer</i>	- There is much going on in both Washington and the State. CEO Sonja Bjork has put together a brief summary and things were evolving even last night as the House Rules Committee was busy working on their budget. The main components of the federal proposal in the House of Representatives includes several aspects that could impact Medicaid – Medi-Cal in California. - The first is a freeze on provider taxes such as the Managed Care Organization (MCO) tax, that would freeze taxes at current levels and would prohibit establishing new taxes. It would impact reimbursement of hospitals and other providers. This will stop the ability to use new intergovernmental transfer (IGT) funds to help support entities such as local ambulance companies and other tax districts. It's also possible that it would impact Prop. 35. - The second is the work requirement where able bodied adults without any dependents would have to work at least 80 hours a month or perform other activities such as community services: the recommendation as of last week was to have that be implemented in 2029, giving the states time to activate monitoring systems. This is a small number of persons in Medi-Cal but this requirement would lead persons to fall out of coverage. - Third is the eligibility verification for the adult expansion population would happen every six months instead of annually. That would begin in October 2027 and is projected to save money because persons no longer meet the eligibility requirements. - Lastly, is a federal funding penalty for the States: like California that chose to cover individuals with unsatisfactory immigration status. The Centers for Medicare and Medicaid Services (CMS) would reduce the federal match for the Medicaid by 10%, beginning in 2027. - Then there is the Governor's May 2025 budget revise. A \$12 billion deficit is projected, partly due to current estimates of current spending based on what has been approved. The federal shortfall is anticipated to increase that deficit. - One of the proposals is to add some requirements for those with unsatisfactory immigration status, including a premium or a monthly premium instead of straight Medi-Cal and a freezing of new individuals who would qualify for that. That's the Governor's proposal. - There are other things, such as the elimination of acupuncture. Adult dental too may be affected. These are just proposals and nothing has happened yet. - In the Partnership realm, Behavioral Health Clinical Director Jeff DeVido, MD, will be doing a June 6 webinar on nitrous oxide overuse. It will be in my next Medical Directors newsletter.	<i>For information only: no formal action required.</i> There were no questions. <i>Meeting Postscripts:</i> - As promised at Q/UAC April 16, the most recent Member Newsletter was distributed to Q/UAC voters attending in Fairfield May 21. Thos who did not get a copy but would like one, should email Leslie Erickson. - The May Medical Directors Newsletter was distributed to Q/UAC clinicians via email at the end of May. On June 2, Partnership CEO Sonja Bjork sent an email to all staff that Partnership Advantage is now delayed until Jan. 1, 2027 because of continuing issues with replacing our core claims system.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	- The last annual regional meeting with medical leaders throughout the primary care network just completed earlier this month in Marysville. Details are now posted on Partnership’s website in two versions, one of which is on the CMO page. The longer, 120-page version is a good reference document to keep available. - We have a number of policies today because we are working hard to accelerate our slate of policies for Partnership Advantage, adapting them to be applicable to both Medi-Cal and Medicare. - The Board of Commissioners had its strategic planning retreat in April. The current strategic priorities are for Partnership to be a champion of local partnerships, to be a catalyst for health equity and quality, and to extend our reach, including via Partnership Advantage. The Board remains very supportive of the core activities and those values: local engagement, while not a regulatory mandate, is a high priority to maintain.	
III. Old Business – None		
IV. New Business – Consent Calendar (Committee Members as Applicable)		
Consent Calendar	G&A PULSE Report / Issue 16 / April 2025 – <i>Wellness & Recovery article included</i> <u>Health Services Policies</u> <u>Behavioral Health</u> is now a Health Services department (formerly in Administration) now taking ownership of three policies transferring today from other departments: MPBP8005 – Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services – the previous ADM52 is now archived in Administration MPBP8013 – Eating Disorder Management Policy – the previous MCUP3145 is now archived in UM <u>Enhanced Health Services</u> MPAP7004 – Community Health Worker (CHW) Services Benefit – the previous MCCP2033 is now archived in Care Coordination MPAP7005 – Street Medicine – the previous MCUP3146 is now archived in UM <u>Quality Improvement</u> MCQP1052 – Physical Accessibility Review Survey SR Part C – new attachment B replaces the old MPQP1038 – Physician Orders for Life-Sustaining Treatment (POLST) MPQP1047 – Advance Directives – previously MCQP1047 MPQP1055 – Provider Preventable Condition (PPC Reporting) MPXG5003 – Major Depression in Adults Clinical Practice Guidelines <u>Utilization Management</u> MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions MPUG3025 – Insulin Infusion Pump and Continuous Glucose Monitor Guidelines MPUG3031 – Nebulizer Guidelines MPUG3110 – Evaluation and Management of Obstructive Sleep Apnea in Adults – previously MCUG3110 MPUP3047 – Tuberculosis Related Treatment – previously MCUP3047	Motion to approve slate as presented: Brian Montenegro, MD Second: Meagan Mulligan. FNP <i>Approved unanimously</i> <u>Next Steps:</u> June 11 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	MPUP3136 – Fecal Microbiota Transplant (FMT) – <i>previously MCUP3136</i> MPUP3144 – Residential Substance Use Disorder Treatment Authorization – <i>previously MCUP3144</i> <u>Non-Health Services Department – Network Services</u> MPNET100 – Access Standards and Monitoring	
V. New Business – Discussion Policies – Note: On June 2 Partnership CEO Sonja Bjork, JD, announced that D-SNP would be put off by a year. Thus, the effective dates below have been changed from Jan. 1, 2026 to Jan. 1, 2027.		
Policy Owner: Quality Improvement – Presenter: Rachel Newman, RN, Manager of Clinical Compliance, QI		
MCQP1025 – Substance Use Disorder (SUD) Facility Site Review and Medical Record Review	C1 and C2 – Added three new sections on the Facility Site Review Tool and Medical Record Tool: Telehealth, Peer Support Services and Adolescent services. VI.E.3: A reduced number of medical records may be reviewed at the discretion of the plan based on actual services. VI.F: Corrective Action Plan: extended timeframe from 30 days to return CAP to 60 days VI.M: Removed Delegation this is covered under the section J – Outside entity reviews Attachments A and B: Updated the site review tools with the new sections and new guidelines Attachment D Change: The Community Based Adults Services Survey tool replaces the Physical Accessibility Review Survey tool. Rachel remarked that the attachments were earlier drafts and asked that the final versions be emailed to voters. She went through the synopsis of changes. There were no questions; however, Robert Quon, MD, commented that “from a regulatory standpoint, ‘up to 10 records’ is loosey goosey as it could be one or two. A regulator might dig deeper as there is no floor here.” After discussion, Q/UAC agreed to amend VI.E.3 to read “Ten medical records will be reviewed unless there are not enough member claims to support this.”	Motion to approve as amended: Robert Quon, MD Second: Randy Thomas, MD <i>Approved unanimously</i> <u>Next Steps:</u> June 11 PAC The correct attachments were emailed to Q/UAC voters after the meeting.
Policy Owner: Quality Improvement – Presenter: Jeff DeVido, MD, Behavioral Health Clinical Director		
MPXG5008 – Clinical Practice Guidelines: Pain Management, Chronic Pain Management and Safe Opioid Prescribing	This CPG policy has been updated with suggestions for assessment and reassessment timeframes. References have been augmented, updated, and hyperlink accessibility verified. This CPG will apply to Partnership Advantage, Partnership’s D-SNP product effective Jan. 1, 2027. Definitions: “Partnership Advantage” is now defined in the policy and added where appropriate in each of the attachments’ introductory remarks. The introduction to Section VI. Guideline/Procedure is updated to include mention of Partnership’s seven “Wellness and Recovery” program counties. Further, the following is added: “The Centers for Disease Control (CDC) notes that in practice context where virtual visits are part of the standard of care (e.g., in remote areas where distance or other context makes follow-up visits challenging) or for patients for whom in-person follow-up visits are challenging (e.g., frail patients), follow-up assessments that allow the clinician to communicate with and observe the patient through telehealth modalities might be conducted.” VI.A.5. now additionally notes: Any illegal drug usage (<i>or non-medical use of prescribed medications</i>) should be identified, documents, and addressed.	Motion to approve as presented: Brian Montenegro, MD Second: Jennifr Wilson, MD <i>Approved unanimously</i> <u>Next Steps:</u> June 11 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	VI.A.8 is added: Both the CDC and UpToDate recommend that clinicians should regularly reassess all patients receiving long-term opioid therapy, including patients who are new to the clinician but on long-term opioid therapy, with a suggested interval of every three months or more frequently for most patients. VI.C.2.e. is amended: Offer to prescribe naloxone for any patient prescribed opioids. Intranasal naloxone is also available at pharmacies without a physician’s prescription, although for Medi-Cal and/or Medicare to cover it, a prescription is required. A new VI.D is added: Follow-up and monitoring during chronic opioid therapy: The benefits and harms for patients on chronic opioid therapy should be assessed at least every three months for patients on stable doses of opioids. UpToDate suggests patients should be seen more frequently after dosing changes, particularly if initiating or increasing extended-release long-acting (ER/LA) opioids. The risks for overdose increase in the first week after a dosing change. Patients who are transitioned to or have dosing increases of methadone (for pain) should be seen within three days, or within one week for other ER/LA opioids. Reference section is updated with three additional hyperlinked citations: CDC Clinical Practice Guideline for Prescribing Opioids for Pain. (2022) National Institute on Drug Abuse, National Institute of Health. Tobacco, Alcohol, Prescription medication, and other Substance use Tool (TAPS). UpToDate. Use of opioids in the management of chronic pain in adults. (Dec. 9, 2024) Attachments A-D are updated as necessary to accommodate these changes. Dr. DeVido went through the synopsis. Chris Swales, MD, said he believed state law requires only twice per year follow-ups for those on controlled medications and thought mandating follow-up intervals of three months “a huge burden for an already stressed primary care system for well controlled maintenance patients.” Dr. Swales was also concerned with VI.A.5 wording which suggests to him that a referral to pain management not be done until the primary care physician has done everything they might do first. Doctors Moore and Netherda said these are Partnership recommendations, not mandates. Rachel Newman added that her site review team does not monitor providers on the frequency of their follow-up visits for opioids. John Murphy, MD, said that the referral to pain management is sometimes on the assumption that an injection will be administered. He added that the California Medical Board may have different guidelines than do the CDC and the non-peer-reviewed UpToDate. Brian Montenegro, MD, was curious what his fellow Q/UAC colleagues practice. Meagan Mulligan, FNP, and physicians Jennifer Wilson, John Murphy, Emma Hackett, Randy Thomas, and Sara Choudhry said their clinics’ standards are every three months; however, there was general agreement with Dr. Choudhry that the reality is that follow-ups on stable patients most often occur every four to six months. Dr. DeVido noted that in the addiction world, follow-up intervals are “dictated by what the pharmacy will give you. It’s very hard to get more than 30 days when doing suboxone. In the psychiatry world, we try to see people more frequently given the nature of the work we do.”	
Policy Owner: Behavioral Health – Presenter: Jeff DeVido, MD, Behavioral Health Clinical Director		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
MPBP8003 – Mental Health Services – the previous MCUP3028 is now archived in UM	This policy was updated to reflect changes per APLs 24-012 and 24-019 as well as for the Partnership Advantage D-SNP program we will operate effective January 1, 2027. Title: Ownership of this policy was transferred from the UM Department to the Behavioral Health department. The number will now be MPBP8003, which reflects that it is a Multi-Plan policy applicable to both our Medi-Cal and Partnership Advantage Lines of Business. Section III.F: The definition formerly describing “Mental Health Plan (MHP)” was updated to reflect “Behavioral Health Plan (BHP)” as per new guidance from DHCS. The definition was also updated to include Substance Use Disorder (SUD) treatment services as a contract responsibility for BHPs. MHP was updated to BHP throughout the document. Section III.J: The definition of Partnership Advantage was added. Section III.K: The definition of Professional Person Section III.L: The definition of Specialty Mental Health Services (SMHS) was updated to say that for Partnership Advantage Members, Partnership will coordinate with BHP providers to ensure members have access to and are connected with medically necessary services delivered by the BHP. Section VI.A.: Specified that Partnership provides mental health services to Medi-Cal Members and will also provide mental health services to Partnership Advantage Members effective January 1, 2027. Section VI.B.1.a: Per APL 24-012 Non-Specialty Mental Health Services: Member Outreach, Education, And Experience Requirements, added a link and reference to Partnership’s Member Outreach & Education Campaign for Non-Specialty Mental Health Services (NSMHS). Section VI.E.: Per APL 24-019 Minor Consent to Outpatient Mental Health Treatment or Counseling, added a new policy section to describe the APL requirements. Section VI.T.: A new policy section was added to define Medicare guidelines for Mental Health Services for Partnership Advantage Members. Section VII. R: Added new Reference for APL 24-012 Non-Specialty Mental Health Services: Member Outreach, Education, and Experience Requirements Section VII. S: Added new Reference for APL 24-019 Minor Consent to Outpatient Mental Health Treatment or Counseling Section VII. T: Added new Reference for California Family Code section 6924 Section VII. U: Added new Reference for State Medicare Advantage Contract, Exhibit A, Exclusively Aligned Enrollment D-SNP Section VII. V: Added new References for Code of Federal Regulations: 42 CFR § 422.100(c)(1); 42 CFR § 409.62; 42 CFR § 410.10; 42 CFR § 410.54; 42 CFR § 422.100(c)(1); 42 CFR § 409.62; 42 C.F.R. § 410.15; 42 CFR § 422.112(a)(1)(iii); 42 CFR § 438.3(q); 42 CFR § 438.206(c)(1)(iii) Section VII. W: Added new Reference for Medicare Managed Care Manual, Ch. 4 § 110.1.1 Dr. DeVido went through the synopsis, adding that the more substantive change is that pursuant to AB665, minor consent language was updated. This language has already been reviewed at DHCS and approved. Some of the conditions there have been removed. Minor consent was also updated to provide more	There were no questions. Motion to approve as presented: Robert Quon, MD Second: Brian Montenegro, MD <i>Approved unanimously</i> <u>Next Steps:</u> June 11 PAC This policy will come back to IQI and Q/UAC in September when Partnership de-delegates Carelon.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	specificity about what constitutes an eligible provider or “professional person,” including registered psychologists, registered psycho-social assistants, associated clinical social workers, and board-eligible psychiatrists.	
Policy Owner: Care Coordination – Presenter: Shannon Boyle, RN, Manager of Care Coordination Regulatory Performance		
MPCP2026 – Diabetes Prevention Program – previously MCCP2026	This policy was updated to include regulations for the Partnership Advantage D-SNP line of business that will be effective January 1, 2027. Policy number updated from MCCP2026 to MPCP2026 to reflect Multi Plan Policy Definitions Added: Medicare Diabetes Prevention Program (MDPP) Partnership Advantage Purpose revised: To provide an overview of these external programs; Diabetes Prevention Program and Medicare Diabetes Prevention Program, including eligibility requirements and participation process. VI.A updated to reflect Medicare Prevention Program and reference the Member Handbook for more information VI.B reorganized to include MDPP Specific Eligibility Criteria section and add a separate section VI.B.3 to combine the DPP and MDPP program participants eligible members clinical requirements as they are the same for both programs. VI.C.2 updated to reflect MDPP VI.D.1 reorganized the section to have specific DPP program under one section and added VI.D.2 to have specific MDPP program structure under its own section to show the differences. VI.D.1.c.2) updated to reference both APL 18-018 Diabetes Prevention Program (11/16/2018) and The Medi-Cal Provider Manual (March 2022) VI.E updated section to reflect Delivery Methods for DPP and MDPP Sessions Partnership will cover the following methods for DPP sessions and MDPP sessions (for Partnership Advantage members) as deemed clinically appropriate VI.G through VI.I updated to reflect MDPP VI.J updated to include: Members may be able to obtain certain medical devices that do not require a Treatment Authorization Request (TAR). The PMEDS program serves all Partnership Members as an efficient means of fulfilling orders for certain home medical devices that are prescribed by medical providers. Referenced added: Medi-Cal Provider Manual/Guidelines: Diabetes Prevention Program Prediabetes Risk Test Sheet National Diabetes Prevention Program, Preventing Type 2 Diabetes with Medicare Medicare Diabetes Prevention Program (MDPP) Expanded Model Fact Sheet Medicare Diabetes Prevention Program (MDPP) Medicare Advantage Fact Sheet Medicare Diabetes Prevention Program (MDPP) Basics Disclaimer added	There were no questions or comments after Shannon went through the synopsis of changes. Motion to approve as presented: Brian Montenegro, MD Second: Meagan Mulligan, FNP <i>Approved unanimously</i> <u>Next Steps:</u> June 11 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
MPCP2034 – Transitional Care Services – <i>previously</i> MCCP2024	This policy was updated to include regulations for Partnership Advantage D-SNP line of business that will be effective January 1, 2027. Related Policies Updated: MCUP3142 updated to reflect new policy number MCAP7003- CalAIM Community Supports (CS) MCUP3143 updated to reflect new policy number MCAP7001- CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) Definition rephrased: Admission, Discharge, and Transfer (ADT) data Definitions added: California Integrated Care Management (CICM) HCBS: Home and Community Based Services Individualized Care Plan (ICP) Interdisciplinary Care Team (ICT) Partnership Advantage Purpose updated to include: This policy was written based on the request by DHCS as part of their PHM Policy Guide and the CalAIM Dual Eligible Special Needs Plan Policy Guide VI.A.1 updated to reflect: Across the settings, the TCS shall prioritize member-centered care by: VI.A.1.f section added: Updating a Partnership Advantage Member’s Individualized Care Plan (ICP) as appropriate and distributing the updated ICP to the ICT. VI.B. TCS Member Eligibility & Identification section moved from VI.C VI.B.1.b added: All Partnership Advantage enrolled members VI.B.1.c added: All Non-Partnership Advantage members receiving TCS are differentiated by High- and Low- risk designations VI.C.1.c.1) updated to include: Partnership will include those who are Partnership Advantage Members in California Integrated Care Management (CICM) VI.C.1.c.2)c) added: Any Partnership Advantage Member who is eligible for CICM Population of Focus. VI.C.10.a updated to include: PA Members (CICM) as members who must be identified by the TCS Care Manager as they may be newly eligible for ongoing care management VI.D.2 updated to include: PA Members; CICM benefit as a benefit for which high-risk Members identified for TCS shall be referred to as appropriate. VI.D.3 section added: Partnership Advantage members are assigned a Primary Case Manager for all of the member’s care coordination, including TCS. VI.D.10 updated to include: CICM as one of the programs for which the TCS Care Manager must ensure non-duplication of services VI.E.1.d updated to include: CICM as a program for which the Member could be enrolled in VI.E.1.f updated to include: CICM as a program for which a Member could be considered for eligibility after a transition.	There were no questions or comments after Shannon went through the synopsis of changes. Motion to approve as presented: Brian Montenegro, MD Second: Randy Thomas, MD <i>Approved unanimously</i> <u>Next Steps:</u> June 11 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	VI.E.2.b updated to include: CICM as a program where Partnership will use data including any information from admission, to identify newly qualified Members for outreach and enrollment as appropriate VI.G.3.b updated to include: CICM as a program for additional care management needs are addressed VI.G.5 updated to include: CICM as a program for additional care management needs are addressed References added: CalAIM Dual Eligible Special Needs Plan Policy Guide (2025) References updated: DHCS APL-23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (<i>Revised</i> 01/08/2025)	
Policy Owner: Utilization Management – Presenter: Bettina Spiller, MD, Associate Medical Director		
MPUP3137 – Palliative Care: Intensive Program (Adult) - <i>previously MCUP3137</i>	This policy was updated to include the Partnership Advantage D-SNP program we will operate effective January 1, 2027. It was also updated to reflect the dissolution of the Palliative Care Quality Collaborative system. Section III.C: Definition of Interdisciplinary Care Team (ICT) for Partnership Advantage Members was added. Section III.E: Definition of Partnership Advantage was added. Section V: Purpose statement was updated to remove reference to “Medi-Cal” so that the purpose applies to all types of Partnership Members. Section VI.A.2: Added clarification that the Intensive Palliative Care Management (IO benefit is available to both Medi-Cal and Partnership Advantage Members. Section VI.A.3.f.1): Clarified that Partnership Advantage Members will have a Palliative Care ICT. Section VI.B.2.c.: Deleted paragraph that referred to the Palliative Care Quality Collaborative system as our method of monitoring enrollment and network and data utilization data. Section VI.B.5.n.: Differentiated Partnership Members enrolled with an outside Medicare plan who are <i>not</i> eligible for Intensive Palliative Care with Partnership, from Partnership Advantage Members who are eligible for the benefit. Section VI.B.7.d.6): Deleted paragraph that specified Providers must enter into a Data Sharing Agreement with the Palliative Care Quality Collaborative system because it has been disbanded. Section VIIIH.: Added Reference for the DHCS "CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide - Contract Year 2026" Attachments A – D: All were updated to reflect MPUP change.	There were no questions or comments after Dr. Spiller went through the synopsis of changes. Motion to approve as presented: Robert Quon, MD Second: Meagan Mulligan, FNP <i>Approved unanimously</i> <u>Next Steps:</u> June 11 PAC
VI. Presentations		
Behavioral Health Overview <i>Jeff DeVido, MD,</i>	Mark spoke of the successes of <u>the three-year Student Behavioral Health Incentives Program</u> which, although it sunset in December 2024, continues to pay dividends with the Partnership/schools relationship across each of our 24 counties. By the numbers, SBHIP • Fostered more than 2,600 student visits at 28 new Wellness Centers across schools in seven counties • Screened more than 3.600 additional students in new mental health screenings at 16 Local Educational Agencies across five counties	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
<i>Behavioral Health Clinical Director, Mark Bontrager, Sr. Director, Behavioral Health, and Nicole Escobar, Senior Manager, Behavioral Health</i>	• Launched Social/Emotional Learning (SEL) and wellness programs in eight counties • Facilitated behavioral health staffing expansion by 76 full-time equivalent positions/providers across 16 counties • Trained more than 1,600 staff in SEL and mental health across nine counties • Established data tracking systems and/or closed loop referral processes in 11 counties • Launched Care Teams across four counties • Expanded teletherapy in three counties • Launched suicide prevention programs in two counties. Del Norte County used some of its SBHIP monies to purchase a van to transport clinicians to various sites, including Tribal Health Centers. Trinity County created a student wellness space at Weaverville Elementary School, funding/training staff there to provide “low level” intervention and prevention services. Colusa County created a dedicated space with the technology to render telehealth services to students. The Shasta County Office of Education created a robust closed-loop referral network allowing its 85 schools to interface. DHCS was so impressed with our SBHIP outcomes that it paid for a video to be created on Yuba County’s successes: https://www.youtube.com/watch?app=desktop&v=WAdKzH28Dws . The State has taken a next step in implementing a multi-payer fee schedule through which all health plans (not just Medi-Cal) will reimburse for “school-linked” behavioral health services: Nevada Union High and Solano County Office of Education were the first entities statewide to have their first claims accepted in this new billing system. The new fee schedule expands provider types, adding wellness coaches and guidance counselors. Co-pays will not apply. DHCS has chosen Carelon Behavioral Health as its third-party administrator; thus, the process should be relatively seamless for Partnership as we build upon that existing relationship. In conclusion, Mark noted that students are more likely to complete mental health services if the services are provided at school sites. At SBHIP sunset Dec. 31, 2024, we had about 40% participation (i.e., 121 Local Educational Agency (LEA) partners) in the more than 300 school districts across our 24 counties. Mark reported on <u>non-specialty mental health services (NSMHS) utilization</u> for CY 2024. More than 76,000 Partnership Members sought NSMHS services administered by Carelon Behavioral Health. About 30,000 members also received services from county behavioral health. Combined utilization was about 12% of Partnership’s entire membership. The utilization of telehealth as a mode is increasing (up to 44% in CY 2024), although most children and family services were in person. Nicole spoke about <u>program changes</u>. This year brought the opportunity to shift focus from measurement-based care to access to care, bringing our efforts into alignment with Behavioral Health Healthcare Effectiveness and Data Information Set (HEDIS®) measures. We leveraged community health workers (CHWs) to assist Emergency departments to address behavioral health needs and coordinating follow-up care. Twenty-four hospitals participated in this project, which wraps at the end of June 2025. We also focused on two additional projects seeking modes to engage beneficiaries in care following an ED encounter, either for mental health or SUD diagnosis. Pilot 1 included clinical hospital staff and follow-up activities with the member the day after the emergent encounter. Initial indications show relatively good follow-up rates with 40% of patients responding and connecting with clinicians. Pilot 2 connected contracted mental health staff with telephonic follow-up efforts through a utilization report provided by Partnership. Initial indications showed relatively poor outcomes, with less than 20% of phone numbers being accurate and only half of those accurate numbers being answered.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Behavioral Health has added two new units to its department to support our obligations under mandatory DHCS MOUs: these units focus on expanding relationships with our First Five and Child Welfare agencies within our community. Beginning in September, Partnership will begin in-house operations for care coordination, grievance and appeals, and beneficiary access, removing these functions from Carelon’s delegation responsibilities for mental health and SUD. Carelon’s current phone number will migrate to Partnership. A new access team will respond to member calls, direct scheduling with providers, and follow up with members to make sure appointments are kept or barriers to care are addressed. Dr. DeVido spoke of <u>program improvements into 2025 and beyond</u>. “For regulatory reasons, I am establishing that I am the Behavioral Health Clinical Director. I am a board-certified psychiatrist, also board-certified in addiction psychiatry and addiction medicine.” He spoke of expanding access via • SPRAVATO®, the esketamine nasal spray for adults with treatment-resistant depression, to providers in the NSMHS benefit, recognizing that specialty mental health might not be as robust in rural areas (This will be discussed at the Pharmacy & Therapeutics Committee later this summer.) • Transcranial Magnetic Stimulation (TMS), newly added to our NSMHS (Clinical criteria is currently underway.) • Narcan education and medication to Partnership staff in our office lobbies to help expand community access to this tool to combat opioid overdoses • Medicare (D-SNP) planning underway to move into spaces we haven’t historically been, including inpatient psychiatric review and development of clinical criteria around review and utilization, as well as intensive outpatient (IOP) in conjunction with InterQual® guidelines. Dr. DeVido said he is proud of our eating disorder policy and program. This disorder and systems to care for it are both complicated. We have been able to centralize and protocolize much of how we deal with eating disorders internally so we can collaborate with our county partners. The 2024 numbers of requests by type and by county are included in this report. Nicole noted that Partnership has now marked five years with our <u>Wellness & Recovery program</u>. About 600 additional members were served in CY 2024 compared to CY 2023 (an 11.3% increase). Five providers were added, bringing our network to 72 programs; nine additional are slated to join in early FY 2025-2026. Timely access to services continues within our SUD network with 93% of regular services provided within 10 days and 94% of urgent services being rendered within three days. One metric that we pay close attention to is direct referrals as this is an indication that members are accessing services independent of a coordinating service provider. Within our SUD model, we offer a full continuum of service from detox through recovery, which makes transitions of care important. In CY 2024, our SUD levels of care decreased to 1.65 days. This is a direct result of community partnerships, awareness and offerings of MAT (medication assisted treatment), and our Emergency departments providing swift medical clearance when other settings are not available. Randy Thomas, MD, asked about behavioral health done in schools: what efforts are made to engage parents? Mark responded this is a great question, speaking to one of his concerns about the exclusion of parents who work. This is a challenge. Partnership has worked with the State to provide some curated messaging for our schools. In the North, particularly, there has been some parental reluctance to share insurance information with the schools. Partnership is helping DHCS message to parents that this is a shared interest in the well-being of your child. One of the unintended consequences will be that if this is predominately delivered by school-employed staff or contractors, they are often limited to the school day. Oftentimes this prevents working parents from participating. In addition to the expansion of minor consent that we talked about	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	earlier, where anybody 12 and older can consent to this treatment, where is the parental involvement in that? It is a concern that should be monitored. Southwest Regional Medical Director Lisa Ward, MD, commented that in Santa Rosa there are two high schools that do this work. They each have both a student advisory council and a community advisory council. Parents are involved in the latter, and on-campus meetings are held in the evenings. Associate Medical Director Dave Katz, MD, asked if there has been any focus on easing pathways for parents to refer their children, especially teens, to these services. Mark said this responsibility is the schools' and we don't have much direct influence on that. He added he likes the idea of tracking parent-initiated referrals as a means of looking at engagement. Dr. Katz suggested Partnership might create a best-practices flow to share with schools so they don't need to create their own. Mark said that is a good suggestion, and that although the SBIHP program is over, we continue to meet with all 24 county offices each month. We can put this on a future agenda. Motion to accept this report as presented: Brian Montenegro, MD / Second: Jennifer Wilson, MD <i>Accepted unanimously</i>	
Individual Health Assessments (IHA) Claims & Encounters 2024 Summary / Compliance report <i>Rachel Newman, RN, Manager, Clinical Compliance, QI</i>	In January 2023, DHCS issued APL 22-030, changing the name to the Initial Health Appointment (IHA) and discontinued the requirement of a Staying Healthy Assessment (SHA) questionnaire to be completed by the Member and reviewed by the Primary Care Physician (PCP) annually. The SHA was replaced by the Member Risk Assessment effective Jan. 1, 2024. The initial Member Risk Assessment is related to health and social needs of members, including cultural, linguistic, and health education needs; health disparities and inequities; lack of coverage/access to care; and social drivers of health (SDOH) shall be conducted. An assessment of at least one of the following risk assessment domains meets the standard: Social Determinants of Health (SDOH), Adverse Childhood Experiences (ACEs), and/or Pediatric ACEs and Related Life Events Screener (PEARLs). Partnership ensures that network providers will complete an IHA for new members within 120 days of a member's enrollment with the Health Plan or within 90 days of a Member's assignment to a PCP (whichever is most recent). The IHA is not necessary if the Member's PCP determines that the Member's medical record contains complete information that was updated within the previous 12 months. Partnership abides by DHCS guidance for member screening and assessment, and monitors assessments through the site review process. An IHA must include: • A history of the member's physical and mental health • An identification of risks • An assessment of need for preventive screens or services • Health education • Diagnosis and plan for treatment of any disease(s) • Member risk assessment, and • A plan for bringing the member up to date with all preventative needs, including immunizations. Rachel noted that although the State has heard us, DHCS has yet to approve an IHA procedure code that would help us more accurately capture encounter data. Still, our efforts – including shifting focus to the fourth month for new enrollees (whereas before those who started as Direct Members were excluded) – has brought our enrollment numbers from the hundreds to the thousands each month. A more claims-centric approach has also helped us capture when and where the visit was completed. The most accurate data comes from our site review process since these records are reviewed individually by our DHCS Certified Site Review Nurses. For MY 2024, 2,509 records qualified for IHA during the	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Medical Record Review (MRR) process. Out of these records, 94.8% were compliant. These members met the history and physical requirements and the timeline standards for the IHA. There were no questions.	
VII. FYI Attachments and Adjournment		
QI Initiative: Evaluation of Well-Child Visit Disparity Spring Pilot – <i>refer any questions to James Devan</i>		
QI Initiative: W15 Newborn Enrollment Pilot – <i>refer any questions to Liz Romero</i>		
Q/UAC adjourned at 8:55 a.m. Q/UAC next meets at 7:30 a.m. Wednesday, June 18, 2025		
<i>Respectfully submitted by: Leslie Erickson, Program Coordinator II, QI</i> Signature of Approval: _____ Date: _____ Robert Moore, MD, MPH, MBA Chief Medical Officer and Committee Chair		

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, May 13, 2025 / 1:32 – 3:27 PM

Members Present:

Andrews, Leigha, MBA, Regional Director (Southwest)
 Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
 Bides, Robert, RN, BSN, Manager of Member Safety – Quality Investigations, QI
 Bjork, Sonja, JD, Chief Executive Officer
 Brown, Isaac, MHA/MBA, Director of Quality Management, Quality Improvement
 Brundage O’Connell, Lisa, MHA, Director of Enhanced Health Services
 Campbell, Anna, Policy Analyst, Utilization Management
 DeVido, Jeff, MD, Behavioral Health Clinical Director
 Esget, Heather, RN, BSN, ACM, Director of Utilization Management
 Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
 Gast, Brigid, MSN, BS, RN, NEA-BC, Sr. Director, Care Management
 Hightower, Tony, CPhT, Associate Director, UM Regulations
 Innes, Latrice, Manager of Grievance & Appeals Compliance

Jalloh, Mohamed “Moe,” Pharm.D, Health Equity Officer
 Jones, Kermit, MD, JD, Medical Director for Medicare Services
 Klakken, Vicki, Regional Director (Northwest)
 Kubota, Marshall, MD, Associate Medical Director
 Leung, Stan, Pharm.D, Director of Pharmacy Services
 Moore, Robert, MD, MPH, MBA, Chief Medical Officer, Committee Chair
 Netherda, Mark, MD, Medical Director for Quality, Committee Vice-Chair
 Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
 Randhawa, Manleen, Senior Health Educator, Population Health
 Ruffin, DeLorean, DrPH, MPH, Director of Population Health
 Steffen, Nancy, Senior Director of Quality and Performance Improvement
 Stone, Kelly, RN, Director of Care Coordination, Care Coordination
 Townsend, Colleen, MD, Regional Medical Director (Southeast)
 Villasenor, Edna, Senior Director, Member Services and G&A
 Ward, Lisa, MD, Regional Medical Director (Southwest)

Members Absent:

Ayala, Priscila, Director of Network Services
 Brunkal, Monika, RPh, Assoc. Dir., Population Health
 Davis, Wendi, Chief Operating Officer

Kerlin, Mary, Senior Director, Provider Relations
 Matthews, Richard “Doug,” MD, Regional Medical Director (Chico)
 Sharp, Tim, Regional Director (Northeast)
 Turnipseed, Amy, Senior Director of External and Regulatory Affairs

Guests:

Arrazola, Kelcie, Lead Trainer, Provider Relations
 Bontrager, Mark, Sr. Director of Behavioral Health, Behavioral Health
 Booth, Garnet, Senior Program Manager, Provider Relations
 Broadhead, Candi, Project Manager II, QI
 Clark, Kristen, Manager of Quality & Training, Member Services
 Cook, Dawn R., Program Manager II, QI (NCQA)
 Cunningham, Aryana, Policy Analyst, Care Coordination
 Devan, James, Manager of Performance Improvement, QI (Northeast)
 Donahue, Celena, Improvement Advisor, QI (Eureka)
 Durst, Jennifer, Sr, Manager of Performance Improvement, QI (Santa Rosa)
 Erickson, Leslie, Program Coordinator II, QI (scribe)
 Escobar, Nicole, Sr. Manager of Behavioral Health, Behavioral Health
 Gual, Kristine, Director of Quality Measurement, QI
 Harris, Vander, Senior Health Data Analyst I, Finance
 Isola, Brandy, Manager of Performance Improvement, QI (Chico/Auburn)
 Jamali, Shahrzad, Improvement Advisor, QI (Chico)
 Lee, Donna, Manager of Claims, Claims
 Kim, Amanda, Senior Project Manager, Quality Improvement

Kung, Jen, Sr, Health Data Analyst II, Finance
 Lee, Donna, Manager of Claims, Claims
 Moore, Jordan, Provider Education Specialist, Provider Relations
 Moraghebi, Roudabeh, Manager of Health Analytics, Finance
 Morris, Matthew, MD, Regional Medical Director (Auburn)
 Nguyen, Tom, Manager of Health Analytics, Finance
 Power, Kathryn, Regional Director (Southeast)
 Rathnayake, Russ, Senior Health Data Analyst I, Finance
 Romero, Liz, MPH, MCHES, Improvement Advisor, QI (Northeast)
 Shrivastava, Poorva, Sr Health Data Analyst, Health Analytics, Finance
 Sivasankar, Shivani, Sr Data Scientist, Health Analytics, Finance
 Smith, Christine, Community Health Needs Liaison, Population Health
 Spencer, Ben, Project Coordinator I, Health Equity
 Spiller, Bettina, MD, Associate Medical Director
 Stark, Rebecca, Regional Director (Chico)
 Trosky, Renee, Manager of Provider Relations Compliance
 Vaisenberg, Liat, Associate Director of Health Analytic, Finance
 Vance, Brooke, Program Manager I, Network Services

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order • Approval of Minutes • Announcements	Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 1:32 p.m. • Approval of the April 8, 2025 IQI Minutes • Going forward, Southwest Regional Medical Director Lisa Ward, MD, will be a voting member at IQI and an <i>ex-officio</i> member of the Quality/Utilization Advisory Committee (Q/UAC). Associate Medical Director Marshall Kubota, MD, will still attend both meetings in an advisory capacity. We thank him for his years of service. • POST MEETING: Chief Executive Officer Sonja Bjork, JD, announced June 2 that go-live of the Dual-Special Needs Program (D-SNP) Medicare product line “Partnership Advantage” is delayed from Jan. 1, 2026 to Jan. 1, 2027. These minutes now reference the new date.	Motion to approve IQI Minutes: Mark Netherda, MD Second: Isaac Brown, MHA/MBA
II. Old Business – Internal Policy Review with Mohamed Jalloh, Pharm.D. Health Equity Officer		
MCEP6003 – Race/Ethnicity, Language, Gender Identity, and Sexual Orientation Individual Member Data Collection/ Storage/ Retrieval	Dr. Jalloh said this internal policy is at IQI today because staff recently identified and have since corrected an accidental omission. Under the Race/Ethnicity and Language sections of the policy, there is a description of future training modules for Partnership staff that will guide them in how to refrain from stigmatizing our members when members are reporting personal information. The training modules were also described in attachment MCEO6003-B (SOGI Implementation Plan) for the policy. The verbiage tied to the trainings was approved by our National Committee for Quality Assurance (NCQA) Consultant, Diane, as part of a Mock Survey, which ensured we met specific requirements for Health Equity Accreditation. The approved verbiage was all-inclusive for data types and indicated there would be modules that will train staff on effective strategies to ensure staff do not stigmatize members when collecting race/ethnicity, language, gender identity, and sexual orientation information. When the Policy MCEO6003 was being prepared for review by IQI and Q/UAC last October, there was an accidental omission of the all-inclusive description of the modules. Instead, the training description under the Race/Ethnicity and Language sections of the policy only listed respective data type. The omission was not identified earlier since SOGI data collection is still in the planning stages and staff training was planned for Q2 2025. The policy content supports future data collection activities. At this time, we have updated Policy MCEO6003 to correct this omission. By correcting the omission, the policy once again aligns with attachment MCEO6003-B SOGI Implementation Plan, which included the training modules for staff tied to ensuring members are not stigmatized when data tied to race/ethnicity, language, gender identity, and/or sexual orientation is collected. Attachments A & B will be amended with today’s date. Anna Campbell asked if this policy would apply also to our Dual Special Needs Plan (D-SNP) members and thus need to be re-lettered as a “MP” policy. Edna Villasenor noted that our vendor does call it out as a requirement under Medicare. Dr. Jalloh will take this under advisement offline.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Dawn Cook noted that approval is being sought today so that the policy may be submitted in June for the initial NCQA HEA Survey. The policy will need to be rewritten once Health Rules Payor (HRP) replaces Amisys. Dr. Ward noted that III.H. was missing the word “origins.” The definition is now updated: <u>Hispanic or Latino</u>: A person who identifies with having origins including, but not limited to, Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. The term, “Spanish origin,” can be used in addition to “Hispanic or Latino.”	
III. New Business Consent Calendar (Committee Members as applicable)		
	G&A PULSE Report / Issue 16 / April 2025 – <i>Wellness & Recovery article included</i> Health Services Policies <u>Behavioral Health</u> is emerging as a HS department, assuming direct responsibility for policies previously administered by other departments. MPBP8005 – Dispute Resolution Between Partnership and PHPs on Delivery of Mental Health Services – <i>the previous ADM52 is archived</i> MPBP8013 – Eating Disorder Management Policy – <i>the previous MCUP3145 is now archived in UM</i> <u>Enhanced Health Services</u> MPAP7004 – Community Health Worker (CHW) Services benefit – <i>the previous MCCP2033 is now archived in Care Coordination</i> MPAP7005 – Street Medicine – <i>the previous MCUP3146 is now archived in UM</i> <u>Quality Improvement</u> MCQP1052 – Physical Accessibility Review Survey SR Part C – <i>new attachment B replaces the old</i> MPQP1038 – Physician Orders for Life-Sustaining Treatment (POLST) – <i>pulled for question</i> MPQP1047 – Advance Directives – <i>previously MCQP1047</i> MPQP1055 – Provider Preventable Condition (PPC) Reporting MPXG5003 – Major Depression in Adults Clinical Practice Guidelines – <i>pulled for question on Attachment A</i> <u>Utilization Management</u> MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions MPUG3023 – Insulin Infusion Pump and Continuous Glucose Monitor Guidelines MPUG3031 – Nebulizer Guidelines MPUG3110 – Evaluation and Management of Obstructive Sleep Apnea in Adults – <i>previously MCUP3110</i> MPUP3047 – Tuberculosis Related Treatment – <i>previously MCUP3047</i> MPUP3136 – Fecal Microbiota Transplant (FMT) – <i>previously MCUP3136</i> MPUP3144 – Residential Substance Use Disorder Treatment Authorization – <i>previously MCUP3144</i> Non-Health Services Policies <u>Credentialing</u> – The 300 series below brought for post April 8 IQI Attachment B corrections; to update to current 2025 NCQA dates/element; change “180 days” to “120 calendar” days; revise Medi-Cal verification source – <i>all pulled for questions</i> MPCR13D – Registered Pharmacists for AB114 Credentialing MPCR300 – Physician Credentialing and Re-credentialing Requirements MPCR301 – Non-physician Clinician Credentialing and e-credentialing Requirements	Motion to approve slate without the pulled policies: Brigid Gast, RN Second: Kermit Jones, MD, JD Motion to approve MPQP1038 as amended: Anna Campbell Second: Stan Leung, Pharm.D Motion to approve MPXG5003 as presented with an amended Attachment A: Mark Netherda, MD Second: Anna Campbell Motion to approve Credentialing policies as amended: Mark Netherda, MD Second: Kermit Jones, MD, JD <u>Next Steps</u>: Health Services policies go to May 21 Quality/Utilization Advisory (Q/UAC) and to June 11 Physician Advisory Committee (PAC)

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	MPCR302 – Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements MPCR303 – Applied Behavioral Health and Substance Use Disorder Practitioner Credentialing and Re-credentialing Requirements MPCR304 – Allied Health Practitioners Credentialing and Re-credentialing Requirements <u>Network Services</u> MPNET100 – Access Standards and Monitoring MPPR208 – Provider Notification of Provider Termination, Site Closure, or Change in Location Information <u>Provider Relations</u> MPPR207 – Annual Physician Satisfaction Survey Anna Campbell pulled several policies to suggest clarifications. • MPQP1038 doesn’t identify Punjabi as one of Partnership’s threshold languages. Conversation ensued between Dr. Moore, Kathryn Barresi, and Anna that Partnership cannot translate the POLST into any language. That has to be done by the Coalition for Compassionate Care of California (CCCC) and provided to DHCS. VI.B.4 is amended: “The POLST instructions and form are available at capolst.org/polst-for-healthcare-providers/forms/. Members needing assistance with translation should contact Partnership’s Member Services department.” • MPXG5003 – Attachment A needs to broaden its language for D-SNP applicability to Partnership Advantage, effective Jan. 1, 2027. Behavioral Health Clinical Director Jeff DeVido, MD, agreed to eliminate some restrictive boxes in the flow chart diagram and keep sources and references. Medical Director for Medicare Services Kermit Jones, MD, JD, favored the change. • Credentialing policies should either be left unchecked for Partnership Advantage applicability or language should be added to clarify if/how those who would provide Medicare services for Partnership must be enrolled with Medicare. Further, references mentioning CalAIM Whole Child Model are outdated and must be updated. Dr. Jones and Network Services Project Manager Brooke Vance will coordinate a Medicare statement to be inserted into each policy as applicable. Dr. Moore thanked everyone for their work, saying we are well on our way for Medicare-specific updates to our policies.	Credentialing policies go to May 14 Credentials Committee. MPNET100 goes to Q/UAC and PAC MPPR208 moves to department approval MPPR207 bypasses Q/UAC and goes to June 11 PAC
IV. New Business – Discussion Policies		
Policy Owner: Behavioral Health – Presenter: Jeff DeVido, MD, Behavioral Health Clinical Director		
MPBP8003 – Mental Health Services – <i>the previous MCUP3028 residing in UM is now archived</i>	This policy was updated to reflect changes per APLs 24-012 and 24-019 as well as for the Partnership Advantage D-SNP program we will operate effective January 1, 2027. Title: Ownership of this policy was transferred from the UM Department to the Behavioral Health department. The number will now be MPBP8003, which reflects that it is a Multi-Plan policy applicable to both our Medi-Cal and Partnership Advantage Lines of Business. Section III.F: The definition formerly describing “Mental Health Plan (MHP)” was updated to reflect “Behavioral Health Plan (BHP)” as per new guidance from DHCS. The definition was also updated to include Substance Use Disorder (SUD) treatment services as a contract responsibility for BHPs. MHP was updated to BHP throughout the document. Section III.J: The definition of Partnership Advantage was added. Section III.K: The definition of Professional Person	Motion to approve as presented: Kathryn Barresi, RN Second: Anna Campbell <u>Next Steps:</u> May 21 Q/UAC June 11 PAC Senior Director of Behavioral Health Mark Bontrager noted this policy will come back to

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section III.L: The definition of Specialty Mental Health Services (SMHS) was updated to say that for Partnership Advantage Members, Partnership will coordinate with BHP providers to ensure members have access to and are connected with medically necessary services delivered by the BHP. Section VI.A.: Specified that Partnership provides mental health services to Medi-Cal Members and will also provide mental health services to Partnership Advantage Members effective January 1, 2027. Section VI.B.1.a: Per APL 24-012 Non-Specialty Mental Health Services: Member Outreach, Education, And Experience Requirements, added a link and reference to Partnership’s Member Outreach & Education Campaign for Non-Specialty Mental Health Services (NSMHS). Section VI.E.: Per APL 24-019 Minor Consent to Outpatient Mental Health Treatment or Counseling, added a new policy section to describe the APL requirements. Section VI.T.: A new policy section was added to define Medicare guidelines for Mental Health Services for Partnership Advantage Members. Section VII. R: Added new Reference for APL 24-012 Non-Specialty Mental Health Services: Member Outreach, Education, and Experience Requirements Section VII. S: Added new Reference for APL 24-019 Minor Consent to Outpatient Mental Health Treatment or Counseling Section VII. T: Added new Reference for California Family Code section 6924 Section VII. U: Added new Reference for State Medicare Advantage Contract, Exhibit A, Exclusively Aligned Enrollment D-SNP Section VII. V: Added new References for Code of Federal Regulations: 42 CFR § 422.100(c)(1); 42 CFR § 409.62; 42 CFR § 410.10; 42 CFR § 410.54; 42 CFR § 422.100(c)(1); 42 CFR § 409.62; 42 C.F.R. § 410.15; 42 CFR § 422.112(a)(1)(iii); 42 CFR § 438.3(q); 42 CFR § 438.206(c)(1)(iii) Section VII. W: Added new Reference for Medicare Managed Care Manual, Ch. 4 § 110.1.1 Dr. DeVido noted “the two big buckets of change” were the additions of Medicare language and of “minor consent” language. The latter has been presented to and approved by the Department of Health Care Services (DHCS). The definition of “professional persons” was expanded. There were no questions.	IQI and Q/UAC in September for changes necessitated by the impending de-delegation of Carelon Behavioral Health.
Policy Owner: Quality Improvement – Presenter: Rachel Newman, RN, Manager of Clinical Compliance, QI		
MCQP1025 – Substance Use Disorder (SUD) Facility Site Review and Medical Record Review	Attachment D Change: The Community Based Adults Services (CBAS) Survey replaces the Physical Accessibility Review Survey (PARS). C1 and C2 – Added three new sections on the Facility Site Review Tool and Medical Record Tool: Telehealth, Peer Support Services and Adolescent Services. VI.E.3: A reduced number of medical records may be reviewed at the discretion of the plan based on actual services. VI.F: Corrective Action Plan: extended timeframe from 30 days to return CAP to 60 days VI.M: Removed Delegation this is covered under the section J – Outside entity reviews Attachments A and B: Updated the site review tools with the new sections and new guidelines	Motion to approve as presented: Mark Netherda, MD Second: Isaac Brown, MPH/ MBA <u>Next Steps:</u> May 21 Q/UAC June 11 PAC

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	Rachel noted that the V.I.E.3 change will accommodate those clinics and practice site that do not see enough patients in certain categories. There were no questions.	
Policy Owner: Quality Improvement – Presenter: Jeff DeVido, MD, Behavioral Health Clinical Director, Behavioral Health		
MPXG5008 – Clinical Practice Guidelines: Pain Management, Chronic Pain Management and Safe Opioid Prescribing	This CPG policy has been updated with suggestions for assessment and reassessment timeframes. References have been augmented, updated, and hyperlink accessibility verified. This CPG will apply to Partnership Advantage, Partnership’s D-SNP product effective Jan. 1, 2027. Definitions: “Partnership Advantage” is now defined in the policy and added where appropriate in each of the attachments’ introductory remarks. The introduction to Section VI. Guideline/Procedure is updated to include mention of Partnership’s seven “Wellness and Recovery” program counties. Further, the following is added: “The Centers for Disease Control (CDC) notes that in practice context where virtual visits are part of the standard of care (e.g., in remote areas where distance or other context makes follow-up visits challenging) or for patients for whom in-person follow-up visits are challenging (e.g., frail patients), follow-up assessments that allow the clinician to communicate with and observe the patient through telehealth modalities might be conducted.” VI.A.5. now additionally notes: Any illegal drug usage (<i>or non-medical use of prescribed medications</i>) should be identified, documents, and addressed. VI.A.8 is added: Both the CDC and UpToDate recommend that clinicians should regularly reassess all patients receiving long-term opioid therapy, including patients who are new to the clinician but on long-term opioid therapy, with a suggested interval of every three months or more frequently for most patients. VI.C.2.e. is amended: Offer to prescribe naloxone for any patient prescribed opioids. Intranasal naloxone is also available at pharmacies without a physician’s prescription, although for Medi-Cal and/or Medicare to cover it, a prescription is required. A new VI.D is added: Follow-up and monitoring during chronic opioid therapy: 1. The benefits and harms for patients on chronic opioid therapy should be assessed at least every three months for patients on stable doses of opioids. UpToDate suggests patients should be seen more frequently after dosing changes, particularly if initiating or increasing extended-release long-acting (ER/LA) opioids. The risks for overdose increase in the first week after a dosing change. 2. Patients who are transitioned to or have dosing increases of methadone (for pain) should be seen within three days, or within one week for other ER/LA opioids. Reference section is updated with three additional hyperlinked citations: D. CDC Clinical Practice Guideline for Prescribing Opioids for Pain. (2022) I. National Institute on Drug Abuse, National Institute of Health. Tobacco, Alcohol, Prescription medication, and other Substance use Tool (TAPS). N. UpToDate. Use of opioids in the management of chronic pain in adults. (Dec. 9, 2024) Attachments A-D are updated as necessary to accommodate these changes. Dr. DeVido prefaced his remarks by thanking those who worked on updating this policy, including Marshall Kubota, MD, and Colleen Townsend, MD. Partnership Advantage and Wellness & Recovery language were added where appropriate. The more substantive changes included adding the Centers for Disease Control (CDC)	Motion to approve as presented: Lisa O’Connell, MHA Second: Lisa Ward, MD <u>Next Steps:</u> May 21 Q/UAC June 11 PAC

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	and UpToDate recommendations that virtual visits are allowed for follow-up appointments in intervals of three months, according to clinical judgement. There were no questions.	
Policy Owner: Care Coordination – Presenter: Brigid Gast, RN, Senior Director, Care Management		
MPCP2026 – Diabetes Prevention Program <i>previously MCCP2026</i>	This policy was updated to include regulations for the Partnership Advantage D-SNP line of business that will take effect January 1, 2027. Policy number updated from MCCP2026 to MPCP2026 to reflect Multi Plan Policy Definitions Added: Medicare Diabetes Prevention Program (MDPP) Partnership Advantage Purpose revised: To provide an overview of these external programs; Diabetes Prevention Program and Medicare Diabetes Prevention Program, including eligibility requirements and participation process. VI.A updated to reflect Medicare Prevention Program and reference the Member Handbook for more information VI.B reorganized to include MDPP Specific Eligibility Criteria section and add a separate section VI.B.3 to combine the DPP and MDPP program participants eligible members clinical requirements as they are the same for both programs. VI.C.2 updated to reflect MDPP VI.D.1 reorganized the section to have specific DPP program under one section and added VI.D.2 to have specific MDPP program structure under its own section to show the differences. VI.D.1.c.2) updated to reference both APL 18-018 Diabetes Prevention Program (11/16/2018) and The Medi-Cal Provider Manual (March 2022) VI.E updated section to reflect Delivery Methods for DPP and MDPP Sessions Partnership will cover the following methods for DPP sessions and MDPP sessions (for Partnership Advantage members) as deemed clinically appropriate VI.G through VI.I updated to reflect MDPP VI.J updated to include: Members may be able to obtain certain medical devices that do not require a Treatment Authorization Request (TAR). The PMEDS program serves all Partnership Members as an efficient means of fulfilling orders for certain home medical devices that are prescribed by medical providers. Referenced added: Medi-Cal Provider Manual/Guidelines: Diabetes Prevention Program Prediabetes Risk Test Sheet National Diabetes Prevention Program, Preventing Type 2 Diabetes with Medicare Medicare Diabetes Prevention Program (MDPP) Expanded Model Fact Sheet Medicare Diabetes Prevention Program (MDPP) Medicare Advantage Fact Sheet Medicare Diabetes Prevention Program (MDPP) Basics Disclaimer added After Brigid presented, Anna Campbell noted that including a medical disclaimer here might be a problem for UM as we have said there are no appeals on the Medi-Cal side whereas Medicare allows for appeals. Kermit Jones, MD, concurred that Medicare allows appeals on clinical criteria. Dr. Moore commented. Brigid said this	Motion to approve as amended: Kathryn Barresi, RN Second: Nancy Steffen <u>Next Steps:</u> May 21 Q/UAC June 11 PAC

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	policy regards program structure, and any appeal is from the provider on payment, not from the member. Moreover, it does state that a referral is not required but not that no Treatment Authorization Request (TAR) is required, he added. IQI agreed to amend VI.B.3.d to say A health care professional may refer potential participants to the program, but a referral or treatment authorization are not required for participation. Members meeting the eligibility criteria may self-refer.	
MPCP2034 – Transitional Care Services (TCS) <i>previously MCCP2034</i>	This policy was updated to include regulations for Partnership Advantage D-SNP line of business that will take effect January 1, 2027. Related Policies Updated: MCUP3142 updated to reflect new policy number MCAP7003- CalAIM Community Supports (CS) MCUP3143 updated to reflect new policy number MCAP7001- CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) Definition rephrased: Admission, Discharge, and Transfer (ADT) data Definitions added: California Integrated Care Management (CICM) HCBS: Home and Community Based Services Individualized Care Plan (ICP) Interdisciplinary Care Team (ICT) Partnership Advantage Purpose updated to include: This policy was written based on the request by DHCS as part of their PHM Policy Guide and the CalAIM Dual Eligible Special Needs Plan Policy Guide VI.A.1 updated to reflect: Across the settings, the TCS shall prioritize member-centered care by: VI.A.1.f section added: Updating a Partnership Advantage Member’s Individualized Care Plan (ICP) as appropriate and distributing the updated ICP to the ICT. VI.B. TCS Member Eligibility & Identification section moved from VI.C VI.B.1.b added: All Partnership Advantage enrolled members VI.B.1.c added: All Non-Partnership Advantage members receiving TCS are differentiated by High- and Low-risk designations VI.C.1.c.1) updated to include: Partnership will include those who are Partnership Advantage Members in California Integrated Care Management (CICM) VI.C.1.c.2)c) added: Any Partnership Advantage Member who is eligible for CICM Population of Focus. VI.C.10.a updated to include: PA Members (CICM) as members who must be identified by the TCS Care Manager as they may be newly eligible for ongoing care management VI.D.2 updated to include: PA Members; CICM benefit as a benefit for which high-risk Members identified for TCS shall be referred to as appropriate. VI.D.3 section added: Partnership Advantage members are assigned a Primary Case Manager for all of the member’s care coordination, including TCS. VI.D.10 updated to include: CICM as one of the programs for which the TCS Care Manager must ensure non-duplication of services VI.E.1.d updated to include: CICM as a program for which the Member could be enrolled in	Motion to approve as presented: Kermit Jones, MD, JD Second: Mark Netherda, MD <u>Next Steps:</u> May 21 Q/UAC June 11 PAC

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	VI.E.1.f updated to include: CICM as a program for which a Member could be considered for eligibility after a transition. VI.E.2.b updated to include: CICM as a program where Partnership will use data including any information from admission, to identify newly qualified Members for outreach and enrollment as appropriate VI.G.3.b updated to include: CICM as a program for additional care management needs are addressed VI.G.5 updated to include: CICM as a program for additional care management needs are addressed References added: CalAIM Dual Eligible Special Needs Plan Policy Guide (2025) References updated: DHCS APL-23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (<i>Revised</i> 01/08/2025) Brigid noted the updates are largely to accommodate D-SNP or to not duplicate where Medi-Cal and Medicare would overlap. CICM is an additional referral source for the PA member. Dr. Moore commented that most of these changes are regulatory. There were no questions.	
Policy Owner: Utilization Management – Presenter: Bettina Spiller, MD, Associate Medical Director		
MPUP3137 – Palliative Care: Intensive Program (Adults) <i>previously MCUP3137</i>	This policy was updated to include the Partnership Advantage D-SNP program we will operate effectively January 1, 2027. It was also updated to reflect the dissolution of the Palliative Care Quality Collaborative system. Section III.C: Definition of Interdisciplinary Care Team (ICT) for Partnership Advantage Members was added. Section III.E: Definition of Partnership Advantage was added. Section V: Purpose statement was updated to remove reference to “Medi-Cal” so that the purpose applies to all types of Partnership Members. Section VI.A.2: Added clarification that the Intensive Palliative Care Management (IO benefit is available to both Medi-Cal and Partnership Advantage Members. Section VI.A.3.f.1): Clarified that Partnership Advantage Members will have a Palliative Care ICT. Section VI.B.2.c.: Deleted paragraph that referred to the Palliative Care Quality Collaborative system as our method of monitoring enrollment and network and data utilization data. Section VI.B.5.n.: Differentiated Partnership Members enrolled with an outside Medicare plan who are <i>not</i> eligible for Intensive Palliative Care with Partnership, from Partnership Advantage Members who are eligible for the benefit. Section VI.B.7.d.6): Deleted paragraph that specified Providers must enter into a Data Sharing Agreement with the Palliative Care Quality Collaborative system because it has been disbanded. Section VIII.: Added Reference for the DHCS "CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide - Contract Year 2026" Attachments A – D: All were updated to reflect MPUP change. Dr. Spiller went through the synopsis and noted the policy on the Medi-Cal side is more inclusive, allowing for more qualifying diagnoses than does Medicare. There were no questions.	Motion to approve as presented: Mark Netherda, MD Second: Lisa Ward, MD <u>Next Steps:</u> May 21 Q/UAC June 11 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
V. Presentations		
QI Update – Nancy Steffen, Senior Director, Quality Improvement and Performance		
	- Partnership recently completed a pilot with Open Door Community Health Centers, establishing a follow-up tracking tool to monitor the progress of members with mental health and substance use disorder after Emergency Department discharge. Open Door has agreed to keep working with us so that we might improve learnings on these Health Effectiveness ate Information Set (HEDIS®) measures and then expand the program to other primary care organizations. - Partnership’s Executive team has approved the initiation of Track 2 of the Preventative Care Bridge Project (formerly the Locum Pilot Initiative) to offer into Fiscal Year 2025-2026 strategic opportunities to address provider shortages, enhance health care quality and improve patient outcomes by allocating targeted funding to support temporary staffing to improve well child visits and cervical cancer screening measures, strengthen provider networks, increase access, and enhance the member experience. We hope our providers might expand how they can use locums. Progress reports will be forthcoming. - Following the July 2024 transition of California’s Child Health and Disability Prevention Program (CHDP) to the managed care plans, Partnership has rebranded it as the Comprehensive Health Interventions for Lifelong Development (CHILD). Providers are required to complete CHILD training every three years to align with the site review process.	For information only. There were no questions for Nancy.
Behavioral Health Overview – Jeff DeVido, MD, Behavioral Health Clinical Director; Mark Bontrager, Senior Director for Behavioral Health, and Nicole Escobar, Senior Manager of Behavioral Health		
	Mark spoke of the successes of <u>the three-year Student Behavioral Health Incentives Program</u> which, although it sunset in December 2024, continues to pay dividends with the Partnership/schools relationship across each of our 24 counties. By the numbers, SBHIP - Fostered more than 2,600 student visits at 28 new Wellness Centers across schools in seven counties - Screened more than 3.600 additional students in new mental health screenings at 16 Local Educational Agencies across five counties - Launched Social/Emotional Learning (SEL) and wellness programs in eight counties - Facilitated behavioral health staffing expansion by 76 full-time equivalent positions/providers across 16 counties - Trained more than 1,600 staff in SEL and mental health across nine counties - Established data tracking systems and/or closed loop referral processes in 11 counties - Launched Care Teams across four counties - Expanded teletherapy in three counties - Launched suicide prevention programs in two counties. Del Norte County used some of its SBHIP monies to purchase a van to transport clinicians to various sites, including Tribal Health Centers. Colusa County created a dedicated space to render telehealth services to students. The Shasta County Office of Education created a referral network allowing its 85 schools to interface. DHCS was so impressed with our SBHIP outcomes that it paid for a video to be created on Yuba County’s successes: https://www.youtube.com/watch?app=desktop&v=WAdKzH28Dws . The State has taken a next step in implementing a multi-payer fee schedule through which all health plans will reimburse for “school-linked” behavioral health services: Nevada Union and Solano school districts have now had their first claims accepted in this new billing system. DHCS has chosen Carelon Behavioral Health as its third-party administrator, thus, the process should be relatively seamless for Partnership as we build upon that existing relationship. In conclusion, Mark noted that students are more likely to complete mental health services if the services are provided at school sites.	There were no questions. Motion to accept this Grand Analysis as presented: Mark Netherda, MD Second: Isaac Brown, MHA/MBA <u>Next Steps:</u> May 21 Q/UAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Nicole reported on <u>non-specialty mental health services (NSMHS) utilization</u> for CY 2024. More than 76,000 Partnership Members sought NSMHS services. CY 2024 utilizers averaged 10 visits each, as was the case in CY2023; however, 44% of visits were by telehealth, up from CY2023's rate of 32%. Anxiety disorders (45%) and depressive disorders (25%) continue as the most common of diagnoses. Program changes continuing from 2024 to 2025 include leveraging lessons learned and closing data gaps on the HEDIS® FUA and FUA measures (follow up after Emergency Department visit for substance use and follow up after ED visit for mental health, respectively); expanding Partnership's relationship with the First Five Commission and, in September 2025, de-delegating Carelon to bring in-house mental health and substance use disorder access phone lines, care coordination, and grievance and appeals. Dr. DeVido spoke of <u>program improvements into 2025 and beyond</u>. He • Thanked the Pharmacy team for its work to develop a clinical practice guideline in the use of SPRAVATO®, the only FDA-approved nasal spray for adults with treatment-resistant depression • Noted clinical criteria review is under way on Transcranial Magnetic Stimulation (TMS), newly added to our NSMHS • Commented that the offering of Narcan to Partnership staff in our office lobbies is helping to expand community access to this tool to combat opioid overdoses • Said Partnership will assume responsibilities for higher levels of behavioral health care, including inpatient psychiatric treatment, as we plan for and implement our Medicare (D-SNP) product line Dr. DeVido said he is proud of our eating disorder policy and program. Treatment is a shared financial responsibility with county Mental Health Plans at certain treatment levels: residential, partial, and intensive outpatient (IOP). The 2024 numbers of requests by type and by county is included in this report. The graph, however, does not capture those persons who go in and out of hospital without a specific eating disorder diagnosis. We are working on that. Nicole noted that Partnership has now marked more than five years with our <u>Wellness & Recovery program</u>. About 600 additional members were served in CY 2024 compared to CY 2023 (an 11% increase). Five providers were added, bringing our network to 72 programs; nine additional are slated to join in early FY 2025-2026. As mandated by DHCS, access to services has been maintained by more than 80% since the 2020 W&R program inception. The use of Community Health Workers (CHWs) has improved connections between ED and treatment providers and has also improved our FUM scores. Direct referrals increased 12% above CY 2023. Transitions of care average days dropped to 1.65 by the end of CY 2024 thanks to our collaboration with our partners and relationship building amongst the network to ensure referrals to higher or lower levels of care as appropriate. Member awareness of Medication Assisted Treatment (MAT) services has increased. We are looking to improved options for medical clearance in 2025.	
Individual Health Assessments (IHA) Claims & Encounters 2024 Summary / Compliance Report – Rachel Newman, RN, Manager of Clinical Compliance, QI		
	In January 2023, DHCS issued APL 22-030, changing the name to the Initial Health Appointment (IHA) and discontinued the requirement of a Staying Healthy Assessment (SHA) questionnaire to be completed by the Member and reviewed by the Primary Care Physician (PCP) annually. The SHA was replaced by the Member Risk Assessment effective Jan. 1, 2024. The initial Member Risk Assessment is related to health and social needs of members, including cultural, linguistic, and health education needs; health disparities and inequities; lack of coverage/access to care; and social drivers of health (SDOH) shall be conducted. An assessment of at least one of the following risk assessment domains meets the standard: Social Determinants of Health (SDOH), Adverse Childhood Experiences (ACEs), and/or Pediatric ACEs and Related Life Events Screener (PEARLS).	Rachel is pleased the DHCS FY 2023-2024 audit was successful and no corrective action plan was issued. There were no questions.

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	Partnership ensures that network providers will complete an IHA for new members within 120 days of a member’s enrollment with the Health Plan or within 90 days of a Member’s assignment to a PCP (whichever is most recent). The IHA is not necessary if the Member’s PCP determines that the Member's medical record contains complete information that was updated within the previous 12 months. Partnership abides by DHCS guidance for member screening and assessment, and monitors assessments through the site review process. Rachel noted that although the State has heard us, DHCS has yet to approve an IHA procedure code that would help us more accurately capture encounter data. Still, our efforts – including shifting focus to the fourth month for new enrollees (whereas before those who started as Direct Members were excluded) – has brought our enrollment numbers from the hundreds to the thousands each month. A more claims-centric approach has also helped us capture when and where the visit was completed. The most accurate data comes from our site review process since these records are reviewed individually by our DHCS Certified Site Review Nurses. For MY 2024, 2,509 records qualified for IHA during the Medical Record Review (MRR) process. Out of these records, 94.8% were compliant. These members met the history and physical requirements and the timeline standards for the IHA.	
QI Initiative: Evaluation of Well-Child Visit Disparity Spring Pilot – James Devan, Manager of Performance Improvement, QI		
	This pilot was born in October 2024 in response to DHCS’s decision to withhold a percentage of plan revenue to be earned back through quality measurement beginning with MY 2024. DHCS selected Child and Adolescent Well Visits as the measure of focus, mandating that improvements must be made by the end of December 2024. Partnership proposed offering per-member incentives of \$200 to select providers to conduct well visits for members, especially those in DHCS-identified disparity groups. We identified a small group of practices who held a large portion of this eligible population and sought their participation. (A small cohort was ideal because of time and resource constraints.) Partnership then customized gap lists for these participating providers’ use. These providers then had to complete visits by Dec. 31, 2024, and submit their claims by Jan. 30, 2025 to qualify for the incentives. (Partnership later extended this into February.) Challenges were many: the timeline was short; Partnership’s member demographics do not wholly track with DHCS’s racial/ethnic categories, and DHCS did not inform Partnership how much potential penalties and/or earnings would be. This, Partnership instead balanced conservative estimates against the likely incentive payouts. In the end, a total of \$9,600 was paid for a total of 48 visits. Provider feedback indicated they see the value in addressing inequities across member groups and even in those groups not defined as having inequities. Lessons learned: • Funding for equity activities appears to be a viable strategy • More time is needed to holistically address disparity • DHCS use of MY 2022 HEDIS® data is outdated • Partnership needs a global way to address inequities, not just for selected practices • DHCS will continue to use child and adolescent well visits as a means of withhold Dr. Moore asked if more time would have resulted in a higher success rate. James replied that more time would have helped us better identify issues and barriers. Dr. Moore also asked if larger provider organizations are deciding to focus on disparities. James said the number is less than a dozen; however, he has heard anecdotally that providers are more and more utilizing Partnership’s Health Disparity Dashboard.	Moving forward, Partnership has added an optional Reducing Healthcare Disparity measure to the PCP Quality Incentive Program (QIP). Providers with sufficient member volume (2,400 unique member visits in 2024) had until the end of March 2025 to reply with the intent to participate. The QIP team and the Health Equity Officer will identify which race/ethnicity disparity group to address for 2025. Providers can earn up to 7% enhancement to 2025 QIP payment by reducing the identified disparity. Other efforts are underway.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
FYI: QI Initiative: W15 Newborn Enrollment Pilot – <i>refer questions to Liz Romero, Improvement Advisor, QI</i>		
VI. Adjournment		
Dr. Moore adjourned the meeting at 3:27 p.m. IQI will meet next on Tuesday, June 10, 2025.		
<i>Respectfully Submitted by Leslie Erickson, Program Coordinator II, Quality Improvement</i> <i>Approval Signature:</i> _____ <i>Date:</i> _____ <i>Robert Moore, MD, MPH, MBA</i> <i>Chief Medical Officer and Committee Chair</i>		

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MEMBER GRIEVANCE REVIEW COMMITTEE

Meeting Minutes for May 22, 2025

The Member Grievance Review Committee (MGRC) represents a multi-disciplinary oversight forum with representatives across multiple Partnership HealthPlan departments to track and trend Grievances, Appeals, Exempt Grievances, and State Hearing cases. It serves as a collaborative work group to discuss complex cases or improvement opportunities with the following key focus areas: quality improvements, clinical oversight, operational excellence, member experience, and regulatory compliance. Findings may be presented in the Internal Quality Improvement (IQI) Meeting and/or Quality Utilization Advisory Committees (QUAC).

DATE:	Thursday, May 22, 2025
TIME:	3:00 p.m. to 4:00 p.m.
LOCATION:	*WebEx link in meeting invite
	Fairfield West Board Room
	Airpark Burney Falls Conference Room
	Avtech Whiskeytown Conference Room
	Mark Netherda, MD, Medical Director, Quality
FACILITATOR:	Kory Watkins, Director, Grievance & Appeals
	Latrice Innes, Compliance Manager, Grievance & Appeals

ATTENDEES			
☐	Aaron Maxwell, Transportation	☐	Manleen Randhawa, Population Health
☒	Ajee'lon Boyd, Regulatory Affairs & Compliance	☐	Maria Cabrera, Member Services
☒	Anthony Sackett, Quality	☒	Michela Englehart, Administration
☐	Amanda Bernal, Population Health	☒	Mark Netherda, MD, Health Services
☒	Amanda McNair, Health Equity	☐	Mary Kerlin, Provider Relations
☐	Bettina Spiller, MD, Health Services	☒	Melissa Perez, Provider Relations
☒	Chloe Ungaro, Provider Relations	☐	Michelle Mootz, Transportation
☒	Cori Olney, Transportation	☒	Mori McLennan, Grievance & Appeals
☐	Danielle Biasotti, CPhT, Care Coordination	☐	Mohamed Jalloh, Pharm D, Health Equity
☒	Dorian Roberts, Provider Relations	☐	Nicole Talley, Behavioral Health
☒	Edna Villasenor, Member Services	☐	Nicole Curreri, Population Health
☒	Gary Robinson, Regulatory Affairs & Compliance	☐	Nikki Rotherham, Claims
☐	Garnet Booth, Provider Relations	☐	Ramneek Kaur, Population Health
☐	Hanh Hoang, Provider Relations	☒	RayLyn McBroome, Grievance & Appeals
☐	Hannah O'Leary, Population Health	☒	Rebecca Stark, Administration
☐	Heather Esget, Utilization Management	☐	Renee Trosky, Provider Relations
☐	James Cotter, MD, Health Services	☒	Robert Bides, RN, Quality
☒	Jayne Cappello, Grievance & Appeals	☐	Robert Moore, MD, Health Services
☒	Jill Blake, Administration	☐	Rosemenia Santos, RN, Quality
☐	Katherine Barresi, RN, Care Coordination	☐	Stan Leung, Pharm.D., Pharmacy
☐	Kathryn Power, Administration	☐	Stephanie Nakatani-Phipps, Provider Relations
☒	Kenzie Hanusiak, Regulatory Affairs & Compliance	☐	Tim Sharp, Administration
☒	Kory Watkins, Grievance & Appeals	☐	Tony Hightower, Utilization Management
☐	Latrice Innes, Grievance & Appeals	☒	Vicquita Velazquez, Health Equity
☒	Ledra Guillory, Provider Relations	☒	Vicky Klakken, Administration
☒	Leigha Andrews, Administration	☒	Vivian Gill, RN, Grievance & Appeals
☒	Lisa Ooten, Pharm. D., Pharmacy	☐	Wendi Davis, Administration
☐	Lonni Hemphill, CPhT, Regulatory Affairs & Compliance	☒	William Kinder, Transportation

HANDOUTS

1	Meeting Agenda	2	Meeting Minutes from February 27, 2025
3	Meeting PowerPoint Presentation		

I. WELCOME & INTRODUCTIONS

A. Meeting Minutes

Minutes from the MGRC meeting on February 27, 2025 were reviewed and approved without changes

Motion to Approve: Gary Robinson

Second: Rebecca Stark

II. STANDING AGENDA

B. Department Updates

1. Department Updates

DHCS

- G&A received a 2024 audit finding for exceeding the 30-day timeframe on multiple Quality of Care grievances because the cases were sent to the Quality department for potential quality issues (PQI) without fully addressing the member's concerns in our resolution letters.
- In response, we reinforced the requirement to keep cases open, past the 30-day timeframe, until all documentation is received. The case will stay in a pending status until the information is received to close the case. G&A implemented monthly audits on 50% of Quality of Care grievances closed (minimum of 8) to ensure a timely and complete resolution.

NCQA

- We completed a mock audit in April, scoring 100% on the first 8 cases reviewed.
- We continue working with the NCQA team to prepare for the 2026 renewal survey. Currently, we are in the look-back period for evidence (policy and procedures), and the look-back on cases begins on September 22, 2025.

D-SNP

- We have drafted the first version of the G&A Partnership Advantage policy and received stakeholder feedback.
- Revisions are underway, with a goal to finalize in June for presentation at the July IQI meeting.

JIVA

- We have been working with our new consultant, Excell, and identified the need to integrate assessments into our workflows.
- Workflow updates are in process and UAT testing is expected to begin soon.

2. Staffing

We have two (2) vacant Grievance Case Associates (GA) positions open, one (1) Grievance Case Analyst (GCA) and 1 Grievance Nurse Specialist (GNS) open. The two (2) GA positions have been filled with a start date of May 27, 2025. The GNS position has been filled with a start date of June 9, 2025.

B. Case Statistics

1. Case Statistics

There were 1,747 cases closed in 1Q25. Eight (8) cases were closed past 30 days, resulting in a 99.4% timeliness performance rate. Members were notified that their case was received within five (5) calendar days of receipt for all but 13 cases, resulting in a 99.1% timeliness rate. G&A's timeliness goal in both categories is 98.6%.

There were two (2) lost State Hearings during 1Q25. Most of the overturned State Hearings have been related to transgender services and transportation related expenses.

April is the month with the most cases closed (895). The trends each year prove to be consistent with the highs and lows. While tracking the trends, the Cases Received for April totaled 951 cases. The exempt grievances increased drastically in April, which normally accounts for 10-15% of G&A's overall cases. In March, the number of exempt grievances started to rise and continued. After some research, the increase in exempt grievances was found to be coming from the Transportation department. The Transportation department provided retraining to the staff on how to identify exempt grievances in March 2025. Due to the influx of exempt grievances, G&A made some adjustments to help the GNSs with their workload by having the GCA do more administrative work on the case.

C. Compliance & Strategy

1. Delegation Oversight

Carelon

Carelon has not submitted 4Q24 Supplemental Report for the resolutions of cases that were open in the previous quarter. Carelon will be fully delegated to the Children and Youth Behavioral Health Initiative (CYBHI).

VSP

VSP was put on a CAP after the audit of their policy and their phone call log. There was a discrepancy regarding the amount of time to respond to Partnership for a Grievance. Grievances need to be closed within 30 days, and VSP's policy stated they have 25 days to respond. VSP submitted a correction of the policy to read that VSP has 14 days for Grievances and 7 days for Appeals. The other CAP issued was regarding VSP miscategorizing phone calls. VSP noted "Member Dissatisfaction," but there were no corresponding grievances submitted to Partnership and when the call was reviewed there was no indication of member dissatisfaction. We requested that VSP conduct a re-training to correct this problem.

Kaiser Permanente

Kaiser has not submitted quarterly reports since April that was reporting 1Q24.

Gary Robinson stated that the Supplemental Report from Carelton has been added to the new RDI, which should be signed in September 2025. At that time, if Carelton is not submitting the report as requested, Partnership can put Carelton on a CAP.

2. Inter-Rater Reliability (IRR) Findings

IRR assesses the accuracy of clinical decisions made by Grievance Nurse Specialist (GNS). The assessment is completed by the Chief Medical Officer (CMO), or his designee, and provides a clinical oversight on cases that are at higher risk for errors. The cases are also assessed by G&A leadership to identify learning opportunities. The following issues were identified during the assessment of cases closed in 4Q24:

- The Grievance Case Analyst did not consistently attach relevant documentation to their cases. For example, they have occasionally omitted relevant emails, referral responses, or translated copies of Resolution and Acknowledgment Letters. This will be discussed during the Bi-Weekly GCA meeting on June 19, 2025.
- The Grievance Case Analysts did not consistently close cases in a timely manner once all required actions were completed. For example, there were instances where all steps, including the Resolution Call and mailing of the Resolution Letter were completed, but the case was not closed until the following day. This will be discussed during the Bi-Weekly GNS meeting on June 19, 2025.

The GNSs scored a 100% on the audits this quarter. Dr. Netherda noted that previously only five (5) cases per nurse had been audited each quarter. Due to the overall increase in cases G&A processes, Dr. Netherda audited ten (10) cases per GNS.

3. The PULSE Report

The 2Q25 PULSE Report will be released June 2025. If you would like to be added to the email distribution list, please email Latrice and Jayne. The report can also be found on the Grievance & Appeals page on PHC4ME.

A highlight to look for:

- Increase in Exempt Cases

C. Investigations

Case Spotlight

Issue:

A member was denied Direct Member Reimbursement in the amount of \$2,919.91 for Cold Cap Therapy administered by an out-of-plan provider.

Background:

The member was initially denied DMR due to Cold Cap Therapy not being a covered benefit. The member filed an Appeal, and the denial was upheld. The member then filed a State Hearing (SH). The decision to pay was made by one of our Medical Directors (MD) during a pre-state hearing review based on a medical necessity exception to Medi-Cal's non-covered benefit status. Review of available medical studies and literature indicates support for the use of scalp cooling systems to prevent chemotherapy-induced alopecia. The claim went to SH

and was denied in part and granted in part by stipulation. The member was approved for DMR in the amount of \$1,796.00.

Learning Opportunity:

The GCA can work more collaboratively with the MDs to review policies in more detail and determine if services that are deemed not a covered benefit meet the medical necessity exception criteria.

FOLLOW-UP

Next Meeting: Thursday, August 28, 2025 | 2 p.m. – 3 p.m.

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Over/Under Utilization Workgroup



Meeting Name: Over/Under Utilization Workgroup

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

Date: April 30th, 2025

Time: 3:00pm – 4:00pm

Location: Board Room

Owner: Dr. Ribordy

Coordinator: Radha Chebolu (Health Analytics)

Attendees:

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

Action Items	Presenter	Due	Revise / Approve Date
Approve Minutes from 01/29/2025		04/30/2025	

Topic	Notes
1) Introductions & Objective of Meeting <i>Speaker: Dr. Jeff Ribordy</i>	Identify potential concerns for over/under utilization within the PHC network
2) Review & approve minutes from last meeting <i>Speaker: Dr. Jeff Ribordy</i>	
Underutilization Analysis Discussion Topics	
1) PCP Visit Report Owner: HA	Discuss Findings The Santa Rosa office region had the highest PCP office visits rate in 2024 (2.7 Visits per member per year) followed by the Chico region at 2.6 visits PMPY. The Fairfield region had the lowest rate at 1.8 visits PMPY. The Auburn region also had a 1.8 average visits PMPY. Redding had 2.4 visits PMPY and Eureka had 2.5. The overall PHC visits PMPY rate has been steadily increasing since 2024. In 2024, Colusa County led all 24 counties with the highest visit rate, and the entire Chico region exceeded the target. In 2024Q4, however, none of the counties in the Auburn Region, nor the counties - Yolo, Redding, and Eureka met the target. Amongst all the races, Native American race had the highest visit rate in 2024. Lake County Tribal Health, Primary Care Practice, and Woodland Clinic are the top 3 clinics that had higher visit rates. The clinics that experienced lowest visit rates are – Wellspace Health Roseville, Solano County Health Services and Blue Stone Health Wellness. Action item: - HA will work with PR to investigate if the low rate in Wellspace is due to claims processing issues or is it really access issues - HA to update the report to include Blue Stone Wellness clinic both PCP IDs
2) Maternal Vaccinations Owner: HA	Discuss Findings The overall flu prenatal vaccine rate has reduced from 35% in 2023 to 28% in 2024. In 2024, members who speak Russian had the lowest rate (5%) while members who speak Spanish had the highest rate (41%) when compared to other languages. In 2024, the White and native Hawaiian population had the lowest rate (18%) while Hispanic and Asian members had the highest rate (35%). In the Redding region, Trinity had the lowest rate in 2024 (7%), which decreased from 13% in 2023, while all the other counties had increased rates. In the Eureka region, Del Norte had the lowest rate of 13%, which

decreased from 20% in 2023. All the counties in Fairfield and Santa Rosa regions have higher-than-average rates for 2024 but decreased from 2023. In the Chico and Auburn regions, Sutter (19%) and Nevada (12%) had the lowest rates, respectively.

The overall TDap prenatal vaccine rate has reduced from 68% in 2023 to 66% in 2024. In 2024, by language, members who speak Russian had the lowest rate (19%), and members who speak Spanish and Punjabi had the highest rate (42%). By ethnicity, the native Hawaiian population had the lowest rate (54%), and Hispanic members had the highest rate (75%). In the Redding region, Trinity had the lowest rate in 2024 (39%), which decreased from 42% in 2023, and Modoc decreased the most from 78% to 56%, while all the other counties had increased rates. In the Eureka region, Humboldt had the lowest rate of 55%, which increased from 47% in 2023. All the counties in Fairfield region and Santa Rosa region have higher-than-average rates for 2024, with Marin having the highest rate (84%). In the Chico region, Butte had the lowest rate (52%), while in the Auburn region, all counties had lower-than-average rates for 2024, with Sierra having the lowest rate (33%).

The overall COVID prenatal vaccine rate has reduced from 8% in 2023 to 3% in 2024. In 2024, by language, members who speak Punjabi and Tagalog had the lowest rate (0%). By ethnicity, the white population and the black population had the lowest rate (2%), and the native American population had the highest rate (5%). In the Redding region, except for Modoc all the regions had lower than average rates for 2024. In the Eureka region, Humboldt had the highest rate of 10%, which increased from 7% in 2023. All the counties in the Fairfield Region and Santa Rosa region had average or lower-than-average rates for 2024. In the Chico region, Sutter had the lowest rate (1%), while in the Auburn region, Plumas had the lowest rate (2%) and Sierra had the highest rate (11%) among all counties in 2024.

The overall RSV prenatal vaccine rate has increased from 2% in 2023 to 12% in 2024. In 2024, by language, members who speak Russian had the lowest rate (2%), and members who speak Spanish had the highest rate (13%). By ethnicity, the white population and the black population had the lowest rate (10%), and the native American population had the highest rate (14%). In the Redding region, Lassen (0%) and Modoc had the lowest rate in 2024 (2%) and Siskiyou had the highest rate of 18%. In the Eureka region, Lake had the lowest rate of 9%, while Humboldt had the highest rate (21%) among all counties. All the counties in the Fairfield Region and Santa Rosa region have higher-than-average rates for

	2024. In the Chico region, Sutter and Yuba had the lowest rate (3%), while in the Auburn region, Placer had the lowest rate (9%).
3) Childhood immunizations Owner: QI	Discuss Findings For measurement year 2024 (MY2024), Partnership HealthPlan of California's (Partnership's) performance on the HEDIS Childhood Immunization Status (CIS-10) measure relative to NCQA national Medicaid benchmarks shows three out of five sub-regions performing at or below the 25th percentile, which is below the DHCS minimum performance level (MPL) which is the 50th national percentile. Scheduled vaccinations are an important strategy to ensure that children in our communities are protected, and Partnership strives to work with the provider network to ensure vaccines are administered. Measure Definition: The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates. Partnership is committed to improve the performance of CIS-10 through the following initiatives – - Media Campaigns - Child and Adolescent Workgroup - Addition of Flu UOS Measure to PCP QIP - Provider Trainings - eReports Tools and Dashboards - Expansion of Growing Together Program (GTP)
4) ACEs Screening Report Owner: HA	Discuss Findings Adverse Childhood Experiences are traumatic events children between 0-18 may experience such as violence, drug abuse, self-harm, family abuse, and more. ACE screenings identify whether children are in unhealthy or unsafe environments and to seek ways to prevent and address the risks of the traumatic events. Both the groups, 0-18 and 19+, saw an increase in ACEs from 2023 to 2024. The counties that had higher screening rates are Placer, Tehama, and Humboldt. The top 3 providers by claims count in 2024 are Avala Pediatrics, Lassen Medical Clinic, and Eureka Community Health Center. There were 11,728 and 20,939 ACEs in 2023 and 2024 respectively with a 77% increase in providers. The biggest screening rate hikes from 2022 to 2024 were:

	• In the 0-18 age group, Placer County rose from 0 to 305. • In the 19+ category, Siskiyou County led with an increase from 0.1 to 17.5, followed by Placer County's rise from 0 to 11.4.
5) Mental Health Utilization Owner: HA	The overall utilizer rates increased by 10% from 2023 to 2024 for County MH and Carelon, and a 2% increase for Rx was observed, while PCP utilizer rate dropped by 5%. In 2024, amongst all the 6 office regions, the Redding Region observed the highest utilizer rate for Pharmacy and Carelon utilization. Eureka Region for PCP utilization and Auburn Region for County MH observed the highest utilizer rates. For PCP utilization: ○ In 2024, Nevada County led all the 24 counties with the highest utilizer rate. ○ From 2023 to 2024: ○ Trinity County had the highest increase in rate of 9.3%, followed by Mendocino County's hike by 8.9%. ○ The largest drop was observed by Solano County at 18.7%. ○ Utilizer rates fell in all language groups, with Punjabi speakers' rate dropping the most, by 38%. ○ All races saw a drop in rates, led by Asian race's 15% decline. For Rx utilization: - In 2024, Humboldt had the highest rate - From 2023 to 2024: ○ Siskiyou County followed by Lassen and Shasta counties observed higher increase in rates compared to the other counties. ○ The highest drop was observed by Marin County (-11%) ○ All language groups except English speakers (+4%) experienced a drop in the rates ○ All ethnicity groups saw a rise in rates, except Asian that had drop in the rate of 5% For Carelon utilization: - Shasta County experienced the highest rate in 2024 - From 2023 to 2024:

	○ Solano and Napa counties observed the highest increase in rates compared to the other counties. ○ Tagalog speakers had the highest increase in rates followed by English speakers and all the other language speakers had dropped rates. ○ Although White race had highest rate in 2024, Black or African race saw the highest increase in rates from 2023 to 2024. For County MH utilization: - Modoc County experienced the highest rate in 2024, followed by Glenn and Nevada counties. - From 2023 to 2024: ○ Lake and Trinity counties observed the highest increase in rates compared to the other counties. ○ Lassen and Del Norte observed a notable drop in the rates at 91.8% and 89.4% respectively. ○ Punjabi speakers had the highest drop in the rates (-79%) followed by Russian speakers (-22%) ○ Black/African race had highest rate amongst all the races in 2024 and the highest increase in rate (+56%) from 2023 to 2024.
Overutilization Analysis Discussion Topics	
1)	
Future Agenda Items	PCP visit rates will continue to be monitored
Next Meeting Date: TBD	



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

QUALITY IMPROVEMENT PROGRAMS (QIPs)

PROGRAM	UPDATE
PRIMARY CARE PROVIDER (PCP) QIP	- Measurement Year (MY) 2024 PCP QIP payment is on track to distribute the week of 06/09/2025. In total, \$51.8 million in performance rewards are being distributed, representing an increase of \$13.3 million from MY2023. This increase represents improvements in the new Equity Adjusted Per Member Per Month rates and the addition of the expansion county providers. A comprehensive evaluation of MY 2024 PCP QIP will be presented to quality committees this fall. - MY2026 measure development is in progress. - The QIP team is preparing the network for a 2-week blackout period taking place in July, to support the new core claims system (HRP) go-live and cut-over processes.
PALLIATIVE CARE QIP	- The July – December 2024 payment are distributing in June. - The program in MY2025 will shift from requiring participating providers to submit assessment data into a palliative care data registry and instead, require them to submit results from administered Patient Satisfaction surveys directly to Partnership. This is in response to the recent dissolution of the Palliative Care Quality Collaborative (PCQC).
PERINATAL QIP	- Fiscal Year (FY)2025/2026 begins next month and will include a new gateway measure focused on provider participants contracting with DataLink, Partnership's certified NCQA HEDIS Data Aggregator (DAV). - FY2025/2026 specifications will be posted by the end of June.
ENHANCED CARE MANAGEMENT QIP	2025 payments for second quarter are in process and will be distributed this month.
HOSPITAL QIP (HQIP)	- The new FY2025/2026 measurement year kicks off in July. - FY2025/2026 specifications will be posted by the end of June.

QUALITY DATA TOOLS

TOOL	UPDATE
PARTNERSHIP QUALITY DASHBOARD (PQD)	PQD 2025 is expected to be released after the launch of HRP later this year. The Final PCP QIP Payment Summary Dashboard for MY2024, however, is on track for release with upcoming distribution of payments.
EREPORTS	2025 eReports is in the final stages of preparation for the HRP go-live. This platform will go down for a two-week period in July and re-launch with HRP data

<u>PERFORMANCE IMPROVEMENT (PI)</u>	
ACTIVITY	UPDATE
STATE MANDATED WORK: <i>PERFORMANCE IMPROVEMENT PROJECT (PIP) & PLAN-TO-DO- STUDY-ACT (PDSA) CYCLE</i>	DHCS-required PDSAs - Progress reports on mandated PDSAs in the Redding and Eureka Regions are due to DHCS by 06/11/2025. Updates will be included on the following topics: - Pediatrics Measures - Fluoride Varnish application improvement - Well visit data capture and expediting enrollment - Chronic Disease Measures - Academic detailing for diabetes and asthma - Data improvement for asthma and diabetes medications - Reproductive Health and Cancer Prevention Measures - Mammography access via mobile mammography and fixed imaging - Chlamydia and cervical cancer improvement projects - Similarly, progress reports representing mandated PDSAs in the Fairfield and Santa Rosa Regions are due to DHCS by 06/11/2025. Updates will be included on the following topics: - Pediatrics Measures - Blood Lead Screening improvement - Fluoride Varnish application improvement
QUALITY MEASURE SCORE IMPROVEMENT	Brief status highlights from the domain specific Quality Measure Score Improvement workgroups at Partnership: Elder Care: This workgroup continues deepening foundational knowledge of the Dual Special Needs Plan (D-SNP) program and related measures. HRP transition will affect ability to review baseline data. Pediatric: No updates this month. Behavioral Health: Phase I of the Institute for Health Improvement (IHI)/ Behavioral Health Collaborative ends on 06/11/2025. The goal of this collaborative effort between Partnership and Nevada County Behavioral Health was to establish strong data sharing practices and understanding. Although this collaboration will continue, Partnership and Nevada County have decided not to participate in the optional Phase II within the IHI structure. Chronic Disease Management: Partnership funded ten (10) retinal cameras in imaging center deserts across the network. Partnership has received several memorandums of understandings from providers and has started issuing payments for devices to impact MY2025. Women’s Health & Perinatal: On 05/09/2025, the FDA approved a completely at-home test collection device created by Teal Health. Partnership’s Performance Improvement team has been in contact with Teal Health since early March to discuss how to make this option available to our members and use it to improve our cervical cancer screening rates. Currently, we are awaiting Teal Health to be an approved Medi-Cal, telehealth provider.

IMPROVEMENT ACADEMY	• Attendance at the 2025 Improving Member Outcomes (IMO) webinars, occurring over February through April, ranged from 53-90 attendees, with each session representing 28-45 unique organizations. Of attendees who completed the post-session evaluations for all six webinars, 99% selected <i>Strongly Agree</i> or <i>Agree</i> when asked if the webinar was relevant and useful. • The ABCs of Quality Improvement was offered via three in-person sessions this fiscal year. Attendance ranged from 21-48 attendees, representing 8-15 unique organizations. 100% of respondents rated this session as <i>Extremely Satisfied</i> or <i>Satisfied</i>. During each training session, an evaluation was implemented at the start of each of the four sections to measure participants' baseline knowledge. The same evaluation was launched after completion of each section. Participants' baseline knowledge was compared to post-session evaluation results to document improvements in content knowledge, comprehension or application as a result of the training. Each post-session evaluation revealed higher percentages of <i>Strongly Agree</i> and <i>Agree</i> as compared to pre-session evaluations. • The Preventive Care Dashboard microlearning is currently under development and projected to be completed late June/early July.
JOINT LEADERSHIP INITIATIVE (JLI)	• Joint Leadership Initiative meetings for the 4 selected providers in the Chico and Auburn regions are scheduled for fall 2025. • Fairfield Region: Held 2nd Quarter meeting with Solano Family Health Services on 05/06/2025. Sonja Bjork and Amy Turnipseed were in attendance, along with regional & QI leadership: Katheryn Power, Dr. Townsend, Flor Torres, Isaac Brown, and Jennifer Durst. Next Meeting is 08/05/2025. • Santa Rosa Region: No JLI participants. • Eureka Region: Open Door Community Health Center is scheduled 06/26/2025 and Adventist Health is 07/09//2025. • Redding Region: Fairchild Medical Center is scheduled 07/01/2025.
REGIONAL IMPROVEMENT MEETINGS	• Regional Quality meetings have been scheduled for the Chico and Auburn regions for July 21st and 24th respectively. • Fairfield: The second quarter meeting was held on 05/20/2025. CommuniCare+OLE shared their experience with the cervical self-swab pilot. • Santa Rosa: The regional team continues working to establish a Santa Rosa Regional Quality Meeting. Dr. Lisa Ward, the Regional Medical Director for Partnership, has socialized the idea with regional health center leaders and is distributing a survey regarding logistics and topics of interest. The goal is to hold the first meeting in third quarter of 2025. • Redding: The second quarter meeting is scheduled for 06/23/2025. • Eureka: The second quarter meeting was recently completed on 06/04/2025.

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>

<u>QI PROGRAM & PROJECT MANAGEMENT</u>	
ACTIVITY	UPDATE
CAHPS SURVEY PROGRAM - MEDI-CAL PRODUCT LINE AND FY 24/25 ORG GOALS AND FY 25/26 ORG GOALS	CAHPS® Regulated Measurement Year (MY) 2024 / Report Year (RY) 2025 Survey - Closed Preliminary Year-Over-Year Survey Respondent Rate Comparisons: - Adult Population 2023-2024 - 15.3% (3,375/510) 2024-2025 - 15.4% (3,375/511) - Child Population 2023-2024 - 16.1% (4,125/659) 2024-2025 - 15.8% (5,000/783) Additional Updates - The National Committee for Quality Assurance (NCQA) provided results and member-level files to both Press Ganey, the plan’s survey vendor, and the HEDIS team. - The HEDIS team is now in the process of validating the NCQA survey results. - The preliminary analysis is underway for the FY 2024/25 ME 7: Member Experience Grand Analysis (MEGA) report. Fiscal Year 2025/2026 Organizational Goal 5: Member Experience (MX) - The Partnership Project Review Board (PRB) approved the Project Charter in May. - The kickoff for the Member Experience Organizational Goal is set for early July.
EXACT SCIENCES: PROMOTING COLORECTAL CANCER SCREENINGS	Colorectal Cancer Web Page The new provider facing webpage is now available on Partnership’s website to support colorectal cancer screening efforts. The page includes a variety of internal and external resources, including: - Educational videos on Cologuard, developed by the Population Health Team - Information on how to order FIT tests - Links to materials for providers and patients The Cologuard overview outlines all available screening options and includes guidance on how to effectively address care gaps. If you’re interested in reviewing the page, you can find it at https://www.partnershiphp.org/Providers/Quality/Pages/Cologuard.aspx
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. The funding is divided between three (3) programs; the Initial Planning Incentives

Payments (IPIP), the Provider Directed Payment Program (PDPP), and the Statewide Learning Collaborative (SLC).

PDPP Participation and Deliverables

- All twenty-seven (27) provider organizations invited by DHCS to participate in the PDPP accepted by the 01/26/2024 deadline. Partnership had the third most accepted applications of all managed care plans with a 49% acceptance rate vs 29% state-wide. Accepted provider organizations span Partnership’s sub-regions, including five (5) from the 2024 - 10 county expansion, eight (8) tribal health centers, and seven (7) provider organizations already engaged under Partnership’s Enhance Provider Engagement (EPE) program.
- Following a statewide budget revision, DHCS recalculated the final PDPP award amounts. While other MCP’s experience a 5% dropout rate in their EPT cohorts, all 27 of Partnership participating providers have remained enrolled and actively engaged. DHCS has recalculated the final award amounts, due to budget revisions.
- As part of their continued participation, practices that were unable to submit their required 2024 deliverables by the original 11/01/2024 deadline now have until 11/01/2025 to fulfill those requirements. These deliverables include:
 - the Empanelment Assessment and Policy & Procedure under the Empanelment and Access milestones
 - the Data Governance and HEDIS Reporting Assessment, along with a corresponding Policy & Procedure under the Population Health Management (PHM) milestones
- Similarly, practices that did not submit the May 2025 deliverables by the 05/01/2025 deadline are also granted an extension to 11/01/2025. These deliverables include the PHM Implementation Plan and stratified HEDIS-like measures.
- If a practice did not complete the Year 2 PhmCAT by the extended 05/19/2025 due date, they will not have another opportunity to submit this deliverable for future submission. They will also be ineligible for any associated EPT payment for this deliverable.
- PHLC is currently reviewing submissions and will update practices and MCPs on the status – whether they were accepted, rejected, not submitted, or flagged for resubmission during the next submission period.

Revised EPT Payment Methodology

DHCS delayed the 2024 EPT payments due to CMS required changes. In response, MCPs and EPT practices received an updated payment methodology and detailed explanation for the delay. One key change from CMS was the exclusion of D-SNP members from assigned member counts. This adjustment prompted DHCS to request new member counts from participating MCPs, which were then used to recalculate payment amounts.

	- Under the original methodology, each practice was eligible for a total potential payment of \$250K regardless of their assigned member counts. Practices with more than 2,001 assigned lives earned an additional \$20 per assigned life. The new payment methodology introduces a tiered system, where payments are based on specific member count ranges and the per-member payment rate decreases as the number of assigned lives increases. - This change had a mixed impact on practices. While some saw an increase in their maximum potential payment, six (6) of our participating practices experienced a reduction. Statewide Learning Collaborative - The Statewide Learning Collaborative (SLC) is meant to support practices awarded PDPP funding in the implementation of practice transformation activities, sharing and spread of best practices, practice coaching activities, and achievement of quality and equity goals stated in their PDPP applications. Participation in the SLC is a requirement for all participants in the PDPP. - In June, the Redwood Learning Community hosted a two-part session to ensure flexibility in attendance. Part 1 was offered on 06/23/2025 and 06/24/2025, followed by Part 2 on 06/25/2025 and 06/26/2025. These sessions focused on strengthening core elements of the REPT care model and translating clinical transformation strategies into real-world practices.
PREVENTATIVE CARE BRIDGE PROJECT (FORMERLY: LOCUM PILOT INITIATIVE)	Overview of the Preventative Care Bridge Project The Preventive Care Bridge Project was developed as a short-term solution to provide access to clinicians with the goal of improving HEDIS performance in preventative care, specifically well-child visits and cervical cancer screenings. This offering was designed as a limited grant program; whereby select provider organizations are granted funds to hire a Locum Tenens Provider for a 4-week period in Pilot 1. Pilot 1 Summary and Funding Model A total budget of \$250,000 was approved for Pilot 1 with some funding remaining; participants received up to: \$45,000 when hiring a Physician. \$31,600 when hiring an Advanced Practicing Clinician. The Grant was paid in two installments: 50% upon signing the agreement. 50% upon completion of the four-week assignment and submission of a post-program survey. Program Implementation and Participation The initial cohort of providers was selected from those participating in the PCP Modified QIP. Out of six extended invitations, four applications were received and approved. The Locum assignment periods were carried out asynchronously through

January of 2025. Weekly Provider check-ins and data collection were conducted by a Partnership Improvement Advisor throughout the Locum Provider’s employment. Locum Providers alleviated a backlog of Well-Child and Adolescent Visits (WCV) while enabling urgent care coverage and allowing patients to schedule visits with their preferred physician.

Pilot 1 Provider Specific Outcomes

Hill Country Community Clinic, Community Medical Center, and Pit River Health Services completed their grant requirements. Despite an extension through May 2025, Round Valley Indian Health was ultimately unable to recruit a locum and complete the grant-related activities.

Pilot 2 Funding and Planning

Pilot 2 has been approved with a total budget of \$480,000, to support up to five (5) locum providers for three-month assignments aiming to:

- Increase provider capacity;
- Reduce appointment backlogs;
- Improve WCV and CCS HEDIS® priority preventive care measures.

By addressing access barriers through targeted locum support—and by proactively guiding providers to maximize these resources through clear onboarding, scope alignment, and data tracking—the pilot offers a cost-effective, high-impact strategy for improving clinical quality scores, reducing quality withholds and sanctions tied to low visit rates, and enhancing the overall member experience.

Pilot 2 Objectives:

- Refine effective strategies for using short term locum support to increase preventive care visit rates in the near term.
- Develop a practical locum toolkit that providers can integrate into their practices with a high probability of success with minimal disruption.

Pilot 2 Implementation:

Four providers have submitted applications and will be awarded up to \$96,000; one additional application is pending while exploring member reassignments.

- Ampla Health
- Western Sierra Medical Clinic
- Shasta Community Health
- Open Door Community Health
- La Clinica (application pending)

Participating providers will be required to meet obligations outlined in the agreement and will be monitored through weekly progress reports and regular check-ins with the Partnership program team.

	Kick-off meetings will be scheduled with participating providers to establish structured support during the recruitment and preparation period. Providers aim to have locums in place in time to optimize well-child visit capacity during the critical summer months.																																				
MOBILE MAMMOGRAPHY PROGRAM	Upcoming Event Days (FY Q4) – no changes from last month’s report <table><tr><th colspan="4">Upcoming Event Days 04/01/2025 – 06/30/2025</th></tr><tr><th>Region</th><th># of Provider Organizations</th><th># of Provider Sites</th><th># of Event Days</th></tr><tr><td>Auburn</td><td>2</td><td>2</td><td>2</td></tr><tr><td>Chico</td><td>1</td><td>2</td><td>2</td></tr><tr><td>Eureka</td><td>4</td><td>4</td><td>4</td></tr><tr><td>Fairfield</td><td>1</td><td>2</td><td>2</td></tr><tr><td>Redding</td><td>4</td><td>4</td><td>4</td></tr><tr><td>Santa Rosa</td><td>2</td><td>2</td><td>2</td></tr><tr><td>Plan Wide</td><td>14</td><td>16</td><td>16</td></tr></table> Scheduling for Mobile Mammography event days for FY 25/26 Q1 and Q2 (July – December 2025) is currently in progress.	Upcoming Event Days 04/01/2025 – 06/30/2025				Region	# of Provider Organizations	# of Provider Sites	# of Event Days	Auburn	2	2	2	Chico	1	2	2	Eureka	4	4	4	Fairfield	1	2	2	Redding	4	4	4	Santa Rosa	2	2	2	Plan Wide	14	16	16
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Plan Wide	14	16	16																																		
PARTNERING FOR PEDIATRIC LEAD PREVENTION PROGRAM	LeadCare II Device Access and Evaluation Partnership continues to support the Partnering for Pediatric Lead Prevention (PPLP) program, which provides funding for point-of-care lead testing devices to eligible practices. Applications are now accepted year-round. Details can be found on the PLPP page on Partnership's website. PPLP Webpage																																				
QI TRILOGY PROGRAM	- Updates for the FY2024/25 QI Work Plan have been finalized. - Updates for the FY2024/25 QI Evaluation are currently being compiled. - Goal submissions for the FY2025/26 QI Work Plan are due 06/18/2025. - All Trilogy documents (FY2025/26 QI Program Description; FY2024/25 QI Work Plan; FY2024/25 QI Evaluation; and FY2025/26 QI Work Plan) are on track to be submitted in July for formal quality committee approval.																																				
<u>D-SNP</u>																																					
ACTIVITY	UPDATE																																				
	In preparation for Partnership Advantage Star Strategy performance, leaders across the organization have designated Sponsors, Business Owners (BOs) and Process Owners (POs) for all Quality D-SNP measurements including Stars measures (CMS Part C and Part D), display measures, DHCS Quality metrics and Model of Care accountable measures. Sponsors, BOs and POs will meet with QI																																				

	Department members to understand the monitoring process and assist in stakeholder feedback for data visualization. • The QI Department is collaborating with Wakely (part of HMA) to develop a HEDIS visualization dashboard and a Stars analytics tool. • D-SNP is collaborating internally with the Project Management Office (PMO) and Regulatory and Compliance (RAC) in development of the D-SNP Metrics Monitoring project. This project will give departments across the organization real time data on Partnership Advantage performance metrics. • “Capturing Patient Acuity through Coding Part 2”, a webinar addressing coding acuity for D-SNP, is tentatively scheduled on Wednesday, 10/08/2025 at 12 p.m. and will be led by Dr. Kermit Jones. The webinar will be promoted to physicians and coding support personnel in the Partnership Advantage counties. Attendees will be eligible for 0.75 CME/CE credits upon completing the post-webinar evaluation.

QUALITY ASSURANCE AND PATIENT SAFETY

ACTIVITY	UPDATE																														
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: 04/24/2025 to 05/26/2025	• 19 PQI referrals were received with 12 coming from Grievance and Appeals, 4 from Utilization Management, 2 from Care Coordination, and 1 from QI Patient Safety. • 25 cases were processed and closed. 74 PQI cases are currently open. • One case was discussed at Peer Review Committee (PRC) on 05/21/2025 and there is one case awaiting PRC review. • Five cases were sent to the Medical Review Institute of America (MRIOA) for subject matter expert (SME) review, and one case was referred to an external SME physician. • The upgrade of the Sugar CRM PQI application (Processing, Documentation, and Tracking System) is ongoing and currently in the testing phase, with an updated completion target set for June 2025.																														
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR THE PERIOD: 4/21/2025 to 5/23/2025	• As of 5/29/2025, we have a total of 477 PCP and OB sites with an additional 35 reviews due to multiple check-ins (totaling 512 reviews). Primary Care and OB Reviews: <table><tr><th>Region</th><th># of FSR conducted</th><th># of MRR conducted</th><th># of FSR CAP issued</th><th># of MRR CAP issued</th></tr><tr><td>Auburn</td><td>5</td><td>4</td><td>0</td><td>1</td></tr><tr><td>Chico</td><td>2</td><td>2</td><td>0</td><td>2</td></tr><tr><td>Eureka</td><td>5</td><td>1</td><td>0</td><td>1</td></tr><tr><td>Fairfield</td><td>2</td><td>1</td><td>1</td><td>1</td></tr><tr><td>Redding</td><td>3</td><td>5</td><td>0</td><td>3</td></tr></table>	Region	# of FSR conducted	# of MRR conducted	# of FSR CAP issued	# of MRR CAP issued	Auburn	5	4	0	1	Chico	2	2	0	2	Eureka	5	1	0	1	Fairfield	2	1	1	1	Redding	3	5	0	3
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	Santa Rosa	6	5	2	2	
New sites opened this period → - Eureka: United Indian Health-Valley East Village - Fairfield: CommuniCare Ole Travis						

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE
Annual HEDIS® Projects	- The HEDIS team submitted final MY2024 measure rates to HSAG (designated DHCS HEDIS auditor) and Advent Advisory (designated NCQA accreditation HEDIS auditor) on 05/23/2025. Advent Advisory has approved Partnership’s final HEDIS rates for Health Plan Accreditation; HSAG’s approval is pending. - Partnership will also submit final rates for MCAS measures at the county level by 06/06/2025. County rates, which will not go through the MY2024 auditing process, will be used by DHCS for their accountability programs for the first time in MY2024. (Note that the 10 incoming counties to Partnership in 2024 will be exempt from sanctions for MCAS measure performance.)
HEDIS® Program Overall	- Partnership participates in DHCS’s Quality Sanctions Workgroup and recently responded to DHCS’s proposal to sanction MCP’s at the County level for MCAS measures performing below the Minimum Performance Level (50th percentile). At issue is DHCS’ proposal for sanctioning county-level measures with small denominators, defined by DHCS as measure denominators with under 100 members – this describes 43 of 252, or 17%, of Partnership’s county-level measures eligible for sanctions for MY2024 MCAS measures. Of note, DHCS’ 100-member threshold for county-level measures is inconsistent with NCQA’s Technical Specifications guidance on hybrid measure sampling criteria, which sets a threshold of 411 members to generate a statistically significant measure rate. - DHCS proposes that county-level measures with small denominators be aggregated with neighboring counties with small denominators until the 100-member threshold is met. Partnership submitted a counterproposal recommending that all county-level measures be evaluated for sanctions at the Rating Region level, which is consistent with the Withhold and Incentive accountability program that DHCS is also implementing in MY2024 and would generate eligible populations of at least 411 members across the MCAS measure set. We will learn DHCS final decision on quality sanctions methodology for MY2024’s MCAS measures in July 2025.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA)	HPA Mock File Reviews were held with our new NCQA consultant, Managed Healthcare Resources (MHR), in April and May 2025. Most file review

	requirements are Must-Pass requirements, and an organization must receive a MET score on all must-pass requirements to achieve or maintain accreditation. These Mock File Reviews will help to ensure Partnership remains in compliance throughout the look-back period. Some risks and opportunities for improvement were identified by MHR and results were shared with the applicable Business Owners. Business Owners have submitted Action Plans to address each finding/recommendation. Next steps include targeted Mock File Reviews with selected teams prior to the start of the look-back period in September 2025. Additional Mock File Reviews will take place with all applicable teams within three (3) months of implementation of the new system, Jiva, later this year.																
NCQA Health Equity Accreditation (HEA)	- Partnership’s HEA Initial Survey is scheduled for 06/17/2025. The NCQA Program Management Team has uploaded all evidence into NCQA’s online survey tool, the IRT, and is finalizing our submission. There are several post-survey activities, which include: <table border="1"> <thead> <tr> <th>Date</th><th>Activity</th></tr> </thead> <tbody> <tr> <td>07/11-15/2025</td><td>Receive and address initial issues</td></tr> <tr> <td>07/16/2025</td><td>Survey Conference Call with NCQA to discuss and clarify initial issues</td></tr> <tr> <td>07/17-21/2025</td><td>Respond and submit additional existing documentation to NCQA</td></tr> <tr> <td>08/04/2025</td><td>Closing Conference Call with NCQA</td></tr> <tr> <td>Week of 08/11/2025*</td><td>NCQA provides the preliminary report with scoring and assessment</td></tr> <tr> <td>08/12-25/2025*</td><td>Comment period on preliminary report; provide final responses to NCQA</td></tr> <tr> <td>September 2025*</td><td>Official Accreditation notice received</td></tr> </tbody> </table> *Estimated dates - NCQA is offering survey accommodations to organizations to support implementation of the Executive Orders issued in January 2025. These accommodations are effective for all accreditation surveys submitted on or after 02/12/2025 and will remain in effect until 06/30/2026. Partnership will self-score the identified standards as “NA” or “Met”, based on the approved scoring guidance issued by NCQA. Partnership will not submit evidence applicable to the identified standard(s) and will remove bookmarks and annotations in evidence that have approved scoring changes. The HEA Compliance Dashboard has been updated to reflect the scoring modifications. The total applicable points for Partnership is now 26, and our overall compliance rate is 100% based on our consultant’s review and approval of our HEA evidence. Changes and updates have been communicated to the impacted Business Owners during May Business Owner Check-in meetings.	Date	Activity	07/11-15/2025	Receive and address initial issues	07/16/2025	Survey Conference Call with NCQA to discuss and clarify initial issues	07/17-21/2025	Respond and submit additional existing documentation to NCQA	08/04/2025	Closing Conference Call with NCQA	Week of 08/11/2025*	NCQA provides the preliminary report with scoring and assessment	08/12-25/2025*	Comment period on preliminary report; provide final responses to NCQA	September 2025*	Official Accreditation notice received
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Chief Medical Officer Updates

Robert Moore, MD, MPH, MBA

June 18, 2025

1. Primary Care Provider Quality Incentive Program (PCP QIP) performance

The measurement year 2024 PCP QIP results have been processed and payments sent out. Here are some highlights of the results:

- With the 10-county geographic expansion in 2024, the number of sites participating in the PCP QIP increased from 252 to 390 providers by the end of the year. The Adjusted average score dropped from 68% in 2023 to 59% in 2024, largely due to threshold targets that were increased to pre-pandemic levels for legacy counties. New PCP sites (mostly in the expansion counties) had lower thresholds for their first year, as they became accustomed to the QIP, but in 2025 all established PCPs will have the same thresholds.
- Approximately \$52.2 million was earned by all sites, including just over \$1 million in Unit of Service incentives.
- Among sites with at least 50 members assigned, here are the ones scoring over 90%:

Private Practices:

West Marin Medical Center:	100%
Shasta Family Care:	91%

Medical Groups:

Sutter Medical Group , Yolo, Suite 200:	95%
Center for Primary Care (Northbay Hospital), Hillborn Rd.:	93%
Queen of the Valley Medical Associates , Trancas	92%

Tribal Health Centers:

Lake County Tribal Health , Bevins Ct. Lakeport:	93%

Federally Qualified Health Center Sites

Marin Community Clinics:

Larkspur	98%
Greenbrae	97%
San Rafael 3260 Kerner Blvd.	94%
Novato	92%
South Novato	92%
San Rafael 3110 Kerner Blvd:	92%

Communicare+Ole

St. Helena	98%
Calistoga	98%
South Napa Campus	90%

Santa Rosa Community Health Centers	
Lombardi	93%
Petaluma Health Center	
Petaluma	93%
Pt. Reyes	92%
Mendocino Coast Clinics	
Pediatric Group	92%
Open Door CHC	
Ferndale	90%

Among tribal health centers, **Lake County Tribal Health** sites had their best year ever, with scores between 84-93%. Small sites **Round Valley Tribal Health** and **K'ima:w Medical Center** both scored 75%, a dramatic improvement from last year.

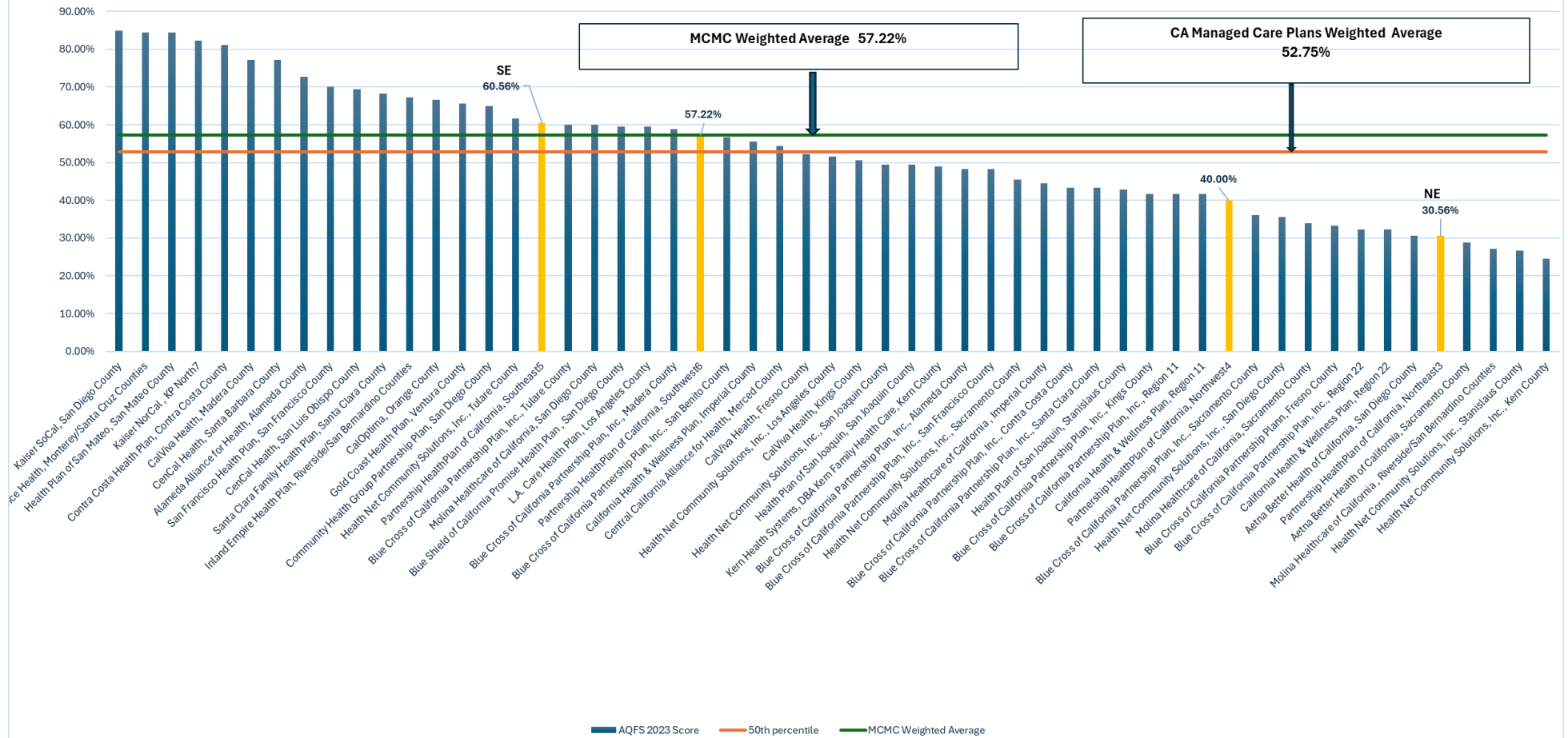
In the expansion counties, in the first year participating in the PCP QIP, eight of **Ampla Health** sites scored above the overall weighted average (Yuba City Pediatrics scored highest with 78%), as did two of **Northern Valley Indian Health** sites (Willows site scored highest at 77%).

2. Quality Factor Scores for Health Plans in California 2023

DHCS finally released the comparative results of the Healthcare Effectiveness Data Information Set (HEDIS®) Measurement Year (MY) 2023, as summarized below with Partnership's four regions noted in Yellow. The top performance (which had been 100% in most years) was down to 84% and the California Managed Care Plan weighted average was 5% below the national Medicaid Managed Care average for the first time ever. This is attributable to the addition of several new Managed Care Accountability Set (MCAS) measures with data reporting issues, as noted later.

The spread of performance in Partnership regions is typical of past years, reflecting the strong influence of rural health inequities due to several underlying sociodemographic factors.

AQFS MY2023 Score



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

Consent Calendar

June 18, 2025

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

Note that many Medi-Cal (“MC”) policies are being re-lettered “MP” as they are updated to apply to both Medi-Cal and Medicare (Partnership Advantage, eff. Jan. 1, 2027)

	Pages
G&A PULSE Report / Issue 17 / June 2025	63 – 73
Care Coordination	
MCCP2024 – Whole Child Model for California Children’s Services (CCS)	75 – 95
MPCP2014 – Continuity of Care – <i>new policy number and title change (“Medi-Cal” dropped) as policy will now apply to Medicare too. The policy is bundled here without Attachment C (400 pages of codes).</i>	97 – 136
Population Health	
MCNP9004 – Regulatory Required Notices (NEW Title)	137 – 151
MPNP9007 – Lactation Policy and Guidelines – <i>the former MCCP2020 in CC is archived on p.</i>	153 – 160
MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program – <i>the former MCCP2021 in CC in archived on p.</i>	169 – 172
Quality Improvement	
MPQP1004 – Internal Quality Improvement Committee	177 – 180
MPQP1008 – Conflict of Interest Policy for QI Activities	181 – 183
MPXG5009 – Lactation Clinical Practice Guideline	184 – 188
Utilization Management	
MCUG3134 – Hospital Bed/Specialty Mattress Guidelines	189 – 193
MCUP3044 – Urgent Care Services	195 – 197
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Our Mission

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



G&A PULSE REPORT

INSIDE THIS ISSUE

PG. 4

Breakdown of cases filed
per 1,000 members by
county

PG. 6

The number of
transportation-related
concerns decreased this
quarter

ISSUE 17 | JUNE 2025

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 2025.

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

Fluctuations in data can happen. Therefore, statistics included in this report are presented with a 95% confidence level.

1Q25 HIGHLIGHTS

OVERALL NUMBERS

In 1Q25, G&A investigated 1,748 cases. The chart below shows a breakdown of the cases investigated this quarter. Of the 1,403 cases subject to DHCS-mandated timeframes, 99.4% were closed on time, which is significantly above our goal.

1Q25 TOTAL # INVESTIGATED CASES		
Case Type	# Cases	% Grand TTL
Grievance	1,206	69.0%
Exempt	279	16.0%
Appeal	198	11.3%
State Hearing	65	3.7%
Grand Total	1,748	100.0%

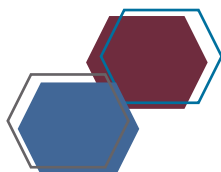
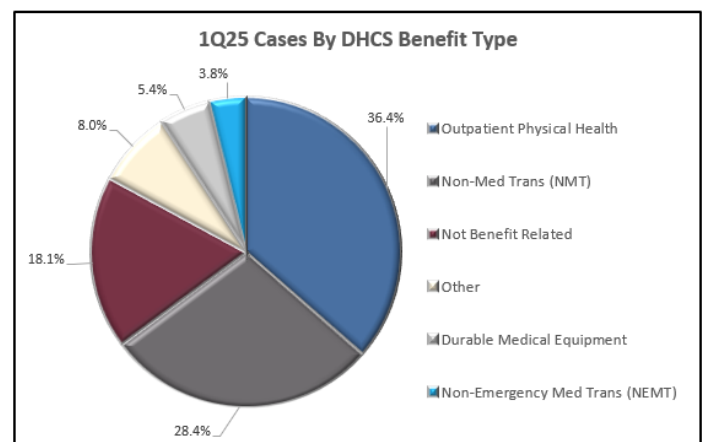
KEY POINTS & TRENDS

Provider Communication / Poor Provider Attitude – Two of the highest reported concerns this quarter were provider communication and poor provider attitude. Within these categories, approximately 20.3% of the grievances involved allegations of discrimination, suggesting that members perceive communication issues that go beyond general dissatisfaction. In many of the grievances within this category, members reported that providers or office staff were rude, dismissive, or unprofessional, highlighting concerns around both interpersonal conduct and cultural sensitivity.



DHCS CATEGORIES

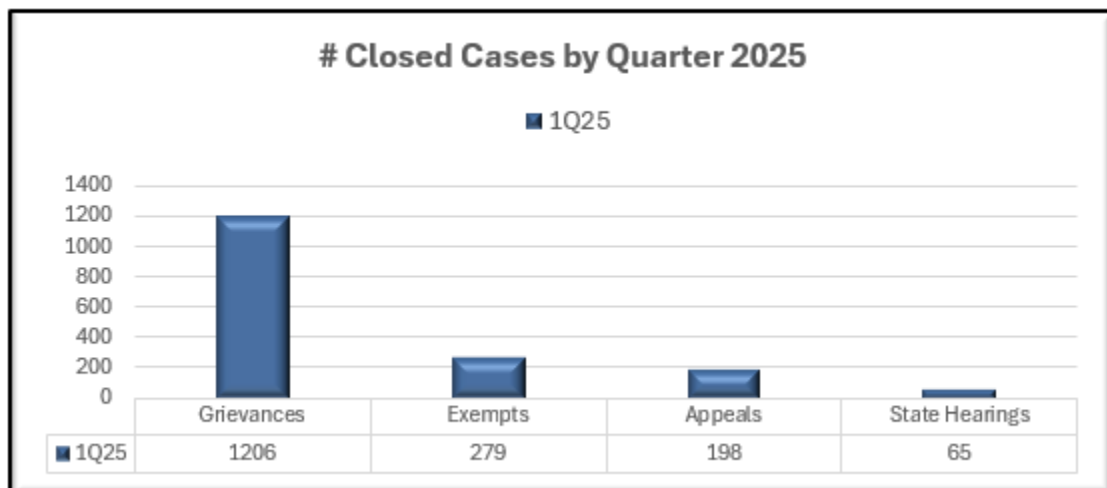
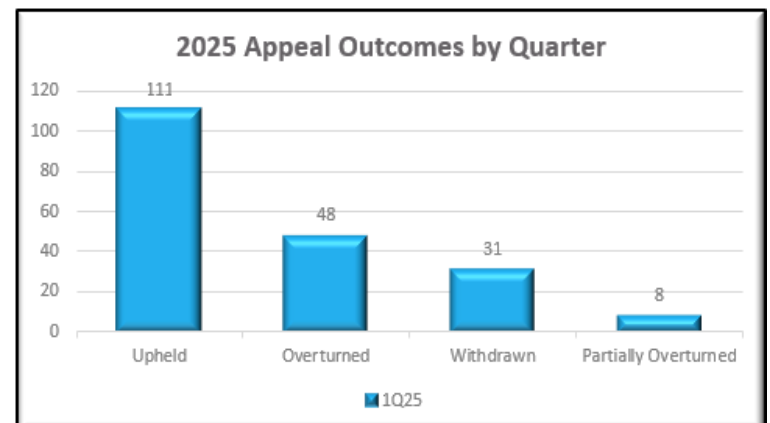
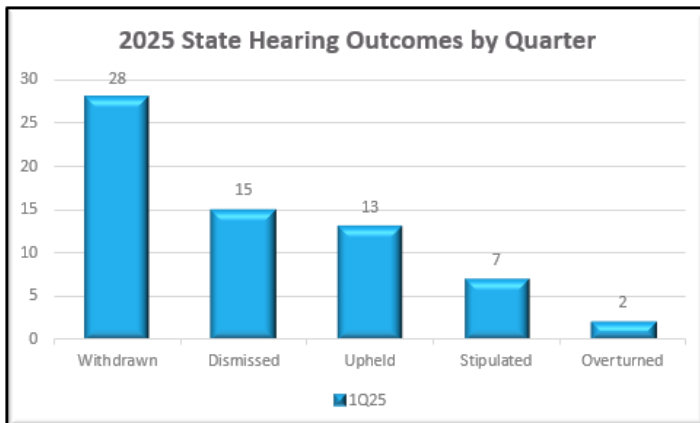
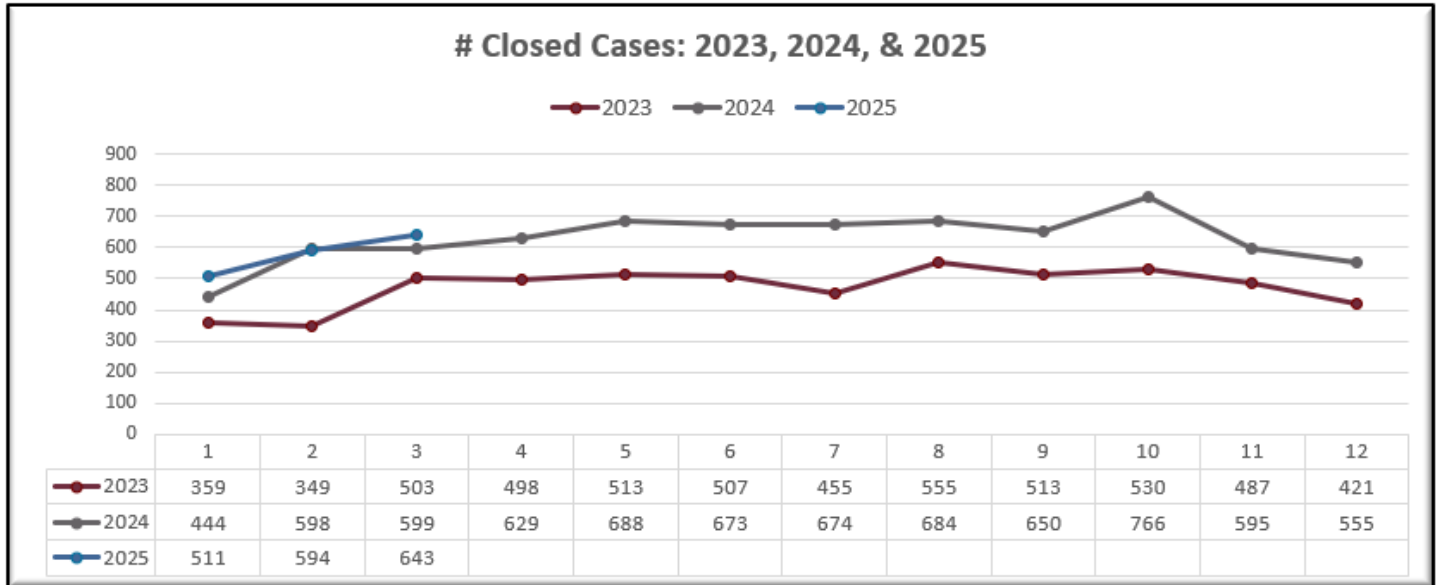
Outpatient Physical Health services were the most frequently reported Benefit Type which represented 36.4% of the reported concerns, followed by Non-Medical Transportation (NMT), which represented 28.4%. Cases that were Not Benefit Related accounted for 18.1% of the DHCS Benefit Type categories. Cases 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.



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 1Q25.



1Q25 CASES BY COUNTY			
AUBURN			
County	# of Cases	Avg Membership	Cases p/1,000
Nevada	58	28,643	2.02
Placer	158	60,635	2.61
Plumas	7	5,851	1.20
Sierra	2	875	2.29
Total	225	96,004	2.34

1Q25 CASES BY COUNTY			
EUREKA			
County	# of Cases	Avg Membership	Cases p/1,000
Del Norte	38	12,424	3.06
Humboldt	156	58,344	2.67
Lake	57	34,199	1.67
Mendocino	72	40,772	1.77
Total	323	145,739	2.22

1Q25 CASES BY COUNTY			
CHICO			
County	# of Cases	Avg Membership	Cases p/1,000
Butte	136	85,650	1.59
Colusa	5	10,184	0.49
Glenn	18	13,640	1.32
Sutter	44	43,422	1.01
Yuba	44	36,632	1.20
Total	247	189,528	1.30

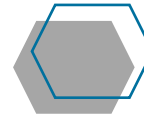
1Q25 OF CASES BY COUNTY			
REDDING			
County	# of Cases	Avg Membership	Cases p/1,000
Lassen	18	8,769	2.05
Modoc	12	3,974	3.02
Shasta	208	65,917	3.16
Siskiyou	40	17,769	2.25
Tehama	68	30,171	2.25
Trinity	22	5,326	4.13
Total	368	131,926	2.79

1Q25 OF CASES BY COUNTY			
SANTA ROSA			
County	# of Cases	Avg Membership	Cases p/1,000
Sonoma	138	112,031	1.23
Marin	77	46,633	1.65
Total	215	158,664	1.36

1Q25 CASES BY COUNTY			
FAIRFIELD			
County	# of Cases	Avg Membership	Cases p/1,000
Solano	229	102,247	2.24
Napa	38	25,451	1.49
Yolo	103	52,848	1.95
Total	370	180,546	2.05



DEMOGRAPHICS



CHARACTERISTICS OF FILING MEMBERS

The following charts represent key demographic data of members who filed an Appeal, Grievance, or State Hearing during 1Q25.

1Q25 % CASES BY AGE		
Member Age	% Cases	% Membership
Age 0-10	6.2%	18.5%
Age 11-19	4.7%	16.4%
Age 20-44	26.6%	34.5%
Age 45-64	43.7%	19.7%
Age 65+	18.7%	10.9%

1Q25 % CASES BY GENDER		
MBR Gender	% Cases	% Membership
Female	62.9%	52.0%
Male	37.1%	48.0%

1Q25 % CASES BY ETHNICITY		
Member Ethnicity	% Cases	% Membership
White	56.2%	38.4%
Hispanic	15.1%	34.0%
Other/Unknown	7.9%	18.0%
Black (African American)	1.0%	3.5%
Asian	16.4%	2.5%
Native American	2.2%	1.8%
Asian Indian	1.1%	1.6%
Native Hawaiian or	0.1%	0.2%
Other Pacific Islander		

1Q25 % CASES BY LANGUAGE		
Member Language	% Cases	% Membership
English	90.8%	76.0%
Spanish	7.3%	20.7%
Other	0.9%	1.9%
Russian	0.6%	0.6%
Punjabi	0.1%	0.5%
Tagalog	0.3%	0.3%

“Jessi’s work was fast, professional and I got quick results. I have had nothing but great experiences with any Partnership staff I have interacted with. I want everyone to know how grateful I am for how kind, helpful and wonderful Partnership staff have been.”

- Partnership Member

TRANSPORTATION



REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Transportation during 1Q25.

1Q25 STATISTICS

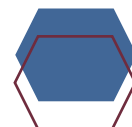
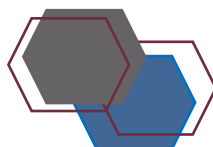
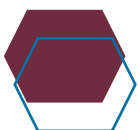
Transportation cases in 1Q25 accounted for 589 cases of the total 1,748 cases closed. This represented 33.6% of all cases closed in 1Q25. This is a decrease compared to the previous quarter in which 38.3% of the cases were related to transportation services. There were 46 Appeals, 533 Grievances (Exempt and Standard), and 10 State Hearings, this represented 0.16% of the 348,634 rides provided to members this quarter.

Ten of the cases closed in this quarter were State Hearings. Five (5) State Hearings were related to transportation expenses that were upheld by the Administrative Law Judge (ALJ), two (2) cases were stipulated, two (2) cases were withdrawn by the members, and one (1) case was dismissed due to non-appearance by the member.

G&A identified multiple complaints against the Transportation Services department. The top two (2) complaints against the Transportation department for 1Q25 included scheduling issues and reimbursement for Lodging/Meals.

TRENDING ISSUES

NorthBay Transit, Lyft, Redline Transit, Budget Friendly, and Silver Lining are the top five providers our members reported concerns about in 1Q25. Members had issues such as missed rides, drivers arriving late, driver behavior and scheduling issues. The highest number of transportation related cases were reported in Humboldt County, which consisted of 13.9% of the cases, followed by Solano County with 10.3% of the cases. There were 67 NEMT cases and 511 NMT cases in 1Q25.



W&R RELATED

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Wellness & Recovery (W&R) during 1Q25. 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.

1Q25 NUMBERS

There were six (6) W&R cases received in 1Q25, representing 0.3% of the total concerns reported this quarter.

TRENDING ISSUES

G&A received six (6) grievances and zero (0) appeals. All of the grievances received in 1Q25 were also resolved in the same quarter.

After investigation of the cases, it was determined that the providers were not at-fault in four (4) of the cases. However, G&A was able to substantiate the two (2) remaining cases.

In one case, the member reported concerns regarding a staff member at Southern Solano Alcohol Council Detox facility, who was allegedly rude and discharged them prematurely. Upon investigation it was confirmed that the staff member did not allow proper discharge procedures.

In the other case, the member raised the concern that an incident was reported to their probation officer, by the Cache Creek Lodge Emergency Room, which they believed constituted a HIPAA violation. We confirmed that the information was indeed shared with the probation officer. However, it was also confirmed that Partnership HealthPlan is not involved in the probation communication process.

All of the grievances were related to provider care and/or case management. Two (2) of the six (6) grievances were related to the member not following program rules.

The program rules that were not followed included smoking/vaping on the premises and not completing the full 90-day treatment period.



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.

1Q25 W&R Cases	
# of Grievance Received	6
# of Grievance Resolutions	6
# of Appeal Received	0
# of Appeal Resolutions	0

2025 DHCS Grievance Categories	
Access to Care	2
Quality of Care	1
Program Requirements	2
Interpersonal Relationship Issues	1
Failure to Respect Enrollee's Right	0
Other	0



CCS RELATED

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to California Children's Services (CCS) and Whole Child Model (WCM) during 1Q25.

1Q25 STATISTICS

A total of 21 CCS-related cases were closed in 1Q25, representing 1.2% of the 1,748 cases closed. These cases are broken down into 10 Grievances and 11 Appeals.

TRENDING ISSUES

The most commonly reported issues were related to transportation and Durable Medical Equipment (DME). There were five (5) Grievances, and one (1) Appeal related to transportation issues and six (6) Appeals related to DME. This accounted for 57.1% of the 21 cases submitted. Among these cases, members most frequently had issues with the delay in getting reimbursement for gas mileage associated with CCS-related services, and requests to overturn the denial of CCS-related DME.

Of the remaining cases unrelated to transportation and DME, four (4) of them were Appeals. Three (3) of the four (4) Appeals were upheld due to lack of medical necessity, one (1) was overturned as member met the medical necessity criteria.



DISCRIMINATION AGAINST CCS MEMBERS

G&A reviews all allegations of discrimination to determine if they fall under a civil rights law. There were no cases of discrimination reported for CCS members during 1Q25.



ETHNICITY AND PREFERRED LANGUAGE

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

1Q25 % CASES BY ETHNICITY		
Member Ethnicity	# Cases	% Cases
Other/Unknown	8	38.1%
White	7	33.3%
Hispanic	4	19.0%
Asian/Pacific Islander	1	4.8%
Other Asian	1	4.8%
Grand Total	21	100.0%

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

1Q25 CCS CASES BY LANGUAGE		
Member Gender	# Cases	% Cases
English	18	85.7%
Spanish	3	14.3%
Grand Total	21	100.0%

DISCRIMINATION

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to discrimination during 1Q25. 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.

1Q25 DISCRIMINATION STATISTICS

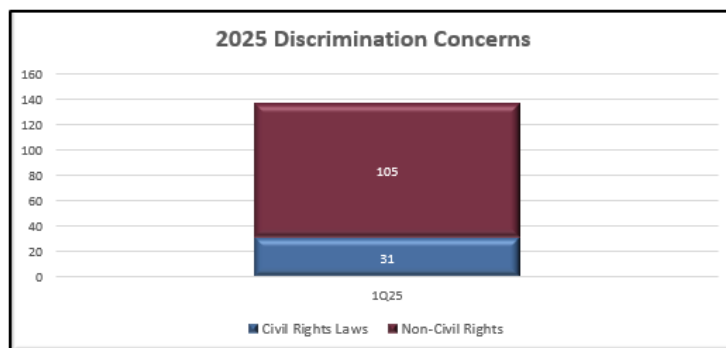
G&A investigated 113 cases containing 136 discrimination allegations in 1Q25. This represented 6.5% of all cases closed. Of the 113 cases, 82 fell under applicable federal or state civil rights law. Twenty-two (22) cases contained allegations that fell under multiple categories.

After investigation, it was determined discrimination likely occurred in twelve (12) cases.

In four (4) of the cases, there was a failure to provide an interpreter. These issues were related to language assistance services. Similarly, in another case, no language assistance resulted in a patient missing multiple appointments and rides due to limited English skills.

In another five (5) cases, there were issues of inappropriate behavior and/or rude comments made by the driver, doctor, or office staff. These incidents were related to a variety of issues such as Disability, Race/Ethnicity, Age, and Gender.

In two (2) of the cases filed, the same member faced similar issues with different NEMT transportation providers. They expected door-to-door service in which the driver refused to accommodate. Feedback and education were provided to the vendor to avoid this issue from occurring again.



Discrimination allegations that do not fall under a civil rights law accounted for 31 of the 113 alleged discrimination cases filed. Members alleged discrimination based on reasons such as having certain health insurance coverage, being labeled a medication/drug seeker or negligent parent, their physical appearance, or socioeconomic status.

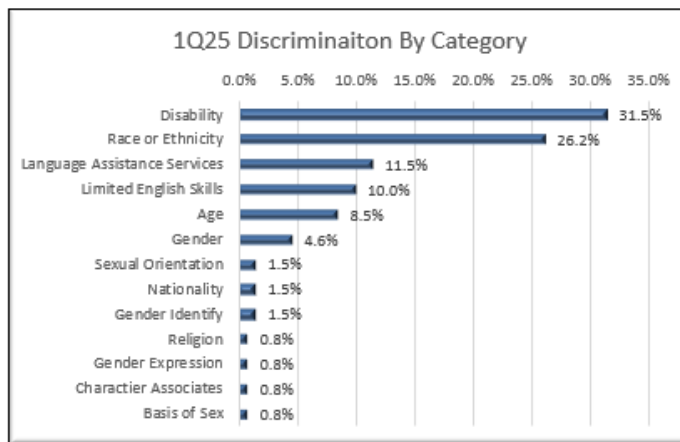
1Q25 DISCRIMINATION TRENDS

Overall, the number of discrimination allegations has increased. There was a 14.1% increase in discrimination allegations compared to the previous quarter.

1Q25 CASES BY CATEGORY

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

The most commonly reported allegation was Disability accounting for 31.5% concerns reported followed by Race/Ethnicity accounting for 26.2% of the concerns.



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.

THE RESULTS

A sample size of 49 cases were evaluated for 1Q25 consisting of only Grievances.

The G&A Nurse Specialists categorized all the cases evaluated by the Medical Director correctly and the solutions were satisfactory.

There were several opportunities for improvement identified by G&A leadership. The first being timely and accurate documentation. G&A staff must ensure that all relevant attachments are uploaded to their cases promptly, and that the correct naming conventions are consistently used. Second, all cases should be thoroughly reviewed and closed in their entirety once all required actions have been completed, to ensure proper documentation and workflow continuity.



TIMELINESS

For 1Q25, 1,403 cases were subject to DHCS Turnaround Times (TAT).

The target timeliness goal for investigations is 98.6%, and we achieved 99.4%.

There were 12 late acknowledgment letters (ack-letters), but the timeliness goal for this category was still met. Reasons for these delays included internal issues with sending letters to translation and system problems.

1Q25 DHCS Timeliness Performance				
Performance Category	Performance Goal	# Late	Performance Result	Status
Investigations	98.6%	8	99.4%	●
Ack-Letters	98.6%	12	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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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCCP2024			Lead Department: Health Services Business Unit: Care Coordination	
Policy/Procedure Title: Whole Child Model For California Children's Services (CCS)			☒ External Policy ☐ Internal Policy	
Original Date: 11/14/2018 Effective Date: 01/01/2019 per DHCS		Next Review Date: ~~04/09/2026~~ 08/13/2026 Last Review Date: ~~04/09/2025~~ 08/13/2025		
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD		☐ COMPLIANCE	☐ FINANCE
	☐ CEO	☐ COO	☐ CREDENTIALS	☒ PAC
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: 04/09/202508/13/2025	

I. RELATED POLICIES:

- A. MPCD2013 – Care Coordination Program Description
- B. MCCP2007 – Complex Case Management
- C. MCCP2023 – New Member Needs Assessment
- D. MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services
- E. MPCP2006 – Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities
- F. ~~MPCP~~2014 – Continuity of Care
- G. ~~MPTP2503CCP2030~~ – Ancillary Transportation Services: Lodging, Meals, Attendants, Parking and Tolls
- H. MCRP4064 – Continuation of Prescription Drugs¹
- I. ~~MCUP3039~~MPUP3039 – Direct Members
- J. MCUP3013 – Durable Medical Equipment (DME) Authorization
- K. MCUP3041 – Treatment Authorization Request (TAR) Review Process
- L. MCCP2032 - CalAIM Enhanced Care Management (ECM)
- M. MCAP7001 - CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
- N. MCCP2035 - Local Health Department (LHD) Coordination
- O. MCUP3104 - Transplant Authorization Process
- P. MCCP2025 - Pediatric Quality Committee Policy
- Q. MCUP3037 - Appeals of Utilization Management/ Pharmacy Decisions
- R. CGA024 - Medi-Cal Member Grievance System
- S. MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities

II. IMPACTED DEPTS:

- A. Health Services
- B. Claims

¹Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal fee-for-service (FFS) as described in All Plan Letter [\(APL\) 22-012 Revised](#), and all medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/DHCS-contracted pharmacy administrator instead of Partnership. Refer to the Partnership website page for pharmacy authorization criteria and a link to the State Medi-Cal Contract Drug List (CDL): <http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx>

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Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

- C. Member Services
- D. Provider Relations

III. DEFINITIONS:

- A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
- B. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status may be based on the Member's medical condition, prime insurance, demographics or administrative eligibility status. Direct Members do not require a Referral Authorization Form (RAF) to see a specialist.
- C. ICF/DD: Intermediate Care Facilities for the Developmentally Disabled
- D. ICF/DD-H: Intermediate Care Facilities for the Developmentally Disabled/Habilitative
- E. ICF/DD-N: Intermediate Care Facilities for the Developmentally Disabled/Nursing
- F. Individualized Care Plan (ICP): A care plan developed through Care Coordination tailored to the needs of the Member and supporting him/her to attain the health/wellness goals that he/she has identified. This care plan may be developed through discussion with the Member and/or with the Member's caregiver, and will reflect collaboration with the Member's providers.
- G. Memorandum of Understanding (MOU): Where no reimbursement is to be made, Partnership shall negotiate in good faith a MOU for services provided by said agency. MOU shall describe the scope and responsibilities of both parties in the provision of services to Members; billing and reimbursements; reporting responsibilities; and how services are to be coordinated.
- H. Newly Eligible WCM Members: Members recently determined to be eligible for the WCM Program with no history of participation in the WCM or CCS Programs.
- I. Newly Transferred WCM Members: Any Member who is new to the MCP but already a part of the CCS/WCM Program, as in the case of Intercounty Transfer (ICT).
- J. Pediatric Health Risk Assessment (PHRA): An assessment form mailed to newly enrolled pediatric Members (under age 21) with corresponding Seniors and Persons with Disabilities (SPD) aid codes and/or California Children's Services (CCS) identifiers who may be at risk for adverse health outcomes without support from an Individualized Care Plan (ICP).
- K. Pediatric Risk Stratification Process (PRSP): A process in which a child's medical needs are triaged into high-risk and low-risk. This process will help identify those children that are at a higher risk for needing medical case management.
- L. Receiving County: i.e. County to which a Member is moving to and in which they will claim residence.
- M. Sending County: i.e. CCS counties from which Members are moving.
- N. Whole Child Model (WCM): A comprehensive program for the whole child encompassing providing comprehensive diagnostic and treatment services and care coordination in the areas of primary, specialty, and behavioral health for any pediatric Member with CCS eligible conditions insured by Partnership. A comprehensive program for the whole child encompassing providing comprehensive diagnostic and treatment services and care coordination in the areas of primary, specialty, and behavioral health for any pediatric Member insured by Partnership.

IV. ATTACHMENTS:

- A. Pediatric Risk Stratification Process
- B. FAC Charter

V. PURPOSE:

Policy/Procedure Number: MCCP2024			Lead Department: Health Services Business Unit: Care Coordination
Policy/Procedure Title: Whole Child Model For California Children's Services (CCS)			☒ External Policy ☐ Internal Policy
Original Date: 11/14/2018 Effective Date: 01/01/2019 per DHCS			Next Review Date: <u>08/13/2026</u> <u>04/09/2026</u> Last Review Date: <u>08/13/2025</u> <u>04/09/2025</u>
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

To describe how California Children's Services (CCS) and the coordination of care for the CCS-eligible population assigned to Partnership HealthPlan of California (Partnership) will be integrated into the operations of Partnership as part of the Whole Child Model (WCM); and to outline the collaboration between Partnership, providers, county CCS agencies, community resources, and the CCS Mmember and their caregiver. The goals of the WCM are as follows:

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

VI. POLICY / PROCEDURE

A. CCS Program Eligibility

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

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- c. Demonstrates a potential MTP eligible condition.
4. Partnership will refer NICU, HRIF, and MTP Mmembers with potential CCS eligible conditions to the County CCS Program for review and determination of eligibility for services.
 - a. CCS NICU eligibility may involve identification of a potential CCS-Eligible Condition which may confer CCS Program eligibility beyond the NICU stay. Partnership will inform the County CCS Program if a Member is at any point subsequently identified as having a potential CCS-Eligible Condition so that the County CCS Program can conduct the CCS eligibility determination process for the Member. MCPs will review authorizations and determine if services meet CCS NICU referral requirements in accordance with CCS Program guidelines found in CCS NICU Standards and CCS N.L. 02-0413.
 - b. Partnership will conduct NICU eligibility assessments in accordance with CCS Program guidelines for medical eligibility for care in a CCS-approved NICU, as found in CCS NL 05-0502. All Mmembers identified as meeting the criteria for the NICU eligibility assessment will be referred to the County CCS program as described above.
 - c. Partnership will refer all Members with a potential MTP eligible condition to the County CCS Program and will include all supporting documentation with the referral. As a part of the CCS eligibility review, the County CCS Program will review and determine MTP eligibility. County MTPs will submit referrals to Partnership for Medically Necessary specialty services and follow-up treatment, as prescribed by the MTC physician or CCS-paneled physician who is providing the MTP medical direction for occupational and physical therapy services. Partnership will collaborate with county MTU/MTP programs to facilitate referrals to the program, when MTU/MTP service needs are identified, including the Mmembers under age three who are at risk for needing MTU/MTP services.
 - d. Partnership will conduct a HRIF program acuity assessment and authorize any HRIF services for the Mmember in accordance with the HRIF Eligibility Criteria. Partnership will ensure access or arrange for the provision of HRIF case management services. Partnership will notify the county of any CCS-eligible neonates, infants, and children up to three years of age who have been identified as having a potential CCS-eligible condition through the HRIF program.
 - e. Partnership will include supporting documentation of the Mmember's potential CCS-Eligible condition when submitting referrals to the CCS Program for eligibility determinations for HRIF, MTP, and NICU. Documentation may include NICU discharge summaries, HRIF reports and final reports, or necessary documentation as listed below.
5. Partnership will provide available necessary documentation received or retrieved by Partnership's case management or utilization management staff, or assist Network Providers in referring with necessary documentation, including but not limited to current medical records, case notes, discharge summaries (if applicable), physical examination results, laboratory test results, radiologic findings, and other tests/examinations or reports that pertain or support to the CCS-Eligible Condition, including any MTP diagnosis to the CCS county. Independent counties will review for the initial medical determination for the CCS program and dependent counties will send it to DHCS, who is responsible for dependent county medical determinations. All documentation will be, to the extent possible, produced within the last 6 months but no later than 12 months. Partnership will make outreach attempts to the Network Provider and the CCS Mmember to obtain medical records, as well as take appropriate action if medical records recovery is unsuccessful. County CCS will notify Partnership within 5 days of receipt if referral is incomplete where Partnership will then notify Network Provider for record request. The case manager will send the received or retrieved medical record documentation to the County CCS.
 - a. A complete referral shall include:
 - 1) First and last name of the referred Mmember

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- 2) First and last name of parent or legal guardian (except for Mmembers aged 18 years or older)
- 3) Date of birth
- 4) Address and telephone number
- 5) Statement of services requested
- 6) A comprehensive medical documentation identifying the suspected CCS-eligible medical condition
- b. The referral shall be transmitted by a method mutually agreed upon by both Partnership and the county CCS program/DHCS. Referrals will be made upon identification and will not be postponed until the annual CCS medical eligibility redetermination period.
6. For the Annual Medical Redetermination, Partnership will receive a list from the counties a minimum of 120 days in advance of the eligibility end date. Partnership sorts by soonest eligibility end date and will make outreach attempts to the Network Provider and the CCS Mmember to obtain medical records, as well as take appropriate action if medical records recovery is unsuccessful.
 - a. Partnership will provide the documentation received or retrieved by Partnership's case management staff (VI.A.5.a), including efforts made to receive required documentation when it is not available, to the County CCS program no later than 60 calendar days before the Member's program eligibility end date, unless the County CCS Program verified that all needed medical information is already available to them. DHCS is responsible for dependent county medical determinations and independent counties conduct medical determinations for their counties.
 - b. The county CCS program/DHCS will notify the Mmember and/or primary caregiver of the CCS program eligibility determination.
 - c. The County CCS Program/State will complete CCS program eligibility on new Medi-Cal covered referrals within 10 working days of receipt of a referral or receipt of adequate medical reports to a medical eligibility determination. The disposition of eligibility determination will be documented in the state eligibility tracking system and will be made available to Partnership at the time the decision is made.
7. When Partnership becomes aware that a Mmember has lost Partnership eligibility or has moved out of Partnership's service area, Partnership will notify the County CCS program.
8. The County CCS Program will alert Partnership of any CCS case closure or loss of eligibility and a CCS Notice of Action (NOA) will be sent to family upon case closure.
9. Partnership will inform the Mmember/caregiver and primary care provider of the referral.
- B. Utilization Management
 1. Under WCM, CCS Mmembers are able to receive the same CCS benefits and services through Partnership as they did through County CCS programs. These services are based on medical necessity and are reviewed by Partnership Health Services staff. In addition, care for pediatric Mmembers will also consider the benefits outlined in APL 23-005 "Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members under the age of 21" and Partnership policy MPCP2006 "Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities."
 2. Partnership ensures coverage for medically necessary Medi-Cal covered services for the Mmember's potential CCS eligible condition while CCS eligibility is determined.
 3. Once CCS program eligibility is established, Partnership is responsible for the provision of all medically necessary covered services under the WCM and assigns the Mmember to "Direct Member" status as described in policy M~~P~~CUP3039 Direct Members. Direct Members do not require a Referral Authorization Form (RAF) to see a specialist, however, Partnership assigns the Mmember a medical home to ensure completion of preventative care.
 4. Partnership shall provide the CCS Maintenance and Transportation (M&T) benefits for CCS eligible

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- Members or the Member's family seeking transportation to a medical service related to their CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services and per criteria set forth in DHCS Numbered Letter (NL) 03-0810. M&T services include meals, lodging, and other necessary costs (i.e. parking, tolls, etc.). (See policy MTP2503CCP2030 – Meals, Lodging, Parking and Tolls for Members under 21 years of Age).
5. County MTU/MTP programs will perform the initial review of therapy services, durable medical equipment (DME), orthotics and prosthetics per state guidelines. (See Attachment E of Partnership policy MCUP3013 Durable Medical Equipment (DME) Authorization for recommended review process).
 - a. Once the MTU/MTP review is completed by MTU/MTP staff, a referral packet will be sent to vendor for their use in submitting a Treatment Authorization Request (TAR). [See policy MCUP3041 Treatment Authorization Request (TAR) Review Process.] A TAR packet will include the following:
 - 1) First and last name of the Member
 - 2) Date of birth
 - 3) Client Identification Number (CIN)
 - 4) Statement of services requested/ prescription form
 - 5) Medical justification for the requested services, such as therapy notes, physician visit notes, etc.
 - b. If the request is deemed unnecessary or inappropriate, the MTU/MTP program will forward a copy of their recommendation with supporting documentation to Partnership.
 - c. The county MTU/MTP will provide technical assistance to the vendor, family and Partnership in the approval process.
 6. Partnership is required to cover all medically necessary blood, tissue, and solid organ transplants for WCM Members, please refer to Partnership policy MCUP3104 Transplant Authorization Process for more details.
 7. Partnership will conduct, at least quarterly, a review of their inpatient utilization data to assess whether all potential WCM Members have been appropriately referred to the County CCS program. If Partnership identifies any Members that have a potential CCS Eligible-Condition and a referral has not been made to the County CCS Program, Partnership will promptly refer the Member, providing their most recent medical records as outlined above.
- C. Case Management and Care Coordination
1. Partnership Members participating in the WCM and their families/caregivers are eligible to receive comprehensive Care Coordination and Case Management services. Partnership WCM case management and care coordination is a Member and family centered care approach which ensures needed clinical and non-clinical services for the CCS eligible condition; are made available to each WCM Member through comprehensive, interdisciplinary, and person-centered case management and care coordination to ensure that WCM Members have access to diagnostic and treatment services of the whole child in the areas of primary, specialty, and behavioral health for CCS eligible and non-CCS eligible conditions. Partnership collaborates with the WCM Member, Member's family, or authorized representative of the WCM Member to identify needs, goals, and preferences in accessing such diagnostic and treatment services. Partnership interventions to identified barriers to access to care include coordination of services for appointments, referrals, DME, transportation, and subsequent confirmation that ICP access goals are met. Members may decline Case Management services without impact to their enrollment and/or participation in the WCM Program.
 2. Pediatric Members who are new to Partnership will be mailed a survey to stratify their risk in accordance with policies MCCP2023 New Member Needs Assessment, and MCCP2019 Identification and Care Coordination for Seniors and Persons with Disabilities and/or California

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Children's Services.

- a. Pediatric Mmembers assigned a Seniors and Persons with Disabilities (SPD) aid code and/or those with a CCS identifier will be sent a PHRA survey within 10 calendar days of enrollment into the plan.
 - 1) The Health Risk Assessment (HRA) will address:
 - a) General health status as reported by the Mmember and/or primary caregiver(s)
 - b) Recent health care utilization (ex. outpatient, emergency room, inpatient visits, school days missed due to illness, etc.)
 - c) Review of health history; both CCS and non-CCS diagnoses and past surgeries.
 - d) Referral needs
 - e) Prescription medication utilization
 - f) Durable Medical Equipment (DME) needs
 - g) Need for specialized therapies if applicable (ex. physical, occupational, speech, mental or behavioral health services, and educational or developmental services).
 - h) Limitations of Activities of Daily Living (ADLs) or daily functioning if applicable.
 - i) Demographics and Social History, including but not limited to Mmember demographics, home/school environment(s), and cultural and linguistic needs and preferences.
 - b. New pediatric Mmembers who are not assigned an SPD aid code, or who are not identified as a CCS beneficiary, will be sent a Health Information Form (HIF) survey with their Partnership Welcome Packet.
3. Partnership will use a Pediatric Risk Stratification Process (PRSP) to assess the risk new pediatric Mmembers, newly CCS-eligible Mmembers, or WCM transition Mmembers within 45 days of the County CCS program eligibility determination for newly eligible WCM Mmembers and newly transferred WCM Mmembers. Members will be assigned a risk score (High or Low) based on PRSP results. The methodology of the PRSP is as follows:
 - a. Members with available claims data:
 - 1) Application of a Pediatric Risk Stratification Algorithm (see Attachment A)
 - 2) Analysis of utilization and costs
 - b. Members previously managed by a County CCS Program:
 - 1) Case Review with County CCS staff, when possible
 - c. Risk Assignment:
 - 1) High Risk:
 - a) Members who qualify as High Risk through any of the screening methods
 - b) Members without available medical utilization data, claims data, or other assessments and/or survey information available
 - c) Members in the NICU
 - d) Members with a new CCS diagnosis
 - e) Newly CCS-eligible Mmembers
 - f) New CCS Members enrolled in Partnership
 - 2) Low Risk:
 - a) Members who do not meet the criteria for High Risk
4. Partnership will use the results of the PRSP and the HRA or HIF responses to triage Care Coordination interventions.
 - a. High Risk Members will be assessed telephonically, by video or in-person by Care Coordination staff within 90 calendar days of a completed HRA or when identified by PSRP to be High Risk to assist in the development of the Mmember's ICP.

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- b. Low Risk Members will be assessed telephonically, by video or in-person by a Health Care Guide within 120 days of completed HRA or when identified by PRSP to be Low Risk to identify the Member's health care needs.
5. Partnership will offer care coordination to all CCS Members. Building upon the information gathered through the risk assessment process, and in collaboration with the Member, his/her family, and/or his/her designated primary caregiver(s), Partnership's Care Coordination department will review the Member's needs and document the results in the case management system.
 - a. All CCS Members will be assigned an Acuity Level ranging from One to Five, and the acuity level may be adjusted throughout the course of the case as the Member's needs change. See MPCD2013 Care Coordination Program Description for further information on Acuity Levels and associated activities.
 - b. Low Risk CCS Members (Acuity Levels One to Two) will be assessed through targeted questions that ensure WCM Members have access to care and coordination of benefits to support their health and wellbeing. Low Risk Members will be reassessed annually to ensure that the Member's needs are addressed and that there have been no significant changes in the Member's condition. Specific areas for review will include:
 - 1) Information and education regarding Partnership's Care Coordination services and where to go for ongoing information, care, and support
 - 2) Medical (primary care and CCS specialty) services
 - 3) Other medically necessary services provided within Partnership's network, or when necessary, services provided by an out-of-network provider
 - 4) Resources available in the community
 - 5) Age-specific questionnaires
 - c. High Risk CCS Members (Acuity Levels Three, Four, and Five) will be assessed through comprehensive, age-specific questions to support transitions of care across settings or from pediatric to adult care, complex care coordination, facilitate interactions between providers and community agencies, and bolster fragile support systems. The results will be documented in an Individualized Care Plan (ICP) tailored to the needs of the Member, incorporating the Member/caregiver's goals and preferences, and providing measurable objectives and timetables. ICP for Members determined to be high risk based on the results of the risk assessment process will be established within 90 calendar days of a completed risk assessment survey or other assessment by telephonic and/or in-person communication. However, if a Member's family declines having an ICP developed, Partnership will notate the denial in the Member's medical record as evidence of compliance. The ICP will gather information, as appropriate, such as:
 - 1) Information and education on the roles of the interdisciplinary care team, where to go for ongoing information, care, and support.
 - 2) Medical (primary care and CCS specialty) services, including care needs that may be met under Early and Periodic Screening Diagnostic, and Treatment (EPSDT) services including but not limited to palliative care.
 - 3) Developmental, behavioral, and mental health concerns. This includes mild-to moderate or county specialty mental health services, as well as county substance use disorder (SUD) or Drug Medi-Cal service needs.
 - 4) Family/community supports.
 - 5) Home health services.
 - 6) Services provided in school and community.
 - 7) Other medically necessary services provided within Partnership's network, or when necessary services provided by an out-of-network provider.

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- 8) Resources available in the community, including those outside the scope of responsibility of Partnership.
 - 9) Identification of other programs with which the Mmember is affiliated, such as: Regional Centers, MTP/MTUs; High Risk Infant Follow-Up (HRIF); Genetically Handicapped Persons Program (GHPP), etc., in order to promote collaboration and reduce duplication of effort.
 - 10) Planning for when the CCS Mmember will age-out of the CCS program.
 - 11) Pediatric provider phase-out planning, supporting the transition from pediatric to adult providers while taking into consideration the Mmember's medical condition and the established need for care with adult providers.
- d. For Mmembers transitioning into the WCM Program from Classic CCS Programs, Partnership will complete the PRSP within 45 calendar days of transition to determine each Mmember's risk level. Partnership will also complete all required telephonic and/or in-person communication and ICPs for high-risk Members, and all required telephonic and/or in-person communication for low risk Members, within one year of the transition. Additionally, Partnership will reassess a Member's risk level and needs at the annual medical eligibility redetermination, or upon a significant change to a Member's condition. Regardless of a Mmember's risk level, all communications, whether by phone, mail, or other forms of communication, will inform the Mmember and/or the Mmember's designated caregivers that assessments will be provided in a linguistically and culturally appropriate manner, and will identify the method by which providers will arrange for in-person assessments.
- e. Partnership's Care Coordination department facilitates referrals to specialty care when appropriate. If needed, Partnership Care Coordination will make direct referrals as well.
- 1) WCM Mmembers are assigned to Direct Member status which allows for direct referral to specialty clinics by providers and Mmember self-referral without a Referral Authorization Form (RAF). Partnership provides guidance and facilitates sharing of information between clinical settings as needed and per DHCS guidelines.
 - 2) Partnership identifies needs, goals, barriers, and interventions to access to diagnostic and treatment services including access to primary and specialty care by a CCS-Paneled Provider and preventive care services with specialty care services through the collaborative case management and care coordination process with WCM Members. Partnership evaluates Risk Assessments, ICP's, AMR's, ongoing case management with the WCM Member, family, or authorized representative, and available data to identify referred services in plan of care and confirm Member received referred treatments.
- f. Partnership will provide information on what community resources exist for Mmembers to utilize via Mmember's preferred method of communication or by telephone. The Partnership External Website which includes the Partnership's Community Resources pages has information readily available for the Mmembers.
- g. For pediatric Mmembers stratified as high risk, Partnership shall offer the CalAIM Enhanced Care Management (ECM) benefit for eligible Mmembers. The ECM benefit is unique and distinct from the care management services or programs offered by Partnership. ECM can be provided in addition to the WCM Program and Partnership will ensure non-duplication of services. When WCM Members are eligible for and choose to receive both CCS Case Management and ECM services, Partnership may assign some or all CCS Case Manager functions to be delivered by qualified ECM Providers. To be qualified for assignment of CCS Case Management functions, ECM Providers must meet all existing CCS and WCM requirements to provide Case Management services. In addition, these qualified ECM Providers must have previous experience directly providing CCS Case Management and/or CCS clinical

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services. This only applies when Partnership assigns some or all CCS Case Manager functions to an ECM Provider. If these functions are not being assigned, an ECM provider does not need to meet these additional requirements. Refer to policies MCCP2032 CalAIM Enhanced Care Management (ECM) and MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) for more details.

6. No less than annually, or upon significant change in the WCM Mmember's condition, Partnership will reassess the WCM Mmember and his/her:
 - a. Risk level via the PRSP,
 - b. Age-specific needs and milestones,
 - c. Age-Out transition plan and Pediatric Provider Phase Out plan, where appropriate
 - d. Documentation needed to support eligibility re-determination
 7. When a Partnership Mmember is receiving services through an MTP/MTU, Partnership staff will act as a liaison with the county MTP/MTU, and collaborate in providing coordinated delivery of care.
 8. All information and communications with Mmembers and/or designated caregiver(s) will be provided in a linguistically and culturally appropriate manner.
 9. In collaboration with Partnership's Utilization Management Department, Care Coordination staff will coordinate and authorize HRIF services for Mmembers needing case management services.
 - a. Partnership will notify the CCS county of record of CCS-eligible neonates, infants and children up to 3 years of age that lose Medi-Cal coverage for HRIF services. Partnership will provide continuity of care information to the Mmember.
 10. For Mmembers aging out of WCM, Partnership will provide comprehensive, individualized case management support to assist the Mmember, family, designated caregiver(s), and providers in transition care to the appropriate setting. The care coordination plan will be developed at least 12 calendar months before the Mmember ages out. Per state guidelines, Partnership will monitor the WCM Mmember for at least 36 calendar months following age out of the WCM Program, to the extent feasible.
 11. A pediatric phase-out occurs when a treating CCS-paneled Provider determines that their services are no longer beneficial or appropriate to the treatment of the WCM Member. Partnership will provide Care Coordination to WCM Members in need of an adult Provider when the WCM Mmember no longer requires the services of a pediatric Provider. The timing of the transition will be individualized to take into consideration the WCM Member's medical condition and the established need for care with adult Providers.
- D. Inter-County Transfer (ICT)
1. Partnership and the County CCS program will collaborate to facilitate the exchange of ICT data to ensure that CCS WCM Mmembers who relocate to another county can effectively transfer their CCS benefits without interruption, including the provision of continuation of services and the transfer of current service authorization request.
 2. CCS-eligible Members that move out of a WCM county:
 - a. County CCS Programs will initiate the data transfer request to Partnership using Attachment 4 "Whole Child Model Inter-County Transfer Form" of CCS NL 10-1123, "CCS Intercounty Transfer Policy."
 - b. Partnership will provide the County CCS Program office with relevant Mmember transfer data including case management notes and utilization data for the previous 12 months within 10 business days using Attachment 4 or an agreed upon process between the sending county and Partnership.
 - c. The sending county CCS program will coordinate the sharing of CCS-eligible Mmember data to the receiving county.
 3. CCS-eligible Members that move into a WCM county, the sending county CCS Program will

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provider transfer data to Partnership.

4. CCS-eligible Members that move from one WCM county to a different WCM county, Partnership will provide transfer data to the receiving MCP and the County CCS Program.
 5. When the previous county, receiving county, or Partnership cannot agree on the transfer process, the county or Partnership will contact CCSProgram@dhcs.ca.gov.
 6. The sending county is responsible for obtaining the Mmember's medical information even if the transfer is to the same MCP in the receiving county.
 - a. If there are no physical copies of the medical reports within the last 12 months, the transfer case notes should include a written statement indicating that there are no physical copies of medical reports for the last 12 month period.
 7. When a Mmember moves out of Partnership service area:
 - a. Member is assigned to a direct Mmember status called HP 8 (Out of Area), refer to Partnership Policy MPEUP3039 Direct Members for more details.
- E. Continuity of Care
1. Partnership maintains a process to allow for Mmembers to continue receiving care with an existing in-network or out-of-network provider for up to 12 months in accordance with Health and Safety Code 1373.96. For further information, please see policy MPECP2014 Continuity of Care.
 2. In addition to the specifications outlined in Partnership Policy MPECP2014, Mmembers participating in WCM have the additional continuity of care provisions, when applicable, outlined below:
 - a. Specialized or Customized DME: If the WCM Member has an established relationship with a specialized or customized DME provider, Partnership will provide access to that provider for up to 12 months. Partnership may extend the COC with a DME provider beyond the 12 months for specialized or customized DME still under warranty and deemed medical necessary by the treating provider.
 - b. Prescription Drugs ²: CCS-eligible Mmembers transitioning into the Partnership Whole Child Model program are allowed continued use of any currently prescribed prescription drug that is part of their prescribed therapy for the CCS-eligible condition. For further details, please see policy MCRP4064 Continuation of Prescription Drugs.
 3. 60 days prior to the end of their authorized COC period, WCM Mmembers are notified in writing of information regarding the WCM appeal process for COC limitations. This notice explains the Mmember's right to petition Partnership for an extension of the COC period, criteria used to evaluate the petition and the appeals process if Partnership denies the petition.
 - a. WCM Mmembers will direct their first appeal of a COC decision to Partnership.
 - b. WCM Mmember, Mmember's family or designated caregiver of the WCM Mmember may appeal the COC limitation to the DHCS Director (or designee) after exhausting Partnership's appeal process.
 - c. The DHCS Director (or designee) will have 5 business days from the date of appeal to inform the family or caregiver of receipt and will provide a decision on the appeal within 30 calendar days from the date of the request. If the Mmember's health is at risk, the DHCS Director (or

² Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal fee-for-service (FFS) as described in All Plan Letter (APL) 22-012 Revised, and all medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/DHCS-contracted pharmacy administrator instead of Partnership. Refer to the Partnership website page for pharmacy authorization criteria and links to the State Medi-Cal Contract Drug List (CDL): <http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx>

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designee) will inform the Member of the decision within 72 hours.

F. Continuity of Care for WCM Implementation

1. Partnership will be able to initiate, accept, and process COC requests from transitioning Members, providers, and authorized representatives beginning 60 calendar days prior to the transition date.
 - a. Continuity of Care for Providers: Upon receipt of detailed transition data from DHCS for each transitioning Member, or at least 30 calendar days prior to the transition date, whichever occurs sooner, Partnership will conduct outreach to OON COC eligible providers with whom Members have pre-existing relationships to initiate a Network Provider Agreement or a COC for Providers agreement.
 - 1) Partnership will review all available data to identify eligible providers that provided services to CCS beneficiaries during the 12 months preceding the transition.
 - b. Continuity of Care for Covered Services – Prior Authorization and Active Course of Treatment: Partnership will honor active Prior Authorizations identified in any data available to Partnership and/or when requested by a transitioning Member, provider, or authorized representative, and the MCP obtains documentation of the Prior Authorization before or within the six-month period following the transition date.
 - c. Durable Medical Equipment Providers and Medical Supplies: Partnership will allow Members to keep their existing DME rentals and medical supplies from their existing DME Providers without further authorization for the full 12-month period following the transition date and until a reassessment has been completed and the new equipment or supplies are in the possession of the Member and ready for use.
 - d. Continuing Services with County CCS Program Public Health Nurse (PHN): WCM Members or the Member's parents, custodial parents, legal guardians, or other Authorized Representatives may request continuing case management and Care Coordination from their CCS County PHN within 90 calendar days of transitioning to the WCM program. If the requested County CCS Program PHN is no longer available to provide case management and Care Coordination, Partnership will transition those services to one of its CCS Case Managers who has received adequate training on the CCS Program, and has clinical experience with the CCS population or pediatric patients with complex medical conditions.
 - e. Member and Provider Outreach and Education: Partnership will follow the Member notification guidelines for COC requests in APL 23-022 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023 and Partnership will inform Members of their continuity of care protections and include information about these protections in Member information packets, handbooks, and on the Partnership website.
2. For further details regarding COC, please see policy MCCP2014 Continuity of Care.

G. Partnership and CCS County Coordination

1. Partnership and County CCS programs will coordinate the delivery of CCS services to CCS-eligible Members to prevent duplication of services.
2. Partnership and each WCM CCS county shall execute a Memorandum of Understanding (MOU) outlining respective responsibilities and obligations under the WCM, refer to APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities and Template for Memorandum of Understanding between [MCP] Medi-Cal Managed Care Plans and [County] California ~~Childrens~~Children's Services (CCS) Whole Child Model Program for more details.
3. Partnership shall hold collaborative meetings with WCM CCS counties no less than quarterly to assist in overall coordination of services, to update policies, procedures and protocols as appropriate,

Policy/Procedure Number: MCCP2024			Lead Department: Health Services Business Unit: Care Coordination
Policy/Procedure Title: Whole Child Model For California Children's Services (CCS)			☒ External Policy ☐ Internal Policy
Original Date: 11/14/2018 Effective Date: 01/01/2019 per DHCS			Next Review Date: <u>08/13/2026</u> <u>04/09/2026</u> Last Review Date: <u>08/13/2025</u> <u>04/09/2025</u>
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

and to discuss activities related to the MOUS and WCM matters.

4. Partnership shall work collaboratively with the CCS county office of record to assist in the inter-county transfer for CCS-eligible Mmembers who move from a WCM county to a non-WCM county. Similarly, the county CCS office will provide transfer data to Partnership if a CCS-eligible Mmember moves into a WCM county. The county CCS program retains the responsibility for providing transfer data, including clinical and other relevant data, from one county to another.
 5. Partnership coordinates with Regional Centers and Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) to ensure Mmembers who are individuals with developmental disabilities receive all medically necessary covered services in accordance with APL 23-023 *Revised* Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care, please refer to MCUG3058 Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities for more details.
 6. Partnership ensures that Mmembers living in ICF/DD Homes have access to a comprehensive set of services based on their needs and preferences across the continuum of care, including Basic Population Health Management (BPHM), Transitional Care Services (TCS), care management programs, and Community Supports as appropriate in coordination with the Regional Center. Please refer to MPCD2013 Care Coordination Program Description for more details.
- H. Advisory Committees
1. Partnership meets quarterly with a Clinical Advisory Committee. For more details on Partnership Clinical Advisory committees, refer to Partnership policy MCCP2025 Pediatric Quality Committee.
 2. Partnership meets quarterly with a Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC includes, but not be limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information centers. For more details, please refer to Partnership Policy MCCP2024- B FAC Charter. Family Mmembers serving on this advisory committee may receive a reasonable per diem payment to enable participation in the advisory committee. For more details on per diem payments, refer to Partnership policy ADM21 Stipends for Committee Members Serving on Partnership's CAC, FAC, PQC, Provider Grievance Review, QIHEC and Q/UAC Committees. A representative of this committee will be invited to serve as a Member of the statewide DHCS CCS stakeholder advisory group.
 - a. Partnership meeting facilitation and representation ensures proper coordination of roles and responsibilities and support to participating Mmembers.
 - b. FAC meetings are conducted with options for attendance in-person and via teleconference.
 - c. Partnership recruits FAC families through opportunities for discussion during ongoing case management interaction, offering per diem payment, engagement and discussion with community based organizations, regional centers, and county CCS programs to collaborate on shared communication, opportunity for families to represent on FAC (including outreach to counties where Mmembership representation is needed), and through other Partnership departments where customer service and engagement indicates an opportunity for Mmembers to participate. These Mmembers will be referred to Care Coordination for Mmember or family outreach to discuss the FAC.
 - d. Partnership recruits FAC Mmembers through engagement and discussion during meetings, and outreach to the following representatives from Partnership counties: local providers, CCS County staff, Parent Advocacy groups, or CCS paneled providers. This may include, but not limited to, parent centers, such as family resource centers, family

Policy/Procedure Number: MCCP2024			Lead Department: Health Services Business Unit: Care Coordination
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Original Date: 11/14/2018 Effective Date: 01/01/2019 per DHCS			Next Review Date: 08/13/2026 04/09/2026 Last Review Date: 08/13/2025 04/09/2025
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

- empowerment centers, and parent training and information centers.
- e. Partnership retains FAC families and ~~M~~members through offering per diem payment, facilitating quarterly meeting series that includes diverse range of representation and meeting topics, including resource speakers, for engagement, offering flexibility and encouragement of family participation in advisory capacity, as well as contributions from representative ~~M~~members.
 3. Partnership representatives meet quarterly with the WCM Program stakeholder advisory group composed of representatives of CCS providers, County CCS Program administrators, health plans, family resource centers, regional centers, recognized exclusive representatives of County CCS providers, CCS case managers, CCS MTUs, and representatives from Family Advisory Committees.
- I. CCS Liaison
1. Partnership designates one individual as the point of contact for the MOU and the coordination of services between Partnership and Couty CCS Programs who has the knowledge and adequate training on the CCS Program and clinical experience with either the CCS Population or pediatric patients with complex medical conditions. Partnership designates a liaison with training on the full spectrum of rules and regulations pertaining to the CCS Program, including referral requirements and processes, annual medical eligibility redetermination processes with County CCS Programs, and care management and authorization processes for CCS children. The liaison will ensure the case management assignment is communicated to the county, as needed.
- J. Dispute Resolution and Provider Grievances
1. Medical eligibility determination disputes between Partnership and the County CCS Program will be resolved by the County CCS Program. The County CCS Program, in consultation with DHCS in dependent counties, will make a medical eligibility determination. The CCS County program shall communicate all resolved disputes in writing to Partnership within a timely manner.
 2. If other disputes arise between Partnership and the County CCS Program, all parties will fulfill their responsibilities in alignment with DHCS policies, including APL, NL, MCP Contract and WCM MOU, without delay. This includes ensuring that ~~M~~members have timely access to services as specified under the WCM MOU. Partnership and County CCS Programs will attempt to resolve all disputes at the local level before submitting the dispute to DHCS for resolution.
 3. If disputes between Partnership and the County CCS Program cannot be resolved, the dispute will be submitted to DHCS by either entity, via email with subject "Request for Resolution" to CCSProgram@dhcs.ca.gov, for review and final determination and will include the following:-
 - a. A summary of the disputed issue(s) and a statement of the desired remedies
 - b. A history of the attempts to resolve the issue(s)
 - c. Justification for the desired remedy
 - a-d. Any additional documentation that are relevant to resolve the dispute, if applicable
 - ~~3.4.~~ For more details, please refer to APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities and APL 24-015– California Children's Services Whole Child Model Program.
 - ~~4.5.~~ Partnership will have a formal process to accept, acknowledge, and resolve Provider disputes and grievances. A CCS Provider may submit directly to Partnership a dispute or grievance concerning the processing of a payment or non-payment of a claim by Partnership. The dispute resolution process will be communicated by Partnership to all of its CCS Providers.
- K. Grievance, Appeal, and State Hearing
1. Partnership will ensure that all ~~M~~members are provided information on Grievances, Appeals, and State Hearing rights and processes. All WCM ~~M~~members will be provided the same Grievance, Appeal, and State Hearing rights as other Partnership ~~M~~members. Please refer to Partnership policies MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions and CGA024 Medi-

Policy/Procedure Number: MCCP2024		Lead Department: Health Services Business Unit: Care Coordination	
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Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

Cal Member Grievance System for more details.

IX. REFERENCES:

- A. DHCS All Plan Letter ([APL](#)) [24-015 California Children's Services Whole Child Model Program](#) (12/02/2024 ~~supersedes 23-034~~)
- B. California Code, Health and Safety Code §1373.96
- C. CCS Numbered Letter ([NL](#)) [03-0810 Maintenance and Transportation for CCS Clients to Support Access to CCS Authorized Medical Services](#) (08/19/2010)
- D. DHCS [APL 23-005 - Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21](#) (03/16/2023)
- E. DHCS [APL 22-012 – Governor's Executive Order N-01-19 Regarding Transitional Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx](#) (Revised 12/30/2022)
- F. DHCS [APL 23-029 - Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities](#) (Revised 01/08/2025~~10/11/2023~~)
- G. [Template for Memorandum of Understanding between \[MCP\] Medi-Cal Managed Care Plans and \[County\] California Children's Services \(CCS\) Whole Child Model Program](#) (07/2024)
- H. DHCS [APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care](#) (Revised 11/28/2023)
- I. DHCS [APL 25-005 Standards for Determining Threshold Languages, Nondiscrimination Requirements and Language Assistance Services](#) (02/12/2025)
- J. DHCS [APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Template](#) (08/31/2022)
- K. DHCS [All Plan Letter 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023](#) (08/15/2023)
- L. CCS [NL 05-0502 Medical Eligibility for Care in a CCS Approved Neonatal Intensive Care Unit \(NICU\)](#) (09/06/2024)
- M. CCS [NL 10-1123 CCS Intercounty Transfer Policy](#) (11/1/2023)
Attachment 1: [Intercounty Transfer Process Flowchart](#)
Attachment 2: [Intercounty Transfer Frequently Asked Questions](#)
Attachment 3: [CCS Intercounty Transfer Check List](#)
Attachment 4: [CCS Whole Child Model Intercounty Transfer Check List](#)
- N. [CCS Medical Eligibility Guide](#) (03/15/2017)
- O. CCS [NL 10-1224 California Children's Services Whole Child Model Program](#) (Revised 12/02/2024)
Attachment A: [CCS Case Management Core Activities](#)

X. DISTRIBUTION:

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

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

XII. REVISION DATES: 11/13/19; 02/12/20; 04/14/21; 01/12/22; 01/11/23; 02/14/24; 04/09/25; 08/13/25

PREVIOUSLY APPLIED TO:

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

Policy/Procedure Number: MCCP2024		Lead Department: Health Services Business Unit: Care Coordination	
Policy/Procedure Title: Whole Child Model For California Children's Services (CCS)		☒ External Policy ☐ Internal Policy	
Original Date: 11/14/2018 Effective Date: 01/01/2019 per DHCS		Next Review Date: <u>08/13/2026</u> <u>04/09/2026</u> Last Review Date: <u>08/13/2025</u> <u>04/09/2025</u>	
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

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.

Pediatric Risk Stratification Algorithm

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

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

References

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

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

Purpose:

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

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

Authority and Responsibility:

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

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

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

Membership:

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

Membership includes:

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

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

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

Committee Staff

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

Membership roles and responsibilities:

Family Members

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

Partnership Staff

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

Local Consumer Advocate or Local Provider

- As a Local Consumer Advocate or Provider, the role is to support and enhance the effectiveness of meetings by contributing expertise and insights. They attend and actively listen to meetings to fully understand the discussions and decisions. They provide support and clarity based on their expertise when relevant questions arise. Additionally, they respond to inquiries about their specific community or organization, offering informed and accurate information to assist with decision-making. The contributions are essential for ensuring that meetings are well-informed and that community-specific issues are effectively addressed.

Terms:

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

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

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

FAC Chair and Vice Chair:

The FAC shall select a Chair and Vice Chair. The Chair and Vice Chair shall be a CCS Member or family representative.

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

The role of the Vice Chair is to preside at the meetings of the FAC in the absence of the Chair.

If both Chair and Vice Chair are absent, the WCM FAC members present will select one member to act as Chair for the meeting.

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

Meetings:

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

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

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

Meeting Compensation:

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

Agendas, Minutes, Reports:

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

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

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

Review of Charter:

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

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: <u>MPCP2014</u> (previously MCCP2014) ~~MCCP2014~~			Lead Department: Health Services Business Unit: <u>Care Coordination</u>	
Policy/Procedure Title: <u>Continuity of Care (Medi-Cal)</u> ~~Continuity of Care~~			☒ External Policy ☐ Internal Policy	
Original Date: 08/19/2015 Effective Date: 12/29/2014 per DHCS		Next Review Date: <u>08/13/2026</u> ~~08/14/2025~~ Last Review Date: <u>08/13/2025</u> ~~08/14/2024~~		
Applies to:	☐ Employees	☒ Medi-Cal		☒ Partnership Advantage
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD		☐ COMPLIANCE	☐ FINANCE
	☐ CEO	☐ COO	☐ CREDENTIAL ~~SING~~	☐ DEPT. DIRECTOR/OFFICER
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: <u>08/14/2024</u> ~~08/13/2025~~	

I. RELATED POLICIES:

- A. MCUP3039 ~~MPUP3039~~ – Direct Members
- B. MCUP3126 – Behavioral Health Treatment (BHT) for Members Under the Age of 21
- C. MCCP2007 – Complex Case Management
- D. MCCP2024 – Whole Child Model for California Children’s Services (CCS)
- E. MCUP3028 ~~MPBP8003~~ – Mental Health Services
- F. CGA024 – Medi-Cal Member Grievance System
- G. MCCP2032 – CalAIM Enhanced Care Management (ECM)
- H. MCUP3041 – Treatment Authorization Request (TAR) Review Process
- I. MCAP7001 ~~MCUP3143~~ - CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
- J. MCAP7003 ~~MCUP3142~~ – CalAIM Community Supports (CS)
- K. MCCP2016 - Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)
- L. MCUP3104 - Transplant Authorization Process

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

- A. **Adult Expansion Population:** Senate Bill (SB) 184 (Chapter 47, Statutes of 2022) amended Welfare and Institutions Code (W&I) section 14007.8 to expand eligibility for full scope Medi-Cal to individuals who are 26 through 49 years of age, and who do not have satisfactory immigration status (SIS) as required by W&I section 14011.2. SB 184 took effect on January 1, 2024. Impacted populations include:
 1. **New Enrollee Population:** The new enrollee population consists of individuals who are 26 through 49 years of age in January 2024, who are not currently enrolled in full scope or restricted scope Medi-Cal, but who may apply for Medi-Cal after implementation of the Age 26-49 Adult Expansion and meet all eligibility criteria for full scope Medi-Cal, under any eligibility group, including Modified Adjusted Gross Income (MAGI) and Non-MAGI, except for SIS.

Policy/Procedure Number: <u>MPCP2014 (previously MCCP2014): MCCP2014</u>			Lead Department: Health Services Business Unit: <u>Care Coordination</u>
Policy/Procedure Title: Continuity of Care (Medi-Cal)Continuity of Care			☒ External Policy ☐ Internal Policy
Original Date: 08/19/2015 Effective Date: 12/29/2014 per DHCS			Next Review Date: <u>08/13/2026</u> ~~08/14/2025~~ Last Review Date: <u>08/13/2025</u> ~~08/14/2024~~
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

2. **Transition Population:** The transition population consists of individuals who are 26 through 49 years of age and are currently enrolled in restricted scope Medi-Cal because they do not have SIS or are unable to establish SIS for full scope Medi-Cal under any eligibility group, including MAGI and Non-MAGI, before implementation of this expansion.
- B. **Behavioral Health Treatment (BHT):** -BHT is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior. BHT services teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of targeted behavior. BHT services are based on reliable evidence and are not experimental. BHT services include a variety of behavioral interventions that have been identified as evidenced-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence and are designed to be delivered primarily in the home and in other community settings.
- C. **California Children's Services (CCS):** A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
- ~~G.D.~~ **Dual Eligible Special Needs Plans (D-SNPs):** A type of Medicare Advantage (MA) plan designed specifically for individuals who qualify for both Medicare and Medi-Cal. These plans offer specialized care that addresses the unique health needs of dual-eligible beneficiaries, providing enhanced care coordination, comprehensive services, and additional benefits not typically covered by standard Medicare or Medi-Cal. D-SNPs aim to integrate and streamline medical, behavioral, and long-term care services to improve health outcomes and reduce costs for individuals with complex care needs.
- ~~D.E.~~ **Existing Relationship with Provider (for services other than Behavioral Health Treatment [BHT]):** is defined as the situation where a ~~M~~member has seen an out of network Primary Care Provider (PCP) or specialist at least once during the 12 months prior to the date of their initial enrollment into Partnership HealthPlan of California (Partnership) for a non-emergency visit.
- ~~E.F.~~ **Existing Relationship with Provider (for individuals receiving BHT):** is defined as the situation where a ~~M~~member has seen the out-of-network BHT provider at least one time during the six months prior to either the transition of responsibility for BHT services from the Regional Center to Partnership, or the date of the ~~M~~member's initial enrollment with Partnership if enrollment occurred on, or after, July 1, 2018.
- ~~F.G.~~ **Managed Care Plan (MCP):** Partnership HealthPlan of California (Partnership) is contracted as a Department of Health Care Services (DHCS) Managed Care Plan (MCP). MCPs are required to provide and cover all medically necessary physical health and non-specialty mental health services
- ~~G.H.~~ **Medical Exemption Request (MER):** A request for a Medi-Cal beneficiary to be temporarily exempt from mandatory enrollment into an MCP, and to instead remain in fee for service (FFS) Medi-Cal. This allows the beneficiary to maintain access to providers who are not enrolled as network providers with the MCP until the ~~M~~member's medical condition has stabilized to a level that would enable the ~~M~~member to transfer to a network provider of the same specialty without deleterious medical effects.
- I. **Medical Necessity for EPSDT Services:** For individuals under 21 years of age, a service is medically necessary if the service meets the standards set for in Section 1396d(r)(5) of Title 42 of the United States Code and is necessary to correct or ameliorate defects and physical and mental illnesses that are discovered by screening services.
- J. **Partnership Advantage (PA):** Effective January 1, 2027, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be

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

H.

J.K. **Risk of Harm:** An imminent and serious threat to the health of the Mmember.

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

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

M.

IV. ATTACHMENTS:

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

V. PURPOSE:

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

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

VI. POLICY/ PROCEDURE:

- A. Medi-Cal Mmembers assigned a mandatory aid code who are transitioning into a Medi-Cal managed care plan (MCP) have the right to request continuity of care in accordance with federal and California law and managed care plan contracts with some exceptions.
 1. Consistent with federal law, Mmembers must:
 - a. Have access to services consistent with the access they previously had

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

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- d. Enrolled in 1915(c) wavier programs
 - e. Receiving In-Home Supportive Services (IHSS)
 - f. Children and youth enrolled in CCS/CCS Whole Child Model
 - g. Children and youth receiving foster care, and former foster youth through age 25
 - h. In active treatment for the following chronic communicable diseases: HIV/AIDS, Tuberculosis, Hepatitis B and C
 - i. Taking immunosuppressive medications, immunomodulators, and biologics
 - j. Receiving treatment for end-stage renal disease (ESRD)
 - k. Living with an intellectual or developmental disability (I/DD) diagnosis
 - l. Living with a dementia diagnosis
 - m. In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months
 - n. Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
 - o. Receiving specialty mental health services (adults, youth, and children)
 - p. Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality
 - q. Receiving hospice care (for duration of the terminal illness)
 - r. Receiving home health
 - s. Residing in Skilled Nursing Facilities (SNF)
 - t. Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
 - u. Receiving hospital inpatient care (for duration of the acute condition)
 - v. Post-discharge from inpatient hospital, SNF or sub-acute facility on or after December 1, 2023
 - w. Newly prescribed DME (Implemented within 30 days of January 1, 2024)
 - x. Members receiving Community-Based Adult Services
5. ~~Enhanced~~, Enhanced protections for ~~M~~members accessing the Transplant benefit
- a. If the MCP is unable to bring a Transplant Program in Network, the Receiving MCP must make a good faith effort to:
 - 1) Enter into a CoC for Providers agreement with the hospital ~~where at which a~~ Transplant Program is located as described in Section V.C and according to the following terms:
 - a) Make explicit the existing statutory requirement that Receiving MCPs ~~must pay to~~ pay, and transplant providers ~~must accept~~ accept, FFS rates (section 14184.201(d)(2) of the Welfare and Institutions Code.
 - b) Permit the CoC for Providers agreement to continue for the duration of the ~~M~~member's access to the transplant benefit.
 - 2) If the MCP is unable to enter into a CoC for Providers agreement, the MCP must:
 - a) Arrange for the hospital ~~where at which~~ the Transplant Program is located to continue to deliver services to a ~~M~~member as an out-of-network (OON) provider, in accordance with the timeline in 2024 Medi-Cal Managed Care Plan Transition Policy Guide.
 - b) Explain in writing to DHCS why the provider and the MCP could not execute a CoC for Provider agreement, per guidance in the Transition Monitoring and Related Reporting Requirements, of the 2024 Medi-Cal Managed Care Plan Transition Policy Guide.
 - B. For ~~M~~members with written documentation of being diagnosed with a maternal mental health condition from the treating health care provider, completion of covered services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
 - C. Partnership is not required to provide continuity of care for services that are not covered by Medi-Cal.

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D. Continuity of care protections extend to primary care providers (PCPs), specialists, ECM providers, CS Providers, Skilled Nursing Facilities (SNFs), Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD), Community-Based Adult Services (CBAS) providers, and select ancillary providers, including dialysis centers, physical therapist, occupational therapists, respiratory therapists, mental health providers, behavioral health treatment (BHT) providers, speech therapy providers, doulas, and community health workers (CHW). They do not extend to all other ancillary providers such as radiology, laboratory, non-emergency medical transportation (NEMT), non-medical transportation (NMT), and non-enrolled or carved-out service providers.

D.

E. Partnership will provide continuity of care with an out-of-network provider when the following criteria are met:

1. Partnership is able to determine that the Mmember has an ongoing relationship with the provider (defined as at least one non-emergency visit during the preceding 12 months preceding January 1, 2024 or prior to the date of the Mmembers' initial enrollment in the D-SNP for a non-emergency visit).
- a. Self-attestation is not sufficient to provide proof of an established relationship with a provider.
2. The provider is providing a service that is eligible for COC, and
3. The provider is willing to accept the higher of Partnership's contract rates or Medi-Cal Fee For Service (FFS) rates or current Medicare fee schedule, and
4. The provider meets Partnership's applicable professional standards and has no disqualifying quality of care issues and,
5. The provider is a California State Plan approved provider, and
6. The provider supplies Partnership with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

7. Partnership Advantage Mmembers:

- a. D-SNPs are network based for Partnership Advantage Mmembers, with the following exceptions:
 - 1) Partnership Advantage A Mmembers are allowed to continue receiving care from an out of network provider for up to 12 months after enrolled if they have an acute or serious chronic medical condition as referenced in VI.A.3.
 - 1)2) Partnership Advantage A Mmembers must submit a request to their Medicare plan Partnership including documentation from current medical provider.

F. If a Mmember changes managed care plans or D-SNP by choice following the initial enrollment into Partnership, or if a Mmember loses or leaves D-SNP and then later regains Partnership eligibility or rejoins D-SNP, the 12-month continuity of care period may start over one time. If the Mmember changes managed care plans or D-SNP or loses and regains Partnership eligibility a second time or more, the continuity of care (COC) period does not start over and the Mmember does not have the right to a new 12-month period of continuity of care. If the Mmember returns to Medi-Cal fee-for-service and later re-enrolls in Partnership, the COC period does not start over.

1. Partnership must accept COC requests made over the telephone, electronically, or in writing, according to the requester's preference.
2. Partnership informs Mmembers of their continuity of care protections through the Mmember welcome packet and the Partnership provider website. This information includes how the Mmember, Mmember's authorized representative, and/or provider may initiate continuity of care requests with Partnership. All information provided is made available in threshold languages and alternative formats upon request.
3. Partnership also provides on-going training regarding continuity of care to both the Care Coordination and Member Services staff who interact regularly with Mmembers and/or providers.

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G. Behavioral Health Treatment

- For ~~M~~members under 21 years of age transitioning from a Regional Center (RC), Partnership must automatically generate a continuity of care request. Members do not have to independently request continuity of care from Partnership. The State of California Department of Health Care Services (DHCS) will provide Partnership with a list of transitioning ~~M~~members whose services will transfer from the Regional Center to Partnership. Partnership will make a good faith effort to proactively contact the current treating provider(s) to begin the continuity of care process. For all ~~M~~members assigned to Partnership on or after July 1, 2018, who were not receiving BHT services from a Regional Center, Partnership will offer the same continuity of care as outlined below.
- Continuity of Care for an out-of-network BHT provider can be granted for a ~~M~~member for up to 12 months when all ~~of~~ the following DHCS criteria is met:
 - The ~~M~~member has an existing relationship with a qualified provider of BHT services. An existing relationship means the ~~M~~member has seen the out-of-network BHT provider at least one time during the six months prior to either the transition of services from the RC to Partnership or the date of the ~~M~~member's initial enrollment with Partnership if enrollment occurred on or after July 1, 2018.
 - The provider and Partnership can agree to a rate, with the minimum rate offered by Partnership being the established Medi-Cal FFS rate for the applicable BHT service.
 - The provider does not have any documented quality of care concerns that would cause him/her to be excluded from the Partnership's network.
 - The provider is a California State Plan approved provider.
 - The BHT provider supplies Partnership with relevant treatment information, including the current treatment plan, for the purpose of determining –medical necessity, provided it complies with federal and state privacy laws and regulations, as well as current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.
- If Partnership and the existing ~~M~~member's provider are unable to reach a continuity of care agreement by the date of transition to Partnership, Partnership will reach out to the ~~M~~member to transition through a warm handoff to an in-network BHT provider to ensure no gaps in services will apply.
- Additionally, if a ~~M~~member has an existing relationship (as defined above) with an in-network BHT service provider, Partnership will allow the ~~M~~member to continue BHT services with that provider.
- BHT services will not be discontinued or changed during the continuity of care period until a new behavioral treatment plan has been completed and approved by Partnership, regardless of whether the services are provided by the RC provider under continuity of care or a new, in-network Partnership provider.
- Retroactive requests for BHT service continuity of care reimbursement are limited to services that were provided after a ~~M~~member's transition date to Partnership, or the date of the ~~M~~member's enrollment into Partnership, if the enrollment date occurred after the transition.

H. Specialty Mental Health Services to Non-Specialty Mental Health Services Transition:

- Partnership provides outpatient non-specialty mental health services for ~~M~~members with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health condition as defined by the current Diagnostic and Statistical Manual.
- County ~~Mental Behavioral~~ Health Plans (~~BM~~HPs) are required to provide specialty mental health services (SMHS) for ~~M~~members who have significant impairment or reasonable probability of functional deterioration due to a diagnosed or suspected mental health disorder as described in Behavioral Health Information Notice (BHIN) 21-073. These criteria are less stringent for ~~M~~members under the age of 21 under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit so children with a lower level of impairment may meet medical necessity criteria for SMHS services (see III.G. above).

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3. Partnership will provide continuity of care with an out-of-network SMHS provider in instances where a Mmember's mental health condition has stabilized such that the Mmember no longer qualifies for SMHS service from the county BMHP. Continuity of Care for SMHS services applies only to psychiatrists and/or mental health provider types permitted through California's Medicaid and Medicare State Plan to provide outpatient non-specialty mental health services.
4. Continuity of care requests for non-specialty mental health services must meet all criteria outlined in section VI.A-F.
5. If the Mmember later requires additional SMHS services from the county BMHP to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to Partnership for non-specialty mental health services, the ~~12-month~~12-month continuity of care period may start over one time.
6. If the Mmember requires subsequent SMHS services from the county BMHP after the continuity of care period has ended, the continuity of care period does not start over when the Mmember returns to Partnership or changes managed care plans (i.e., the Mmember does not have the right to a new 12 months of continuity of care).
- I. WCM and CCS Members:
 1. Please see policy MCCP2024 Whole Child Model for California Children's Services for continuity of care guidelines.
- J. Pregnancy and Post-Partum Members:
 1. Pregnant and post-partum Medi-Cal Mmembers who are assigned a mandatory aid code and who are transitioning from Medi-Cal FFS into Partnership or from MCPs with contracts expiring or terminating to Partnership on or after January 1, 2023 have the right to request continuity of care per criteria outlined in VI.A.3. These requirements will apply for pregnant and postpartum Mmembers and newborn children who transition from Covered California to Medi-Cal due to eligibility requirements.
- K. Adult Expansion Population Members:
 1. For Adult Expansion Population Members with an existing PCP that is in-Network with the receiving MCP, Partnership is required to maintain that assignment. Adult Expansion Population Members are not required to request COC to maintain their PCP assignment with PCPs that are in Partnership's Network. If the PCP is out-of-Network, Partnership is not expected to maintain that assignment; however, Partnership must adhere to all Continuity of Care requirements in accordance with APL 23-022.
- L. Continuity of Care (COC) Process:
 1. Members, their authorized representative, or their provider may make a direct request to Partnership for continuity of care. Partnership will begin to process the request within five (5) business days of receipt of the request. The COC process begins when Partnership starts to determine if the Mmember meets the criteria outlined in section VI.A-K and has a pre-existing relationship with the provider. Partnership will complete non-urgent request within 30 calendar days from the date Partnership receives the request, or 15 calendar days if an immediate request or if the Mmember's medical condition requires more immediate action such as upcoming appointments or other pressing care needs, or three (3) calendar days if this is an urgent request or if there is risk of harm to the Mmember (as defined above).
 2. For Mmembers that have one of the following conditions listed under Knox-Keene Health Care Service Plan Act (California Health and Safety Code (H&S) section 1373.96), once Partnership has established a COC for Providers agreement with an eligible provider, Partnership must reimburse the provider for covered services for the appropriate duration (as defined above) and as agreed upon with the provider.
 3. For Mmembers under the Special Population (as defined above), Partnership will initiate the COC process within 30 calendar days from receipt of the Special Populations data.

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4. If the COC request is made in advance of January 1, 2024, Partnership will provide the same level of support and will process the request by January 1, 2024 or according to the timeframes in VI.K.1, whichever is later.
5. Partnership will accept requests for COC over the telephone, electronically, or in writing, according to the requester's preference and will not require that the requester complete and/or submit paper or computer form if the requester prefers to make the request by telephone. Partnership will collect any necessary information from the requester over the telephone. Partnership will consider any Medical Exception Request (MER) that has been denied as an automatic COC request.
6. Partnership will utilize the following criteria to determine if a relationship exists:
 - a. FFS utilization data provided by DHCS, or
 - b. FFS utilization or claims data from an MCP with its contract expiring or terminating, or
 - c. Documentation from the Mmember and/or provider which demonstrates a pre-existing relationship, or
 - d. Partnership claims data
7. If a pre-existing relationship has been established with an out-of-network provider, Partnership will contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish a COC relationship for the Mmember. Specifically, for ECM and CS Providers, if Partnership does not come to an agreement, Partnership must explain in writing to DHCS why Partnership and the ECM Provider could not execute a contract, letter of agreement, single-case agreement, or other form of relationship to establish a COC relationship. Refer to policy MCAP7001~~MCUP3143~~ CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) and MCAP7003~~MCUP3142~~ CalAIM Community Supports (CS) for more details.
8. Partnership will accept and review retroactive COC requests for services that were already provided if the request meets all ~~of~~ the COC requirements in VI.A.- J. and the services that are subject to the request meet the following requirements:
 - a. Have dates of service that occur after the Mmember's assignment to Partnership or dates of service that occur after July 1, 2018-7/1/2018.
 - b. Have dates of services within 30 calendar days of the first date of service for which the provider is requesting, or the date from which they have previously requested COC retroactive reimbursement, and
 - c. Are submitted to Partnership within 30 calendar days of the first date of service for which retroactive continuity of care is being requested.
 - e.d. D-SNP retroactive requests for Partnership Advantage. Mmembers must be accepted if submitted more than 30 days after the first service if the provider can document that the reason for the delay is that the provider unintentionally sent the request to the incorrect entity and the request is sent within 30 days of the denial from the other entity. Examples include, but are not limited to, situations where the provider sent the claim to CMS (as a Medicare Fee-for-Service (FFS) claim), a Medicare Advantage plan, another D-SNP, or the primary plan instead of the delegate).
9. Each COC request is considered complete when the Mmember is notified of the COC decision via Mmember's preferred method of communication or by telephone. A written notice will also be mailed to the Mmember within seven calendar days of the COC decision when:
 - a. Partnership and the out-of-network FFS or prior plan~~MCP~~ provider are unable to agree to a rate
 - b. Partnership has documented quality of care issues; or
 - c. Partnership makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days
10. Member Notifications

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- a. Partnership will provide acknowledgment of the COC request within the time frames specified below, advising the Mmember that the COC request has been received, the date of receipt, whether the request was considered urgent, immediate, or non-urgent (as defined in Section VI.L.1.), and the estimated timeframe of resolution. Partnership will notify the Mmember using the Mmember's known preference of communication or by using one of these methods in the following order: telephone call, email and then notice by mail.
 - 1) For non-urgent, immediate, and Special Population requests, acknowledgment of the COC request will be provided within seven calendar days of the decision.
 - 2) For urgent requests, acknowledgment of the COC request will be provided within the shortest applicable timeframe that is appropriate for the Mmember's condition, but no longer than three calendar days of the decision.
- b. Member Notification of Denial
 - 1) When a COC request is denied, the Mmember will be offered an in-network alternative. If the Mmember does not make an alternate choice, the Mmember will be referred or assigned to an in-network provider. When a COC request is denied and/or a Mmember disagrees with the result of the process, a notice by mail will be sent within seven calendar days of the COC decision to include the following information:
 - a) A statement of Partnership's decision
 - b) A clear and concise explanation of the reason for denial
 - c) The Mmember's right to pursue a grievance and/or appeal (please see policy CGA024 – Medi-Cal Member Grievance System).
- c. Member Notification of Approval
 - 1) If a provider meets all the necessary requirements, including agreeing to a letter of agreement or contract with Partnership, Partnership will grant the COC request to allow access to that provider for the length of the continuity of care period unless the provider is only willing to work with Partnership for a shorter time frame. Upon approval, a notice by mail will be sent within seven calendar days of the COC decision including the following information:
 - a) A statement of Partnership's decision
 - b) The duration of the COC agreement
 - c) The process that will occur to transition the Mmember's care at the end of the continuity of care period and
 - d) The Mmember's right to choose a different provider from Partnership's provider network
 - 2) When the COC agreement has been established, Partnership will work with the provider to establish a plan of care for Mmember.
 - 3) At any time, Mmembers may change their provider to a network provider regardless of whether or not a COC relationship has been established.
- d. Member Notification Prior to End of COC Period
 - 1) 30 days prior to the expiration of the COC approval, Partnership will notify the Mmember using member's preferred method of communication about the process that will occur to transition the Mmember to a network provider at the end of the COC period. Partnership will engage with the Mmember and provider, including the transferring of the Mmember's record, before the COC period ends to ensure continuity of services through the transition to a new provider. This serves as the notification that continuity of care will not be extended past the expiration date unless the Mmember reaches out to Partnership prior to the date on the COC approval letter.
 - a) Any request for extension of a COC request may be subject to Medical Director Review.

Policy/Procedure Number: <u>MPCP2014 (previously MCCP2014): MCGP2014</u>		Lead Department: Health Services Business Unit: <u>Care Coordination</u>	
Policy/Procedure Title: Continuity of Care (Medi-Cal)Continuity of Care		☒ External Policy ☐ Internal Policy	
Original Date: 08/19/2015 Effective Date: 12/29/2014 per DHCS		Next Review Date: <u>08/13/2026</u> ~~08/14/2025~~ Last Review Date: <u>08/13/2025</u> ~~08/14/2024~~	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

- b) Although not required by DHCS, Partnership may continue to work with the Mmember's out-of-network provider past the ~~12-month~~12-month COC period.
- 2) For Mmembers falling under the transition as outline in V.I, the notification timeframe is 60 days prior to the expiration of the COC approval.

11. Referrals

- a. An approved out-of-network provider must work with Partnership and its contracted network and cannot refer the Mmember to another out-of-network provider without authorization from Partnership. In such cases, Partnership will make the referral if ~~it~~the request meets medically necessity criteria and Partnership does not have an appropriate provider within its network.
- b. At the request of the Mmember, the Mmember's authorized representative, or the provider, Partnership will allow transitioning Mmembers to keep authorized and scheduled specialist appointments with out-of-network providers when COC has been established and the appointments occur during the COC period.
 - 1) If a Mmember, their authorized representative, or their provider contacts Partnership to request to keep an authorized and scheduled specialist appointment with an out-of-network provider that the Mmember has not seen in the previous 12 months and there is no established relationship, Partnership may arrange for the Mmember to keep the appointment or may schedule an appointment with a network provider on or before the Mmember's scheduled appointment with the out-of-network provider.
 - 2) If Partnership is unable to arrange a specialist appointment with a network provider on or before the Mmember's scheduled appointment with the out-of-network provider, Partnership will make a good faith effort to allow the Mmember to keep their appointment; however, since the appointment occurs after the transition into Partnership, it does not meet criteria for a pre-existing relationship to request COC.

M. Continuity of Covered Services and Prior Treatment Authorizations:

1. Active prior treatment authorizations for services remain in effect for 6 months and must be honored without a request by the Mmember, Mmember's authorized representative, or provider. Partnership will arrange for services authorized under the active prior treatment authorization with a network provider, or i if there is no network provider ~~to provide the service~~, with an out-of-network provider. Utilization data of Special Populations will be examined to identify active courses of treatment and the MCP will contact providers as needed to establish any necessary prior authorizations.
2. After 6 months, the active treatment authorization remains in effect for the duration of the treatment authorization or until a new assessment is completed, whichever is shorter.
3. If a new assessment is not completed, the active treatment authorization remains in effect ~~and~~and after 6 months, the prior treatment authorization may be reassessed at any time. Reassessments for clinical necessity for Mmembers to continue accessing the transplant benefit will start no sooner than six months after the transition date. A new assessment is considered complete if the Mmember has been seen in-person and/or via synchronous telehealth by a network provider who has reviewed the Mmember's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization.
4. If reassessing Enhanced Care Management (ECM) authorizations after 6 months, the reassessment must be against ECM discontinuation criteria and not the ECM Population of Focus eligibility criteria. Please refer to policy MCCP2032 – CalAIM Enhanced Care Management (ECM), MCAP7001~~MCUP3143~~ CalAIM Service Authorization Process for Enhanced Care Management (ECM) and MCAP7003~~MCUP3142~~ CalAIM Community Supports (CS) for more details.
5. Durable Medical Equipment (DME): Partnership will allow transitioning Mmembers to keep their existing DME rentals and medical supplies from their existing provider under the criteria above (V.I.L.1- 3). Additionally, if the DME or medical supplies have been arranged for a transitioning Mmember but have not yet been delivered, Partnership will allow the delivery and permit the

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Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

Member to keep the equipment or supplies for a minimum of 6 months following Partnership enrollment and until reassessed. Additionally, if the DME or medical supplies have been arranged for a transitioning member but the equipment or supplies have not been delivered, Partnership will allow the delivery and for the member to keep the equipment or supplies for a minimum of 6 months following Partnership enrollment and until reassessed.

6. Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT): Partnership will allow Mmembers to keep the modality of transportation under the previous prior authorization with a network provider until Mmember's continued transportation needs are reassessed. Refer to policy MCCP2016 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) for details.
 7. Treatment Authorization Request (TAR) data or prior authorization data will be used to identify prior treatment authorizations, including authorized procedures and surgeries, and existing authorizations for DME and medical supplies. Partnership will pay claims for prior authorizations or existing authorizations when data is incomplete.
- N. Reporting
1. Partnership will report metrics related to COC provisions to DHCS. DHCS may request additional reporting on COC at any time and in a manner determined by DHCS.

VII. REFERENCES:

- A. DHCS [All Plan Letter 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023](#) (08/15/2023)
- B. DHCS [All Plan Letter 23-010 Revised: Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21](#) (11/22/2023)
- C. Welfare and Institutions Code Sections 14132.03 and 14189
- D. Knox-Keene Health Care Service Plan Act (California Health and Safety Code (H&S) section 1373.96)
- E. DHCS [All Plan Letter 24-01523-034: California Children's Services Whole Child Model Program](#) (12/02/2024)~~12/27/2023~~
- F. DHCS [All Plan Letter 23-018: Managed Care Health Plan Transition Policy Guide](#) (06/23/2023)
- G. DHCS [All Plan Letter 23-031: Medi-Cal Managed Care Plan Implementation of Primary Care Provider Assignment for the Age 26-49 Adult Expansion Transition](#) (12/20/2023)
- H. DHCS [CalAIM Dual Eligible Special Needs Plans Policy Guide- Contract Year 2026 \(2025\)](#)
- G-I. Medicare Managed Care Manual: Chapter 11 – Medicare Advantage Application Procedures and Contract Requirements, Rev. 83 (04/25/2007)

VIII. DISTRIBUTION:

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

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

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2026)
08/13/25

Medi-Cal

Policy/Procedure Number: <u>MPCP2014 (previously MCCP2014): MCCP2014</u>		Lead Department: Health Services Business Unit: <u>Care Coordination</u>	
Policy/Procedure Title: Continuity of Care (Medi-Cal)Continuity of Care		☒ External Policy ☐ Internal Policy	
Original Date: 08/19/2015 Effective Date: 12/29/2014 per DHCS		Next Review Date: <u>08/13/2026</u> ~~08/14/2025~~ Last Review Date: <u>08/13/2025</u> ~~08/14/2024~~	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

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

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

PREVIOUSLY APPLIED TO: N/A

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

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

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

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

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

I. DHCS Provided Data Files

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

Figure A: Summary of DHCS Provided Data Files

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

Figure A.1: Plan Transfer Status Report Data Elements

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

Figure B: Member Level Data

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

Figure C: Plan Data Feed

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

Figure D: Special Populations Member File

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

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

II. Previous MCP Provided Data Files

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

Figure E: Summary of MCP Provided Data Files

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

Figure F: Accompanying Excel Attachments for Previous MCP Provided Data

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

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

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

Figure G: Transitioning Member Identifying Data

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

Figure G.1: Transitioning Member Identifying Data

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

Figure G.2: Transitioning Member Primary Care Provider Information

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

Figure H: Transitioning Member Utilization Data

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

Figure H.1: Transitioning Member Claims / Encounter Information

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

Figure I: Transitioning Member Authorization Data

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

Figure I.1: Transitioning Member Authorization Information

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

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

Figure J: Transitioning Member NEMT/NMT Schedule and Physician Certification Statement Data

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

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

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

Figure J.2: Transitioning Member PCS Information

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

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

Figure K: Transitioning Member Special Populations Information Data

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

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

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

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

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

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

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

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

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

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

III. Continuity of Care Coordination and Management Information

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

Figure L:

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

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

Last Updated: 8/7/2023
Version: 1

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

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

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

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

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

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

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

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

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

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

Last Updated: 8/7/2023
Version: 1

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

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

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

Department of Health Care Services
2024 MCP Transition Policy Guide

Continuity of Care (CoC) Data Template - 2c) Special Populations Accompanying Data

Last Updated: 8/7/2023
Version: 1

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

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

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

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

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

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY / PROCEDURE

Policy/Procedure Number: MCNP9004			Lead Department: Health Services Business Unit: Population Health	
Policy/Procedure Title: ~~Regulatory Required Notices and Taglines~~ <u>Regulatory Required Notices</u>			☒ External Policy ☐ Internal Policy	
Original Date: 07/01/2017		Next Review Date: 08/13/2026 Last Review Date: 08/13/2025		
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD	☐ COMPLIANCE	☐ FINANCE	☒ PAC
	☐ CEO ☐ COO	☐ CREDENTIALS	☐ DEPT. DIRECTOR/OFFICER	
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: 08/13/2025	

I. RELATED POLICIES:

- A. ~~MCNP~~ND9002 – Cultural and Linguistic Program Description
- B. MCUP3064 – Communication Services
- C. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
- D. CGA024 – Medi-Cal Member Grievance System
- E. CMP03 – Compliance Approval Process
- F. COM03 – Communication Standards

II. IMPACTED DEPTS:

- A. Health Services
- B. Member Services
- C. Grievance and Appeals
- D. Provider Relations
- E. Communications

III. DEFINITIONS:

- A. Adverse Benefit Determination (ABD): The definition of an Adverse Benefit Determination encompasses all previously existing elements of an “Action” as defined under federal regulations with the addition of language that clarifies the inclusion of determinations involving medical necessity, appropriateness, setting, covered benefits, and financial liability. An ABD is defined to mean any of the following actions taken by a Managed Care Plan (i.e., Partnership HealthPlan of California):
 - 1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
 - 2. The reduction, suspension, or termination of a previously authorized service.
 - 3. The denial, in whole or in part, of payment for a service.
 - 4. The failure to provide services in a timely manner.
 - 5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
 - 6. The denial of the member’s request to obtain services outside the network.
 - 7. The denial of a member’s request to dispute financial liability.
- B. Regulatory Required Nondiscrimination Notice and Language Assistance Taglines: Nondiscrimination Notice states that Partnership follows federal civil rights laws and does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or any other basis protected by federal or State civil rights laws as outlined in in 45 CFR section 92.10(a) and W&I section 14029.91(e)(1)-(5). It includes information on how to file a discrimination grievance directly with

Policy/Procedure Number: MCNP9004			Lead Department: Health Services Business Unit: Population Health
Policy/Procedure Title: ~~Regulatory Required Notices and Taglines~~ <u>Regulatory Required Notices</u>			☒ External Policy ☐ Internal Policy
Original Date: 07/01/2017			Next Review Date: 08/13/2026 Last Review Date: 08/13/2025
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

[Partnership, as well as with the California Department of Health Care Services' Office of Civil Rights and the U.S. Department of Health and Human Services' Office for Civil Right, as set forth by CGA024 Medi-Cal Member Grievance System.](#)

- C. ~~Regulatory Required Notice of Availability: Language Assistance Taglines~~ - Explains the availability of written member information translated in the member's spoken language, [provision of free auxiliary aids and services for people with disabilities](#), or oral interpretation to understand the information provided, per [APL 25-005 APL 21-004 Revised](#) and California Welfare and Institutions Code ([WIC](#)) [14029.91\(a\)\(3\)](#).
- D. Notice of Action (NOA): A formal letter informing a member of an adverse benefit determination (ABD).
- E. Notice of Appeal Resolution (NAR): A formal letter informing a member that an ABD has been overturned or upheld.
- F. Other Informational Notices: References documents intended for the public, such as member-facing [website](#), material (outreach and education) and marketing materials, but also written notices requiring a response from an individual and written notices to an individual, such as those pertaining to rights or benefits, per [APL 25-0051-004 Revised](#).

IV. ATTACHMENTS:

- A. [Nondiscrimination Notice](#)
- B. [Notice of Availability](#)
- C. [NOA "Your Rights under Medi-Cal Managed Care"](#)
- D. [NAR "Your Rights under Medi-Cal Managed Care"](#)

V. PURPOSE:

To define criteria for sending regulatory required notices and taglines included as Attachments A – D of this policy.

VI. POLICY / PROCEDURE:

MCPs must adhere to the nondiscrimination [notice](#) and [language assistance notice of availability](#) requirements in APL ~~25-005 21-004~~ when sending the required grievance and appeals notifications to members.

- A. Regulatory Required Notices ~~and Taglines~~
 - As required by State of California statute and effectuated by DHCS All Plan Letters (APLs) [20-015](#) and [25-005 21-004](#), Partnership encloses the Nondiscrimination Notice (Attachment A) and ~~Language Assistance Taglines~~[Notice of Availability](#) (Attachment B) inserts with member informing notices including NOAs (Attachment C), NARs (Attachment D), and grievance notices, and all Other Informational Notices targeted to members. [For further details, refer to MPND 9002 Cultural and Linguistic Program Description.](#)
- 1.
- B. Exceptions
 - 1. Nondiscrimination Notice and [Notice of Availability](#) ~~Language Assistance Tagline~~ inserts are not required if they are embedded within the member material (e.g. [Partnership Medi-Cal Member Handbook](#)).
- C. NOA "Your Rights under Medi-Cal Managed Care"
 - 1. The NOA "Your Rights under Medi-Cal Managed Care" document (Attachment C) must accompany any member notification of an ABD.
 - 2. The written NOA must meet all language and accessibility standards, including translation, font, and format requirements, as set forth in APL ~~21-004~~[25-005](#), Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services, federal and state law, and all requirements in the DHCS contract.
- D. NAR "Your Rights under Medi-Cal Managed Care"

Policy/Procedure Number: MCNP9004		Lead Department: Health Services Business Unit: Population Health	
Policy/Procedure Title: ~~Regulatory Required Notices and Taglines~~ <u>Regulatory Required Notices</u>		☒ External Policy ☐ Internal Policy	
Original Date: 07/01/2017		Next Review Date: 08/13/2026 Last Review Date: 08/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

1. The NAR “Your Rights under Medi-Cal Managed Care” document (Attachment D) must accompany member notification of a member’s appeal resolution.
2. The written NAR must meet all language and accessibility standards, including translation, font, and format requirements, as set forth in APL ~~21-004~~25-005, Standards for Determining Threshold Languages, Nondiscrimination Requirements, ~~and~~ Language Assistance Services and Alternative Formats, federal and state law, and all requirements in the DHCS contract.

VII. REFERENCES:

- A. California Welfare and Institutions Code (WIC) 14029.91(a)(3) and 14029.91(e)(1)-(5).
- B. California Department of Health Care Services (DHCS) APL 20-015 State Non-Discrimination and Language Assistance Requirements (06/24/2020)
- C. California Department of Health Care Services (DHCS) APL 25-005 Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services and Alternative Formats APL 21-004 Revised Standards for Determining Threshold Languages, Non-Discrimination Requirements, and Language Assistance Services (05/03/2202/12/2025)
- D. California Department of Health Care Services (DHCS)~~DHCS~~ APL 21-011 Grievance and Appeals Requirements, Notice and “Your Rights” Templates (08/31/20224)
- E. U.S Department of Health and Human Services (HHS) 45 CFR section 92.10(a).

VIII. DISTRIBUTION:

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

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

X. REVISION DATES:

MCNP9004 – Initial 09/09/20; 09/08/21; 03/09/22; 09/14/22; 06/14/23; 09/13/23; 09/11/24; 08/13/25

PREVIOUSLY APPLIED TO:

Medi-Cal (MC359 07/01/2017 to 09/09/2020)
09/09/18; 11/20/19; ARCHIVED 09/09/2020

NONDISCRIMINATION NOTICE

Discrimination is against the law. Partnership HealthPlan of California follows state and federal civil rights laws. Partnership does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

Partnership provides:

- Free aids and services in a timely manner to people with disabilities to help them communicate better, such as:
 - ✓ Qualified sign language interpreters
 - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services in a timely manner to people whose primary language is not English, such as:
 - ✓ Qualified interpreters
 - ✓ Information written in other languages

If you need these services, contact Partnership between 8 a.m. – 5 p.m. by calling (800) 863-4155 or California Relay 711. If you cannot hear or speak well, please call (800) 735-2929. Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to:

Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534
(800) 863-4155
(800) 735-2929 or California Relay 711

HOW TO FILE A GRIEVANCE

If you believe that Partnership has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation,

you can file a grievance with a Partnership Civil Rights Coordinator. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact Partnership's Member Services between 8 a.m. – 5 p.m. by calling (800) 863-4155. Or, if you cannot hear or speak well, please call (800) 735-2929 or California Relay 711.
- In writing: Fill out a complaint form or write a letter and send it to:

Partnership HealthPlan of California
Attn: Grievance: Partnership Civil Rights Coordinator
4665 Business Center Drive
Fairfield, CA 94534

- In person: Visit your doctor's office or Partnership and say you want to file a grievance.
- Electronically: Visit Partnership's website at www.PartnershipHP.org.

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.
- In writing: Fill out a complaint form or send a letter to:

Deputy Director, Office of Civil Rights
Department of Health Care Services - Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413

Complaint forms are available at
http://www.dhcs.ca.gov/Pages/Language_Access.aspx.

- Electronically: Send an email to CivilRights@dhcs.ca.gov.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.
- In writing: Fill out a complaint form or send a letter to:

**U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201**

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

- Electronically: Visit the Office for Civil Rights Complaint Portal at <https://ocrportal.hhs.gov/ocr/portal/lobby.js>

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English

ATTENTION: If you need help in your language call 1-800-863-4155 (TTY: 1-800-735-2929). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-863-4155 (TTY: 1-800-735-2929). These services are free of charge.

العربية (Arabic)

يرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-800-863-4155 (TTY: 1-800-735-2929). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبّي. اتصل بـ 1-800-863-4155 (TTY: 1-800-735-2929). هذه الخدمات مجانية.

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-800-863-4155 (TTY: 1-800-735-2929): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք 1-800-863-4155 (TTY: 1-800-735-2929): Այդ ծառայություններն անվճար են:

ខ្មែរ (Cambodian)

ចំណាំ: បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 1-800-863-4155 (TTY: 1-800-735-2929)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរធំ សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ 1-800-863-4155 (TTY: 1-800-735-2929)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

繁體中文 (Chinese)

请注意：如果您需要以您的母语提供帮助，请致电 1-800-863-4155 (TTY: 1-800-735-2929)。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 1-800-863-4155 (TTY: 1-800-735-2929)。这些服务都是免费的。

فارسی (Farsi)

توجه: اگر میخواهید به زبان خود کمک دریافت کنید، با 1-800-863-4155 (TTY: 1-800-735-2929) تماس بگیرید. کمکی و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با 1-800-863-4155 (TTY: 1-800-735-2929) تماس بگیرید. این خدمات رایگان ارائه میشوند.

हिंदी (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-800-863-4155 (TTY: 1-800-735-2929) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-800-863-4155 (TTY: 1-800-735-2929) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Hmoob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-800-863-4155 (TTY: 1-800-735-2929). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-800-863-4155 (TTY: 1-800-735-2929). Cov kev pab cuam no yog pab dawb xwb.

日本語 (Japanese)

注意日本語での対応が必要な場合は 1-800-863-4155 (TTY: 1-800-735-2929)へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。1-800-863-4155 (TTY: 1-800-735-2929)へお電話ください。これらのサービスは無料で提供しています。

한국어 (Korean)

유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-800-863-4155 (TTY: 1-800-735-2929). 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-800-863-4155 (TTY: 1-800-735-2929). 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ພາສາລາວ (Laotian)

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອ ອໃນພາສາຂອງທ່ານໃຫ້ໃຫ້ທາດປີ 1-800-863-4155 (TTY: 1-800-735-2929). ອັງມີຄວາມຊ່ວຍເຫຼືອ ອແລະການບໍລິການສໍາລັບຄົນພິການ ແລ້ວເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໃຫ້ທາດປີ 1-800-863-4155 (TTY: 1-800-735-2929). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-800-863-4155 (TTY: 1-800-735-2929). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hlou mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-800-863-4155 (TTY: 1-800-735-2929). Naaiv deix nzie Weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-800-863-4155 (TTY: 1-800-735-2929). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬੋਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ 1-800-863-4155 (TTY: 1-800-735-2929). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

Русский (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-800-863-4155 (линия TTY: 1-800-735-2929). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-800-863-4155 (линия TTY: 1-800-735-2929). Такие услуги предоставляются бесплатно.

Español (Spanish)

ATENCIÓN: si necesita ayuda en su idioma, llame al 1-800-863-4155 (TTY: 1-800-735-2929). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-800-863-4155 (TTY: 1-800-735-2929). Estos servicios son gratuitos.

Tagalog (Filipino)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-800-863-4155 (TTY: 1-800-735-2929). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-800-863-4155 (TTY: 1-800-735-2929). Libre ang mga serbisyonang ito.

ภาษาไทย (Thai)

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-863-4155 (TTY: 1-800-735-2929). นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-863-4155 (TTY: 1-800-735-2929). ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Українська (Ukrainian)

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-800-863-4155 (TTY: 1-800-735-2929). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-800-863-4155 (TTY: 1-800-735-2929). Ці послуги безкоштовні.

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-800-863-4155 (TTY: 1-800-735-2929). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khố lớn (chữ hoa). Vui lòng gọi số 1-800-863-4155 (TTY: 1-800-735-2929). Các dịch vụ này đều miễn phí.

**YOUR RIGHTS
UNDER MEDI-CAL MANAGED CARE**

IF YOU DO NOT AGREE WITH THE DECISION YOUR HEALTH PLAN MADE FOR YOUR HEALTH CARE, YOU CAN ASK YOUR HEALTH PLAN FOR AN APPEAL.

HOW DO I ASK FOR AN APPEAL?

You have 60 days from the date of this Notice of Action letter to ask for a routine or expedited appeal. If your health plan decided to reduce, suspend or terminate a service(s) you are getting now, you may be able to keep getting the service(s) until your appeal is decided. This is called Aid Paid Pending. To qualify for Aid Paid Pending, you must ask your health plan for an appeal within 10 days from the date of this Notice of Action letter, or before the date your health plan says the change to your service(s) will happen. Even though your health plan must give you Aid Paid Pending when you ask for an appeal within these timelines above, you should let your health plan know when you ask for an appeal that you want to get Aid Paid Pending until your appeal is decided.

If you miss the 10-day period to request an appeal OR do not ask for an appeal before the date the change to your service(s) will happen, you still have 60 days from the date of this Notice of Action letter to ask for a routine or expedited appeal. However, you will not get Aid Paid Pending while your appeal is being decided.

You can ask for an appeal yourself. Or, you can have someone like a relative, friend, advocate, doctor, or attorney ask for one for you. This person is called an Authorized Representative. Your health plan can provide a form for you to identify your Authorized Representative. You, or your Authorized Representative, can send in anything you want your health plan to look at to make a decision on your appeal. A doctor who is different from the doctor who made the first decision will look at your appeal.

You can file a routine or expedited appeal by phone, in writing, or electronically:

- By phone: Contact Partnership HealthPlan of California between 8 a.m. – 5 p.m. by calling (800) 863-4155. If you cannot hear or speak well, please call (800) 735-2929 or California Relay 711.
- In writing: Fill out an appeal form or write a letter and send it to:

Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534

Your doctor's office will have appeal forms available. Your health plan can also send a form to you.

- Electronically: Visit your health plan's website. Go to <https://partnershiphp.org>.

WHEN WILL MY APPEAL BE DECIDED?

For Standard Appeals, your health plan must respond to your appeal in writing within 30 days. If you think waiting 30 days will hurt your health, you may be able to get a decision in 72 hours. When you ask for an appeal with your health plan, say why waiting will hurt your health. Make sure you ask for an Expedited Appeal.

For Expedited Appeals, your health plan must try to give you an oral notice of its decision on your appeal. For both Standard and Expedited appeals, your health plan will mail you a Notice of Appeal Resolution letter. This letter will tell you what your health plan decided on your appeal.

CAN I ASK FOR A STATE HEARING?

A State Hearing is where a judge will review your case.

In most instances, you are not eligible to request a State Hearing until you have first completed your health plan's internal appeal process. However, there are times when you can directly request a State Hearing. This can happen if your health plan did not notify you correctly or timely about your service(s). This is called Deemed Exhaustion. Here are some examples of Deemed Exhaustion:

- The health plan did not make this Notice of Action letter available to you in your preferred language.
- The health plan made a mistake that affects any of your rights.
- The health plan did not give you a written Notice of Action letter informing you of its intended action regarding your service(s).
- The health plan made a mistake in its written Notice of Appeal Resolution letter.
- The health plan did not decide your appeal within 30 days and send you a Notice of Appeal Resolution letter.
- The health plan decided your case was urgent, but did not respond to your appeal within 72 hours and send you a Notice of Appeal Resolution letter.

If you want a State Hearing, you must ask for one within 120 days from the date of the Notice of Appeal Resolution (NAR) letter.

You will not have to pay for a State Hearing.

HOW DO I REQUEST A STATE HEARING?

As stated above, you may be eligible to request a State Hearing.

You can ask for a State Hearing in the following ways:

- Online at www.cdss.ca.gov
- By phone: Call 1-800-743-8525. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call TTY/TDD 1-800-952-8349.
- In writing: Fill out a State Hearing form or write a letter. Send it by mail or fax to:

Mail: California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-433
Sacramento, CA 94244-2430

Fax: (916) 309-3487 or toll-free at 1-833-281-0903

A State Hearing Form is included with this letter. Be sure to include your name, address, telephone number, Social Security Number and/or CIN number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell the State Hearings Division what language you speak. You will not have to pay for an interpreter. The State Hearings Division will get you one. If you have a disability, the State Hearings Division can get you special accommodations free of charge to help you participate in the hearing. Please include information about your disability and the accommodation you need.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think that waiting 90 days will hurt your health, you can request an Expedited Hearing. If the State Hearings Division approves your request for an Expedited Hearing, you may be able to get a hearing decision within 3 days from the date it receives your case file from your health plan.

You can ask for an Expedited Hearing by calling the State Hearings Division at the number above. Or, you can send the State Hearing form or a letter to the State Hearings Division. You must explain how waiting for up to 90 days for a decision will harm your life, health or ability to get or keep maximum function. You can also get a letter from your doctor to help show why you need an Expedited Hearing.

You can speak for yourself at the State Hearing. Or, you can have someone like a relative, friend, advocate, doctor, or attorney speak for you. If you want someone else to speak for you, then you must sign a form telling the State Hearings Division that the person can speak for you. This person is called an Authorized Representative.

LEGAL HELP

You may be able to get free legal help. Call the California Department of Consumer Affairs at (800) 952-5210, or TTY (800) 326-2297. You may also call the local Legal Aid Office in your county at 1-888-804-3536.

**YOUR RIGHTS
UNDER MEDI-CAL MANAGED CARE**

STATE HEARING

If you still do not agree with this decision, you can ask for a State Hearing and a judge will review your case. You will not have to pay for a State Hearing.

If you want a State Hearing, you must ask for one within 120 days from the date of this Notice of Appeal Resolution (NAR) letter. However, if your health plan continued to provide you with the disputed service(s) (Aid Paid Pending) during the health plan's appeal process and you want the service(s) to continue until there is a decision on your State Hearing, you must request a State Hearing within 10 days of this Notice of Appeal Resolution letter. Even though your health plan must give you Aid Paid Pending when you ask for a State Hearing in this way, you should let your health plan know you want to get Aid Paid Pending until your State Hearing is decided. You should contact Partnership HealthPlan of California between 8 a.m. – 5 p.m. by calling (800) 863-4155. If you cannot hear or speak well, please call (800) 735-2929 or California Relay 711.

You can ask for a State Hearing in the following ways:

- Online at www.cdss.ca.gov
- By phone: Call 1-800-743-8525. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call TTY/TDD 1-800-952-8349.
- In writing: Fill out a State Hearing form or write a letter. Send it by mail or fax to:

Mail: California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-433
Sacramento, CA 94244-2430

Fax: (916) 309-3487 or toll-free at 1-833-281-0903

A State Hearing Form is included with this letter. Be sure to include your name, address, telephone number, Social Security Number and/or CIN number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell the State Hearings Division what language you speak. You will not have to pay for an interpreter. The State Hearings Division will get you one. If you have a disability, the State Hearings Division can get you special accommodations free of charge to help you participate in the hearing. Please include information about your disability and the accommodation you need.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think waiting that long will hurt your health, you might be able to get an answer within 3 days. Ask your doctor or health plan to write a letter for you. The letter must explain in detail how waiting for up to 90 days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, make sure you ask for an Expedited Hearing and provide the letter with your request for a hearing.

You may speak at the State Hearing yourself. Or, someone like a relative, friend, advocate, doctor, or attorney can speak for you. If you want another person to speak for you, then you must tell the State Hearings Division that the person is allowed to speak for you. This person is called an Authorized Representative.

LEGAL HELP

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: <u>MPNP9007 (previously MCCP2020; MCUP3009; MPUG3009; UG100309)</u>			Lead Department: Health Services Business Unit: <u>Care Coordination-Population Health</u>	
Policy/Procedure Title: Lactation Policy and Guidelines (formerly Breastfeeding Guidelines)			☒ External Policy ☐ Internal Policy	
Original Date: <u>04/19/200002/16/2000</u>		Next Review Date: <u>05/14/202608/13/2026</u> Last Review Date: <u>05/14/202508/13/2025</u>		
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD		☐ COMPLIANCE	☐ FINANCE
	☐ CEO	☐ COO	☐ CREDENTIALS	☒ PAC
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: 08/13/2025	

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
- F. MCUP3013 – Durable Medical Equipment (DME) Authorization
- G. MCUG3011 – Criteria for Home Health Services
- H. MCNP9006 - Doula Services Benefit
- I. 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 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.D. Partnership Advantage (PA): Effective January 1, 20276, 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

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Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. -Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

- 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.
- 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

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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*)
- f. 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. 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. 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

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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. 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.
 - b) Please refer to policy MCUG3011 Home Health Services for further information on EVV requirements.
 - i. Doulas offer various types of support, including lactation support. For more details, refer to Partnership policy MCNP9006 Doula Services Benefit and MPCR15 Doula Credentialing and Re-credentialing Criteria.

C. Partnership HealthPlan of California Breastfeeding Services

1. Timing of Lactation Support Services: 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 support services:
 - a. 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. 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

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- 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.
 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. 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.
 - b. Services provided in a contracted hospital outpatient services, physician office, IBCLC private office 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.
 - c. 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. Partnership breast pump benefit is limited to one pump every three years.

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- 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 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:

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<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~~ (APL) 22-012 Revised – Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits From Managed Care to Medi-Cal Rx (12/30/2022)
- 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](#)

VIII. DISTRIBUTION:

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

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

X. REVISION DATES:

Medi-Cal

MPNP9007 (Effective 08/13/25)

N/A

Partnership Advantage (Program effective January 1, 2027)

08/13/25 — N/A

MPNP9007 (08/13/25) MCCP2020 (02/15/17)

N/A

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

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

PREVIOUSLY APPLIED TO:

MCCP2020 (02/15/17 to 08/13/25)

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

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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

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

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Approving Entities:	☐ BOARD	☐ COMPLIANCE	☐ FINANCE	☒ PAC
	☐ CEO ☐ COO	☐ CREDENTIALING	☐ DEPT. DIRECTOR/OFFICER	
Approval Signature: Robert Moore, MD, MPH, MBA			Archived Date: 08/13/2025 Approval Date: 03/12/2025	

I. RELATED POLICIES:

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- D. MCUP3041 - Treatment Authorization Request (TAR) Review Process
- E. MCCP2021 - Women, Infants and Children (WIC) Supplemental Food Program
- F. MCUP3013 – Durable Medical Equipment (DME) Authorization
- G. MCUG3011 – Criteria for Home Health Services
- H. MCNP9006 - Doula Services Benefit
- I. 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 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.

IV. ATTACHMENTS:

- A. N/A

V. PURPOSE:

- A. To support optimal nutrition in the healthy infant by appropriately supporting the parent's efforts to

Policy/Procedure Number: MCCP2020 (previously MCUP3009; MPUG3009; UG100309)			Lead Department: Health Services Business Unit: Care Coordination
Policy/Procedure Title: Lactation Policy and Guidelines (formerly Breastfeeding Guidelines)			☒ External Policy ☐ Internal Policy
Original Date: 04/19/2000			Next Review Date: 03/12/2026 <u>N/A</u> Last Review Date: 03/12/2025
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

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.

- 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

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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)
- f. Postpartum follow-up: Calls are made to Partnership members 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. 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. 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. 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.

Policy/Procedure Number: MCCP2020 (previously MCUP3009; MPUG3009; UG100309)			Lead Department: Health Services Business Unit: Care Coordination
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Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

- 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.
 - b) Please refer to policy MCUG3011 Home Health Services for further information on EVV requirements.
 - i. Doulas offer various types of support, including lactation support. For more details, refer to Partnership policy MCNP9006 Doula Services Benefit and MPCR15 Doula Credentialing and Re-credentialing Criteria.
- C. Partnership HealthPlan of California Breastfeeding Services
1. Timing of Lactation Support Services: 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 support services:
 - a. 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. 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.
 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

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Original Date: 04/19/2000			Next Review Date: 03/12/2026 ~~N/A~~ Last Review Date: 03/12/2025
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

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. 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.
 - b. Services provided in a contracted hospital outpatient services, physician office, IBCLC private office 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.
 - c. 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. 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 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:

Policy/Procedure Number: MCCP2020 (previously MCUP3009; MPUG3009; UG100309)			Lead Department: Health Services Business Unit: Care Coordination
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Original Date: 04/19/2000			Next Review Date: 03/12/2026N/A Last Review Date: 03/12/2025
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

- 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](#) – Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits From Managed Care to Medi-Cal Rx (12/30/2022)
- J. DHCS [APL 22-014](#) Electronic Visit Verification Implementation Requirements (07/21/2022)
- K. Partnership Website: Pregnancy & Breastfeeding - Breastfeeding Booklet

Policy/Procedure Number: MCCP2020 (previously MCUP3009; MPUG3009; UG100309)			Lead Department: Health Services Business Unit: Care Coordination
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Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

<https://www.partnershiphp.org/Members/Medi-Cal/Pages/Health%20Education/Pregnancy--Breastfeeding.aspx>

VIII. DISTRIBUTION:

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

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

X. REVISION DATES:

MCCP2020 (02/15/17)

*03/14/18; 06/12/19; 06/10/20; 08/11/21; 03/09/22; 03/08/23; 03/13/24; 03/12/25; ~~ARCHIVED 08/13/2025~~

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

PREVIOUSLY APPLIED TO:

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

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: <u>MPNP9008 (previously MCCP2021; MCUP3100)</u>			Lead Department: Health Services Business Unit: ~~Care Coordination~~ <u>Population Health</u>	
Policy/Procedure Title: Women, Infants and Children (WIC) Supplemental Food Program			☒ External Policy ☐ Internal Policy	
Original Date: 04/21/2010		Next Review Date: ~~05/14/2026~~ <u>08/13/2026</u> Last Review Date: ~~05/14/2025~~ <u>08/13/2025</u>		
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage	
Reviewing Entities:	☒ ~~IQI~~ ☐ OPERATIONS	☐ P & T ☐ EXECUTIVE	☒ ~~QUAC~~ ☐ COMPLIANCE ☐ DEPARTMENT	
Approving Entities:	☐ BOARD ☐ CEO ☐ COO	☐ COMPLIANCE ☐ CREDENTIALS	☐ FINANCE	☒ PAC
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~05/14/2025~~ <u>08/13/2025</u>	

I. RELATED POLICIES:

- A. MCUG3118 – Prenatal & Perinatal Care
- B. MCQG1015 - Pediatric Preventive Health Guidelines
- C. MCNP9006 – 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 (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.
- A.B. Partnership Advantage (PA): Effective January 1, 2027, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. – Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

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.

Policy/Procedure Number: MPNP9008 (previously MCCP2021; MCUP3100)		Lead Department: Health Services Business Unit: Care Coordination 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: 05/14/202608/13/2026 Last Review Date: 05/14/202508/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

VI. POLICY / PROCEDURE:

A. Coverage Guidelines:

1. WIC services are not covered by Partnership. However, 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. 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. 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 refer each WIC-eligible member to a county WIC program per Federal WIC requirements for program eligibility.
3. 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. PCP/OB will refer all eligible Partnership members to WIC and include the member's hemoglobin or hematocrit lab results.
5. 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 PL 98-010. Referrals occur during various outreach activities. All referrals are documented in member's medical record.

C. Follow-up, Education and Training

1. As part of ongoing provider training, Partnership will work to ensure that providers understand the WIC program, eligibility requirements, and the referral process.
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.

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 execute a MOU outlining respective responsibilities and obligations.
2. Refer to Partnership policy MCCP2036 - Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities for more details.

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>

Policy/Procedure Number: MPNP9008 (previously MCCP2021; MCUP3100)		Lead Department: Health Services Business Unit: Care Coordination 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: 05/14/202608/13/2026 Last Review Date: 05/14/202508/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

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)

~~F.~~

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 Officer

X. REVISION DATES:

[Medi-Cal](#)

[MPNP9008 \(Effective 08/13/25\)](#)

[N/A](#)

[Partnership Advantage \(Program effective January 1, 20276\)MCCP2021 \(02/15/17\)](#)

[N/A](#)

[MPNP9008 \(08/13/25\)](#)

[N/A](#)

[*03/14/18; 03/13/19; 03/11/20; 03/10/21; 03/09/22; 03/08/23; 03/13/24; 03/12/25](#)

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

PREVIOUSLY APPLIED TO:

~~————MCCP2021 (02/15/17 to— 08/13/25)~~

[*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](#)

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

Policy/Procedure Number: MPNP9008 (previously MCCP2021; MCUP3100)		Lead Department: Health Services Business Unit: Care Coordination 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: 05/14/202608/13/2026 Last Review Date: 05/14/202508/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCCP2021 (previously MCUP3100)			Lead Department: Health Services Business Unit: Care Coordination	
Policy/Procedure Title: Women, Infants and Children (WIC) Supplemental Food Program			☒ External Policy ☐ Internal Policy	
Original Date: 04/21/2010		Next Review Date: N/A 03/13/2026 Last Review Date: 03/12/2025		
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD	☐ COMPLIANCE	☐ FINANCE	☒ PAC
	☐ CEO ☐ COO	☐ CREDENTIALING	☐ DEPT. DIRECTOR/OFFICER	
Approval Signature: Robert Moore, MD, MPH, MBA			<u>Archived Date: 08/13/2025</u> <u>Approval Date: 03/12/2025</u>	

I. RELATED POLICIES:

- A. MCUG3118 – Prenatal & Perinatal Care
- B. MCQG1015 - Pediatric Preventive Health Guidelines
- C. MCNP9006 – 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 (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.

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 members 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.

Policy/Procedure Number: MCCP2021 (previously MCUP3100)			Lead Department: Business Unit: Care Coordination
Policy/Procedure Title: Women, Infants and Children (WIC) Supplemental Food Program			☒ External Policy ☐ Internal Policy
Original Date: 04/21/2010			Next Review Date: ~~N/A~~ 03/12/2026 Last Review Date: 03/12/2025
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

B. Identification and Referral

1. 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. 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 refer each WIC-eligible member to a county WIC program per Federal WIC requirements for program eligibility.
3. 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. PCP/OB will refer all eligible Partnership members to WIC and include the member's hemoglobin or hematocrit lab results.
5. Partnership refers the members 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 PL 98-010. Referrals occur during various outreach activities. All referrals are documented in member's medical record.

C. Follow-up, Education and Training

1. As part of ongoing provider training, Partnership will work to ensure that providers understand the WIC program, eligibility requirements, and the referral process.
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.

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 execute a MOU outlining respective responsibilities and obligations.
2. Refer to Partnership policy MCCP2036 - Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities for more details.

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)

VIII. DISTRIBUTION:

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

Policy/Procedure Number: MCCP2021 (previously MCUP3100)		Lead Department: Business Unit: Care Coordination	
Policy/Procedure Title: Women, Infants and Children (WIC) Supplemental Food Program		☒ External Policy ☐ Internal Policy	
Original Date: 04/21/2010		Next Review Date: ~~N/A~~ 03/12/2026 Last Review Date: 03/12/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

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

X. REVISION DATES:

MCCP2021 (02/15/17)

*03/14/18; 03/13/19; 03/11/20; 03/10/21; 03/09/22; 03/08/23; 03/13/24; 03/12/25; ARCHIVED 08/13/2025

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

PREVIOUSLY APPLIED TO:

MCUP3100 (04/21/2010 to 02/15/2017)

05/15/13; 05/20/15; 05/18/16 to 02/15/2017

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

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

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

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

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: ~~MPQP1004~~ (previously QP100104)			Lead Department: ~~Health Services~~ <u>Business Unit: Quality Improvement</u>	
Policy/Procedure Title: Internal Quality Improvement Committee			☒ External Policy ☐ Internal Policy	
Original Date: 05/17/2000		Next Review Date: ~~04/09/2026~~ <u>08/12/2026</u> Last Review Date: ~~04/09/2025~~ <u>08/13/2025</u>		
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage ⁺	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD	☐ COMPLIANCE	☐ FINANCE	☒ PAC
	☐ CEO ☐ COO	☐ CREDENTIALS	☐ DEPT. DIRECTOR/OFFICER	
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~04/09/2025~~ <u>08/13/2025</u>	

I. RELATED POLICIES:

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

II. IMPACTED DEPTS:

- A. All

III. DEFINITIONS:

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

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

IV. ATTACHMENTS:

- A. N/A

V. PURPOSE:

⁺ ~~This policy may also apply in part to Partnership Advantage, the HealthPlan's Medicare product effective Jan. 1, 2026 in eight counties: Del Norte, Humboldt, Mendocino, Lake, Marin, Sonoma, Napa, and Solano, and may be subject to change based on Centers for Medicare and Medicaid Services (CMS) rules.~~

Policy/Procedure Number: MPQP1004 (previously QP100104)		Lead Department: Health Services Business Unit: Quality Improvement	
Policy/Procedure Title: Internal Quality Improvement Committee		☒ External Policy ☐ Internal Policy	
Original Date: 05/17/2000		Next Review Date: 04/09/202608/13/2026 Last Review Date: 04/09/202508/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

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

VI. POLICY / PROCEDURE:

A. Committee Structure

1. Membership:

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

Internal Quality Improvement Committee Standing Members	
Department Represented	Position Title
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Strategy & Government Affairs Officer
	Regional Manager(s)Directors
	Compliance Manager, Grievance and Appeals
Configuration	Configuration Department Leadership
Finance	Director of Health Analytics
Health Services	Chief Medical Officer – Committee Chair
	Medical Director for Quality – Committee Vice Chair
	Medical Director for Medicare Services
	Regional Medical Director(s)
	Associate Medical Director(s)
	Chief Health Services Officer
	Senior Director of Quality and Performance Improvement
	Senior Director of Care Management
	Behavioral Health Clinical Director
	Senior Director, Behavioral Health
	Director of Health Equity (Health Equity Officer)
	Director of Population Health
	Director of Quality Management
	Director of Pharmacy Services
	Director, Care Coordination
	Director, Utilization Management
	Director, Enhanced Health Services
	Associate Director(s), Utilization Management
	Associate Director, Population Health

Policy/Procedure Number: MPQP1004 (previously QP100104)		Lead Department: Health Services Business Unit: Quality Improvement	
Policy/Procedure Title: Internal Quality Improvement Committee		☒ External Policy ☐ Internal Policy	
Original Date: 05/17/2000		Next Review Date: 04/09/2026 Last Review Date: 08/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

	Manager of Care Coordination Regulatory Performance
	Manager of Member Safety - Quality Investigations
	Manager, Clinical Compliance – Quality Inspections
	Policy Analyst, Utilization Management
	Senior Health Educator
Member Services	Senior Director of Member Services & Grievance
	Senior Director, Provider Relations
Provider Relations/ Network Services Credentials	Associate Director of Provider Relations Director of Network Services

- b. Standing members are responsible for maintaining an annual attendance rate of 75% or greater. Committee members may appoint a designee to attend.
 2. Minutes: Minutes of all meetings are maintained according to the Confidentiality policy/procedure. Approved Minutes are submitted monthly to the Delegation Oversight Reporting Subcommittee (DORS) and Regulatory Affairs and Compliance (RAC) inboxes. RAC submits these Minutes to the Department of Health Care Services (DHCS).
 3. Chair: The Chief Medical Officer (CMO) chairs the committee. The Medical Director for Quality serves as Vice Chair. In the event that neither is able to chair, the CMO will appoint a designee.
 4. Meetings: The Committee meets at least 10 times a year with the option to add additional meetings if needed.
 5. Voting: Standing Members ~~(s)~~ [Designee\(s\), including the Regional Medical Directors and Associate Medical Directors specifically assigned by the CMO to sit on this committee](#), will vote and the Chair will acknowledge consensus.
- B. Committee Responsibilities
1. Reviews policies and makes recommendations or revisions for effective monitoring and achievement of Quality Improvement (QI) objectives.
 2. Monitors quality improvement projects across the organization that impact patient care, focusing on areas such as clinical outcomes, patient experience, including access and service, and cost efficiency.
 3. Monitors utilization management activities for both medical and pharmacy management: denials, authorizations, appeals, etc.
 4. Reviews policies and clinical guidelines that relate to physical health or behavioral services for our members, including credentialing, performance improvement initiatives, etc.
 5. Reviews delegation reports for quality, utilization management, credentialing where concerns exist.
 6. Reviews findings from regulatory audits and monitor progress on corrective action plans.
 7. Reviews performance metrics (i.e., dashboards and indicator reports) and make recommendations for corrective action for indicators that are below established thresholds; assures appropriate follow-up on corrective actions that relate to quality of care and service concerns.
 8. Makes recommendations in implementation of the “QI Trilogy” (i.e., the QI Program Description, Work Plan, and Evaluation), and the like “Grand Analyses” of Partnership’s Care Coordination, Population Health, Health Equity, Pharmacy and Utilization Management departments, among others.
 9. Oversees the activities of its subcommittees: the Population Needs Assessment (PNA) Committee, the Member Grievance Review Committee (MGRC), the Over/Under Utilization Workgroup, and the Substance Use Internal Quality Improvement Subcommittee (SUIQI).
- C. Committee Accountability
1. IQI is accountable to the Q/UAC, and through this body, to the PAC and Partnership’s Board of Commissioners.

Policy/Procedure Number: MPQP1004 (previously QP100104)		Lead Department: Health Services <u>Business Unit: Quality Improvement</u>	
Policy/Procedure Title: Internal Quality Improvement Committee		☒ External Policy ☐ Internal Policy	
Original Date: 05/17/2000		Next Review Date: <u>04/09/2026</u> Last Review Date: <u>08/13/2025</u>	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

D. Delegation Oversight and Monitoring

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

VII. REFERENCES:

N/A

VIII. DISTRIBUTION:

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

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

X. REVISION DATES:

Medi-Cal

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

Partnership Advantage (effective Jan. 1, 2027)

N/A

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

PREVIOUSLY APPLIED TO:

Partnership Advantage

MPQP1004 – 03/21/2007 to 01/01/2015

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPQP1008 (previously QP100108 & KK Q1201)			Lead Department: Health Services Business Unit: Quality Improvement	
Policy/Procedure Title: Conflict of Interest Policy for QI Activities			☒ External Policy ☐ Internal Policy	
Original Date: 04/25/1994		Next Review Date: ~~11/13/2025~~ 08/13/2026 Last Review Date: ~~11/13/2024~~ 08/13/2025		
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage	
Reviewing Entities:	☐ IQI	☐ P & T	☐ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD	☐ COMPLIANCE	☐ FINANCE	☒ PAC
	☐ CEO ☐ COO	☐ CREDENTIALS	☐ DEPT. DIRECTOR/OFFICER	
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~11/13/2024~~ 08/13/2025	

I. RELATED POLICIES:

- A. CMP10 – Confidentiality
- B. MPQP1053 – Peer Review Committee
- C. MPQP1002 – Quality/Utilization Advisory Committee
- D. MPCR200 Credentialing Committee and CMO Credentialing Program Responsibilities

II. IMPACTED DEPTS:

- A. Health Services

III. DEFINITIONS:

N/A

IV. ATTACHMENTS:

- A. Conflict of Interest Agreement

V. PURPOSE:

To describe the mechanism to ensure that a conflict of interest does not exist when contracted providers, who are members of Partnership HealthPlan of California (Partnership) committees, perform peer review or quality improvement activities.

VI. POLICY / PROCEDURE:

- A. All non-Partnership persons involved in Partnership peer review activities or committees shall sign a conflict of interest statement annually.
- B. Conflict of interest is defined as any involvement in the care of the member involved in the review, any fiduciary interest or fiduciary relationship with the provider under review, or any other involvement in the case that may impact objectivity in performing the review. Note – a provider is a broad term that could include physicians or other direct care providers and vendors.
- C. Committee members or peer reviewers with a conflict of interest in a particular case will notify the Medical Director for Quality or the Committee Chair, and excuse themselves from receiving related materials and from participating in the review.
- D. Should a situation arise wherein this policy is not followed, the appropriate Committee and/or its Chair will determine appropriate action and notify the individuals(s) verbally and in writing.

VII. REFERENCES:

N/A

Policy/Procedure Number: MPQP1008 (previously QP100108 & KK Q1201)		Lead Department: Health Services Business Unit: Quality Improvement	
Policy/Procedure Title: Conflict of Interest Policy for QI Activities		☒ External Policy ☐ Internal Policy	
Original Date: 04/25/1994		Next Review Date: 11/13/2025 Last Review Date: 08/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

VIII. DISTRIBUTION:

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

IX. PERSON RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal

01/27/95; 10/10/97 (name change only); 12/98; 6/21/00; 05/16/01; 08/20/03; 09/15/04; 04/19/06; 04/18/07; 02/20/08; 03/18/09; 04/21/10; 08/15/12; 08/20/14; 09/16/15; 10/19/16; 11/15/17; *10/10/18; 11/13/19; 11/11/20; 11/10/21; 11/09/22; 11/08/23; 11/13/24; 08/13/25

Partnership Advantage (effectiveness Jan. 1, 2027)

N/A

PREVIOUSLY APPLIED TO:

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

PREVIOUSLY APPLIED TO:

Partnership Advantage:

MPQP1008 - 04/18/2007 to 01/01/2015

Healthy Families:

MPQP1008 - 08/15/2012 to

03/01/2013 Healthy Kids: (KK

QI201, MPQP1008)

04/18/07; 02/20/08; 03/18/09; 04/21/10; 08/15/12; 08/20/14; 09/16/15; 10/19/16 to 12/01/16

(Healthy Kids Program ended 12/01/2016)



PARTNERSHIP HEALTHPLAN of CALIFORNIA

CONFLICT of INTEREST AGREEMENT

As a voting member of Partnership HealthPlan of California's Peer Review, Quality/Utilization Advisory Committee, Credentials Committee or any other peer review entity involved in peer review, I recognize that absence of conflict of interest is vital to the unbiased and candid decisions necessary for effective peer review activities. Therefore, I agree to report any conflict of interest, potential or confirmed, to the Medical Director for Quality or the specific Committee Chair.

As a peer reviewer with a conflict of interest regarding any matter being reviewed or brought before a committee, I will refrain from participation in or completion of said peer review. I will also refrain from casting a vote on any related issue and shall absent myself from any proceedings of the committee in which such issues are raised for consideration.

A conflict of interest is defined as any involvement in the care of the member involved in the review, any fiduciary interest in or relationship with the provider or vendor in question, or any other involvement in the case that may impair objectivity in performing the review.

Furthermore, my participation in peer review and quality improvement activities is in reliance on my belief that the conflict of interest related to these activities will be similarly preserved by every other member of the committee or other individuals involved. I understand that Partnership HealthPlan of California is entitled to undertake such action as is deemed appropriate to ensure that this confidentiality is maintained, including action necessitated by any breach or threatened breach of this agreement.

SIGNATURE

PRINTED NAME

DATE

WITNESS

DATE

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPXG5009			Lead Department: Health Services Business Unit: Quality Improvement	
Policy/Procedure Title: Lactation Clinical Practice Guideline			☒ External Policy ☐ Internal Policy	
Original Date: 01/15/2014		Next Review Date: ~~08/14/2025~~ 08/13/2026 Last Review Date: ~~08/14/2024~~ 08/13/2025		
Applies to:	☐ Employees	☒ Medi-Cal	☒ ☐ Partnership Advantage	
Reviewing Entities:	☐ IQI	☐ P & T	☐ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD		☐ COMPLIANCE	☐ FINANCE
	☐ CEO	☐ COO	☐ CREDENTIALS	☒ PAC
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~08/14/2024~~ 08/13/2025	

I. RELATED POLICIES:

- A. MCCP2020 – Lactation Policy and Guidelines
- B. MPCR16 – Lactation Consultant Credentialing Policy
- C. MCUG3118 – Prenatal and Perinatal Care
- D. MCCP2021 - Women, Infant and Children (WIC) Supplemental Food Program
- E. MCNP9006 – Doula Services Benefit

II. IMPACTED DEPTS:

- A. N/A

III. DEFINITIONS:

- A. Baby Friendly Hospital Initiative – A global initiative sponsored by the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) to encourage and recognize hospitals and birth centers that offer an optimal level of care for infant feeding.

IV. ATTACHMENTS:

- A. N/A

V. PURPOSE:

To support optimal nutrition in the healthy infant by appropriately supporting efforts to initiate and sustain breastmilk feeding exclusively for about six months and with complementary foods (not formula) for at least 12 months per American Academy of Pediatrics (AAP) recommendations.

VI. POLICY / PROCEDURE:

Lactation Guideline/Procedure

- A. General Breastfeeding Guidelines

Introduction: Human breast milk is uniquely specific to the needs of the human infant. Partnership HealthPlan of California (Partnership) and the American Academy of Pediatrics (AAP) acknowledge breast milk feeding as the preferred method of infant nutrition. Research has demonstrated numerous health benefits of breast milk feeding. Additional to health benefits, breast milk feeding also provides social, economic, and environmental benefits for both parent and infant.

- B. Promotion and Support of Breast Milk feeding

1. Lactation Education and Support Services: Each Partnership county has a local Women Infants and Children (WIC) Nutrition Program that includes lactation education, support, and provision of breast pumps for low-income persons, including those with Medi-Cal. All pregnant and postpartum

Policy/Procedure Number: MPXG5009		Lead Department: Health Services Business Unit: Quality Improvement	
Policy/Procedure Title: Lactation Clinical Practice Guideline		☒ External Policy ☐ Internal Policy	
Original Date: 01/15/2014		Next Review Date: 08/14/202508/13/2026 Last Review Date: 08/14/202408/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ ☐ Partnership Advantage

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 are encouraged to provide opportunities for members to learn about the advantages of breastfeeding through educational materials. Referrals for pregnant and postpartum members to-breastfeeding breast milk feeding classes during and after pregnancy will ensure they have current evidence-based information about breast milk feeding.
- b. Prenatal care providers should specifically assess a pregnant member's knowledge and interest in breastmilk feeding 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 breast milk feeding should be ongoing. The pregnant members and their partners should be referred to a breast milk feeding class antenatally and have access to one on one breast milk feeding education prenatally and postnatally. This is especially important for members in their first pregnancy who have not breastfed in the past.
- c. Comprehensive Perinatal Service Programs (CPSP) and Partnership Health Perinatal Services Programs: Partnership strongly supports having all pregnant members receive support services provided though Perinatal Services providers, which provide comprehensive assessments as part of their total prenatal care. CPSP/Perinatal Services Providers may provide their own lactation support services or refer to other community resources to provide breast milk feeding promotion, education, and counseling.
- d. Doula's offer various types of support, including lactation support. For more details, refer to Partnership policy MCNP9006 Doula Services Benefit.
- e. 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 breast milk feeding when wanted.
- f. Postpartum follow-up calls are made to Partnership members within the first month after delivery when possible to encourage a timely postpartum visit. If needed, referrals are made for lactation or newborn feeding assistance, support, education, and information.
- g. Hospitals providing obstetrical care play a key role in supporting successful 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) (<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 birthing person 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 breast milk feeding 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. Lactating persons can be encouraged to hold their infants even when not feeding to better assist them as they begin the process of learning and understanding feeding cues.
 - 4) Members need access to qualified nursing staff to assist with initiation of breastfeeding, evaluation of breastfeeding progress, and providing ongoing information to manage common difficulties during the hospital stay.

Policy/Procedure Number: MPXG5009		Lead Department: Health Services Business Unit: Quality Improvement	
Policy/Procedure Title: Lactation Clinical Practice Guideline		☒ External Policy ☐ Internal Policy	
Original Date: 01/15/2014		Next Review Date: 08/14/202508/13/2026 Last Review Date: 08/14/202408/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ ☐ Partnership Advantage

- 5) Supplements such as water, glucose water or formula should not be given to breast milk feeding newborns unless there is an order from the Health Care Provider. Parents should be counseled in the risks associated with bottles and pacifiers.
- 6) Coordinate discharge to ensure parents and infants have access to ongoing breast milk feeding care and support.
 - a) ~~a.~~ Discharge planning includes consideration of arrangements that include follow-up with WIC, a peer counselor, the infant care office, an International Board of Lactation Consultant Examiner (IBCLC), or a home health or public health nurse visit specifically to assist the parent with breast milk feeding. Whenever possible this should occur within 1-2 calendar days of discharge.
- 7) The Birth Facility should provide lactating patients with a list of resources for support and assistance with breast milk feeding, including information on how to tell if the baby is getting enough milk and referral for breast milk feeding support resources.
- h. Infant care providers should encourage exclusive breast milk feeding per AAP recommendations. Infant care providers should consider referral to a lactation counsellor / educator, certified lactation consultant, doula, licensed midwife, home health nurse or public health nurse for evaluation before suggesting supplementation with formula or cessation of breast milk feeding. Providers need to consider the birthing parent's health and well-being when giving recommendations. If a baby needs to stop feeding at the breast, the lactating parent may be provided with a breast pump and instructions on how to use it to maintain milk supply.
- i. 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.
2. Timing of Lactation Support Services: Lactation Education and Support is different in the prenatal, immediate Postpartum (in the hospital), early postpartum (from hospital discharge to 84 calendar days after delivery), and late postpartum periods (from 84 calendar days to 365 calendar days post-delivery). Lactation visits independent of the standard postpartum visits are covered by Partnership.
3. Providers of Lactation support services:
 - a. Basic Lactation support services may be provided in a provider office by a medical professional as follows: Physician, a Registered Nurse (RN) or Registered Dietitian (RD) working under the supervision of a Physician, Nurse Practitioner (NP), Physician Assistant (PA), Certified Nurse Midwife (CNM), or Licensed Midwife (LM).
 - ~~a.b.~~ Licensed midwives may enroll in Medi-Cal as direct/billing providers and apply as a CPSP provider. See <https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx> for more information.
 - ~~b.c.~~ Certified Lactation Consultants provide more specialized lactation support. Most International Board Certified Lactation Consultants (IBCLCs) have an underlying health professional licensure (RN, RD, MD, DO, CNM, LM, NP, PA) as well.
 - ~~e.d.~~ Lactation Educators, lactation counselors, and other lactation support staff without additional health professional licensure may provide basic lactation support services under the supervision of a Partnership contracted licensed medical professional (Physician, NP, PA, CNM, LM) or Partnership credentialed IBCLC.
 - ~~d.e.~~ Doulas may provide prenatal, peripartum and postpartum education and support

Policy/Procedure Number: MPXG5009		Lead Department: Health Services Business Unit: Quality Improvement	
Policy/Procedure Title: Lactation Clinical Practice Guideline		☒ External Policy ☐ Internal Policy	
Original Date: 01/15/2014		Next Review Date: 08/14/202508/13/2026 Last Review Date: 08/14/202408/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ ☐ Partnership Advantage

4. Breast Pumps: When breastfeeding is interrupted or discontinued, the use of ~~b~~Breast ~~p~~Pumps and alternative feeding fluids may be necessary. If the 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.
5. Supplementation: When supplementation is necessary, consider AAP guidelines for breast milk supplementation.
6. Banked Human Milk: Banked human milk is currently not widely available but may be helpful for specific conditions in the hospital setting. According to WIC, in their landmark publication Ramping up for Reform, “Banked human milk is provided by Medi-Cal and health insurance plans in order to provide infants, especially high-risk infants, the healthiest start in life and reduce costly health complications.”
7. Active Management of Potentially Adverse Breastfeeding Situations
 - a. Active Management and Support of Breastfeeding should follow the guidelines set forth by the authorities listed in the reference section below.
 - 1) These guidelines change often as new research emerges, so providers are expected to stay informed of updated best practice guidelines.
- C. Contraindications
 1. AAP Guidelines should be utilized to identify additional conditions that are contraindicated
 - a. Medications that may require temporary interruption of breastfeeding may be found utilizing AAP Guidelines; or for additional information call the Infant Risk Center at 806-352-2519.
- D. Education Materials for Partnership Members
Educational materials may be helpful for parents. They are readily available through your local WIC office.
- E. Useful Resources
 1. Sources of simplified definitions:
ACA <http://www.investopedia.com/terms/a/affordable-care-act.asp> (updated ~~Sept. 23, 2022~~Jan. 27, 2025)
 2. CPSP <http://cchealth.org/services/perinatal/>
<https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx>
 3. FQHC <https://www.cms.gov/mlnproducts/downloads/fqhcfactsheet.pdf> (updated October 2022)
 4. Bilitool www.bilitool.org
 5. ~~Hale’s Medications & Mothers’ Milk 2023~~Hale’s Medications & Mothers’ Milk 2025-2026, A Manual of Lactational Pharmacology, ~~20th-21st~~ Ed., Springer Publishing
 6. Breastfeeding ANSWERS- Made Simple – A Guide for Helping Mothers, Mohrbacher, N., 2020, Second Edition Hale Publishing, L.P. (PDF digital edition available)
 7. ~~Red Book: 2021-2024 Report of the Committee on Infectious Disease~~ Red Book: 2024-2027 Report of the Committee on Infectious Disease, ~~32nd-33rd~~ Edition, American Academy of Pediatrics, ~~January 2024~~April 2024

VII. REFERENCES:

- ~~B.~~—American Academy of Pediatrics, Clinical Practice Guideline. <https://pediatrics.aappublications.org/content/pediatrics/129/3/3827.full.pdf>
- ~~A.~~
- ~~C.B.~~—Affordable Care Act, Section 4106a, Women’s Health Preventive Services, Infant Risk Center: Call 806-352-2519
- ~~D.~~—[California Department of Public Health: Women, Infants & Children \(WIC\) 2023 Toolkit](#)

Policy/Procedure Number: MPXG5009		Lead Department: Health Services Business Unit: Quality Improvement	
Policy/Procedure Title: Lactation Clinical Practice Guideline		☒ External Policy ☐ Internal Policy	
Original Date: 01/15/2014		Next Review Date: 08/14/202508/13/2026 Last Review Date: 08/14/202408/13/2025	
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E.C.
F.D. Department of Health and Human Services/Center for Medicaid and CHIP Services
 Medicaid Coverage of Lactation Services. CMS Bulletin
G.E. [U.S. Preventive Services Task Force \(USPSTF\) Final Recommendation Statement. Breastfeeding: Primary Care Behavioral Counseling Interventions \(April 11, 2025\)](#)
H. [U.S. Preventive Services Task Force \(USPSTF\), Recommendation: Breastfeeding: Interventions \(July 7, 2022\)](#)
<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breastfeeding-primary-care-interventions>

VIII. DISTRIBUTION:

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

IX. PERSON RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal
 02/17/16; 04/19/17; *03/14/18; 05/08/19; 06/10/20; 08/11/21; 08/10/22; 08/09/23; 08/14/24; 08/13/25
Partnership Advantage (effective Jan. 1, 2027)
N/A

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

PREVIOUSLY APPLIED TO:

HealthyKids MPXG5009 (Healthy Kids program ended 12/01/2016)
 02/17/16 to 12/01/2016

Partnership Advantage
 MPXG5009 – 01/15/2014 to 01/01/2015

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
GUIDELINE / PROCEDURE

Guideline/Procedure Number: MCUG3134			Lead Department: Health Services Business Unit: Utilization Management	
Guideline/Procedure Title: Hospital Bed/ Specialty Mattress Guidelines			☒ External Policy ☐ Internal Policy	
Original Date: 01/20/2016		Next Review Date: ~~06/12/2025~~ 08/13/2026 Last Review Date: ~~06/12/2024~~ 08/13/2025		
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD		☐ COMPLIANCE	☐ FINANCE
	☐ CEO	☐ COO	☐ CREDENTIAL ~~SING~~	☐ DEPT. DIRECTOR/OFFICER
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~06/12/2024~~ 08/13/2025	

I. RELATED POLICIES:

- A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
- B. MCUP3013 – Durable Medical Equipment (DME) Authorization
- C. MCUP3133 – Wheelchair Mobility, Seating and Positional Components
- D. ~~MC~~UP3039 – Direct Members

II. IMPACTED DEPTS:

- A. Health Services
- B. Claims
- C. Member Services

III. DEFINITIONS:

- A. The stages of decubitus ulcer severity are follows:
 - 1. Stage I - a reddened area, skin unbroken
 - 2. Stage II - a superficial blister or open area involving the epidermis
 - 3. Stage III - a deeper lesion that invades the dermis and subcutaneous tissue
 - 4. Stage IV - an extension lesion that may involve muscle and bone

- B. Prevention of decubitus ulcers includes the following:

- 1. Elimination of moisture
- 2. Proper patient positioning with hourly changes
- 3. Relief of spasticity
- 4. Reduction of shear force
- 5. Weight dispersion

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

IV. ATTACHMENTS:

- A. N/A

V. PURPOSE:

Guideline/Procedure Number: : MCUG3134		Lead Department: Health Services Business Unit: Utilization Management	
Guideline/Procedure Title: Hospital Bed/ Specialty Mattress Guidelines		☒ External Policy ☐ Internal Policy	
Original Date: 01/20/2016		Next Review Date: 06/12/202508/13/2026 Last Review Date: 06/12/202408/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☐ <u>Partnership Advantage</u>

The following guidelines are used by the Utilization Management (UM) staff when reviewing a Treatment Authorization Request (TAR) for a hospital bed or a specialty (antidecubitus) bed or mattress.

VI. GUIDELINE / PROCEDURE:

A. HOSPITAL BEDS

1. A hospital bed must be ordered by the Primary Care Provider (PCP) or specialist who is treating the ~~member~~Member through a referral from the PCP. For Direct Members, the hospital bed must be ordered by the provider who is currently managing the medical care for the ~~member~~Member.
2. Bariatric beds for a ~~member~~Member weighing greater than 350 pounds will be considered for authorization on a case by case basis. These requests will require:
 - a. Documentation from a specialist provider delineating the ~~member~~Member's medical need for this equipment.
 - b. Evaluation of the ~~member~~Member's home, documenting the compliance of the structure to safely install the bed in this home.
 - c. Documentation of ~~member~~Member/caretaker's ability to use the equipment safely.
 - d. A recent weight measurement of the patient within the last 12 months.
3. A hospital bed can be ordered for a ~~member~~Member with a medical condition that requires positioning of the body not feasible in a non-hospital bed; promotion of body alignment to prevent contractures in a patient with history of contractures or a documented medical condition that causes risk of contractures; recipient needs elevation of the head of the bed more than 30 degrees due to conditions such as congestive heart failure, chronic obstructive lung disease or history of aspiration; or recipient need use of special attachments or traction equipment. Hospital beds are not covered if elevation of the head/upper body is less than 30 degrees. Pillows and wedges must be ruled out as an option.
4. The TAR must include documentation of medical necessity for the use of the hospital bed that includes the following information related to the condition:
 - a. Description of the severity and frequency of the symptoms
 - b. Description of need for any attachments for the bed
 - c. Evaluation of the ~~member~~Member's functional abilities
 - d. Length of time ~~member~~Member will need the equipment
 - e. Care giver status
5. The TAR must include information regarding the ~~member~~Member or caretaker's ability to properly use the hospital bed.
6. For semi-electrical beds, the TAR must include documentation that the electric feature is medically necessary for one of the following reasons:
 - a. Condition requires the electric feature to allow the patient independent transfer to chair or standing position by enabling the patient to sit up unassisted.
 - b. Condition requires frequent change in body position and/or an immediate need for a change in position and the patient can operate the controls to cause the required position changes.
 - c. Requests for full electric hospital beds will be reviewed on a case by case basis
7. Durable Medical Equipment (DME) items are covered as medically necessary only to preserve the bodily functions essential to activities of daily living or to prevent significant physical disability but not necessarily to restore the ~~member~~Member to previous function.
8. The UM staff will compare the cost of purchase versus rental of the equipment and authorize the most cost effective.

B. SPECIALTY BEDS/ MATTRESSES

1. A specialty bed or mattress must be ordered by the PCP or specialist who is treating the ~~member~~Member through a referral from the PCP. For Direct Members, the specialty bed or mattress must be ordered by the provider who is currently managing the medical care for the

Guideline/Procedure Number: : MCUG3134		Lead Department: Health Services Business Unit: Utilization Management	
Guideline/Procedure Title: Hospital Bed/ Specialty Mattress Guidelines		☒ External Policy ☐ Internal Policy	
Original Date: 01/20/2016		Next Review Date: 06/12/202508/13/2026 Last Review Date: 06/12/202408/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☐ <u>Partnership Advantage</u>

~~member~~Member.

2. Documentation required for the initial TAR includes the following:
 - a. Diagnosis
 - b. Prescription signed by a prescribing clinician
 - c. Documentation of bed-bound status and wound history
 - d. Whether wound(s) are currently present or not
 - e. If wounds are present at time of TAR submission, the following clinical documentation must also be submitted with the TAR:
 - 1) Number of wounds
 - 2) The stage and size of each wound
 - 3) Description of each wound
 - 4) Location of each wound
 - 5) Relevant wound history, including any prior pressure sore(s)
 - 6) Relevant history of patient's use of pressure sore equipment
3. TARs will be reviewed in 3 month increments. Documentation requirements for reauthorization of a TAR include the following:
 - a. Updated treatment & care plans, as indicated
 - b. Re-evaluation of healing status of the pressure sore(s), including update of size, number and location of wounds
4. A specialty bed or mattress may be ordered for a ~~member~~Member with a history of pressure decubitus ulcers unresponsive to conservative therapy.
 - a. Requests for specialty beds (e.g., Clinitron, Mediscus, Hydrofloat, Hydrothermic, KinAir, Flexicair, etc.) are generally authorized only for a ~~member~~Member with the following conditions:
 - 1) Severe decubitus ulcers (Stage III or IV)
 - 2) History of recurrent Stage II or higher decubitus ulcers on the trunk or pelvis that are unresponsive to conservative therapy
5. There are three levels of bed support surfaces which may be authorized as appropriate:
 - a. Group 1 includes gel overlays, foam mattresses and alternating pressure pads with pump which are appropriate for:
 - 1) Current Stage I or II pressure sore(s) on trunk of body
 - 2) History of stage III or IV pressure sore(s) on trunk of body, OR
 - 3) Member is bed bound & requires support surface for pressure sore prevention
 - b. Group II includes Alternating Pressure Pump and Pad System (APP) mattresses and low air loss mattresses which are appropriate for current Stage III or IV pressure sore(s) on trunk of the body
 - c. Group III includes complete bed systems also known as air-fluidized beds and requests will be reviewed on a case by case basis.
6. Requests for decubitus wheelchair pads and cushions may be authorized for ~~member~~Members with the following conditions;
 - a. Stage I or II ulcer
 - b. Bed or wheelchair bound ~~member~~Member to prevent development of ulcers (see policy MCUP3133 Wheelchair Mobility, Seating and Positional Components for wheelchair specifics).
7. The TAR must include information regarding the ~~member~~Member or caretaker's ability to properly use the specialty bed and the type of care currently being provided for the ulcer.
8. Durable Medical Equipment (DME) items are covered as medically necessary only to preserve the bodily functions essential to activities of daily living or to prevent significant physical disability but not necessarily to restore the ~~member~~Member to previous function.
9. The UM staff evaluates all options for care of the decubitus ulcer and authorize the most appropriate modality that will assist in healing of the ulcer. Specialty beds/mattresses are initially approved for

Guideline/Procedure Number: : MCUG3134		Lead Department: Health Services	
		Business Unit: Utilization Management	
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Original Date: 01/20/2016		Next Review Date: 06/12/2025 Last Review Date: 08/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

3 months with reauthorization dependent upon documentation of significant improvement in the decubitus ulcers and prognosis of further healing that requires the continued use of the specialty bed. Re-evaluation for the continued need of a specialty mattress will occur in 3 month authorization periods until the item capitates to purchase at the end of 12 months. Once a decubitus ulcer is healed, a Group 3 Low Air Loss Mattress should be downsized to a lesser product (i.e. gel overlay) for prevention of skin breakdown.

10. Decubitus Pads, Cushions and Mattress

- a. Pads, cushions, mattresses, alternating pressure pads, etc., require at least 3 to 4 inches thickness to be effective in the treatment of pressure sores.
- b. Gel foam mattresses and other special mattresses are useful in the care of a decubitus and may be authorized as appropriate. Other options include alternating pressure mattresses and dry flotation mattresses.

11. Specialty Beds

- a. An anti-decubitus ulcer bed is generally authorized for use in long-term care facilities, or for home use, where it can be documented that appropriate nursing care and the use of more conservative treatments have failed, or would fail, to prevent or treat the patient's pressure sores.
- b. The use of the bed permits care for a chronically ill patient at a lower level of care than acute hospital level and may prevent or reduce recurrent hospitalization for treatment of decubiti.

VII. REFERENCES:

- A. Medi-Cal Provider Manual/ Guidelines: Durable Medical Equipment (DME): Therapeutic Anti-Decubitus Mattresses and Bed Products ([dura thp](#))
A-B.

VIII. DISTRIBUTION:

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

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

REVISION DATES:

02/17/16; 02/15/17; 11/15/17; *02/13/19; 02/12/20; 02/10/21; 05/11/22; 06/14/23; 06/12/24; 08/13/25

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

PREVIOUSLY APPLIED TO:

MCUG3021 (previously UG100321) Hospital Bed Guidelines

Original date: 05/30/1995

Revision Dates: 04/28/00; 11/28/01; 10/16/02; 04/16/03; 10/20/04; 10/19/05; 08/20/08; 01/19/11; 02/20/13; 02/18/15 ARCHIVED 01/20/2016

MCUG3040 (previously UG100340) Specialty Bed/Mattress Guidelines

Original date: 05/30/1995

Revision Dates: 04/28/00; 10/17/01; 10/16/02, 04/16/03; 10/20/04; 10/19/05; 08/20/08; 11/18/09; 05/18/11; 02/20/13; 03/18/15 ARCHIVED 01/20/2016

Guideline/Procedure Number: : MCUG3134		Lead Department: Health Services	
		Business Unit: Utilization Management	
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Original Date: 01/20/2016		Next Review Date: 06/12/202508/13/2026 Last Review Date: 06/12/202408/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☐ <u>Partnership Advantage</u>

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 **PHCPartnership** 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 **PHCPartnership**.

PHCPartnership'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: MCUP3044 (previously UP100344)			Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Urgent Care Services			☒ External Policy ☐ Internal Policy	
Original Date: 04/03/1995		Next Review Date: ~~05/10/2024~~ 08/13/2026 Last Review Date: ~~05/10/2023~~ 08/13/2025		
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD		☐ COMPLIANCE	☐ FINANCE
	☐ CEO	☐ COO	☐ CREDENTIAL ~~SING~~	☒ PAC
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~05/10/2023~~ 08/13/2025	

I. RELATED POLICIES:

- A. ~~MP~~UP3014 - Emergency Services
- B. MCUP3039 - Direct Members

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

Direct Member: Direct Members are those whose service needs are such that inclusion in the Partnership HealthPlan of California (~~PHC~~Partnership) capitation system would be inappropriate. Assignment to Direct Member status may be based on the ~~member~~Member's medical condition, prime insurance, demographics or administrative eligibility status. Direct Members do not require a Referral Authorization Form (RAF) to see a specialist.

IV. ATTACHMENTS:

- A. N/A

V. PURPOSE:

To describe urgent care facility standards for ~~the~~ Partnership HealthPlan of California (~~PHC~~Partnership) contractors.

VI. POLICY / PROCEDURE:

- A. The following standards must be met for ~~PHC~~Partnership to contract with a facility to provide urgent care services. These standards are based on criteria developed by the Accreditation Association for Ambulatory Health Care for urgent care services.
 - 1. The range of services offered by the urgent care facility and its hours of operation must be clearly defined and communicated to the public and relevant organizations.
 - 2. Such facilities, unless they also provide emergency services, must not solicit patients with life-threatening conditions.
 - 3. The urgent care facility must be prepared to evaluate and transfer patients with medical emergencies

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Original Date: 04/03/1995		Next Review Date: 05/10/202408/13/2026 Last Review Date: 05/10/202308/13/2025	
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- that may present as such, or which may arise in conjunction with services provided by the facility.
4. Patients seeking immediate/urgent services may be seen without prior appointments or the provider may require patients to be seen by appointment.
 5. Immediate/urgent care services must be performed only by health care practitioners who are licensed to perform such procedures and who have been granted privileges to perform those procedures by the credentialing body of the urgent care facility, after medical review of the practitioner's documented education, training, experience, and current competence.
 6. During hours of operation, a qualified physician must be available for consultation.
 7. Health care practitioners who maintain skills in basic life support (BLS) must be present in the facility at all times.
 8. Arrangements must be made to assure that adequate specialty consultation services are available.
 9. Equipment, drugs, and other agents necessary to provide immediate/urgent care services must be available.
 10. Laboratory and radiology services should be available on site. If this is not feasible, the urgent care facility must arrange for safe transport of the patient to another site for laboratory or radiology services. A written policy must be in place regarding transport procedures, which includes a statement that financial responsibility for transport services rests with the urgent care facility.
 11. Ability to communicate with local police departments, fire departments, community social service agencies, ambulance services, and hospitals is needed to ensure high-quality patient care.
- B. Claims issues:
1. Direct Members
 - a. Initial urgent care visits for Direct Members may be billed at the urgent care rate.
 - b. Follow-up visits after an urgent care contact or treatment of non-urgent conditions must be billed as an office visit.
 2. Members Assigned to a Primary Care Provider (PCP)
 - a. Members who are assigned to a PCP other than the urgent care provider may be seen for urgent care visits after hours, on weekends, and on holidays. ~~PHCPartnership~~ reimburses for these visits at the urgent care rates. Claims should be submitted to ~~PHCPartnership~~ for these services. Follow-up of urgent problems and treatment of non-urgent conditions must be referred to the assigned PCP. The urgent care provider must forward (preferably FAX) a copy of the urgent care record to the PCP.
 - b. Members assigned to another PCP who contact the urgent care facility during business hours must be referred to the assigned PCP during business hours.
 - c. The urgent care facility cannot bill the urgent care rate for ~~member~~Members capitated to their practice, as extended service hours are part of the PCP's scope of practice.
 3. ~~PHCPartnership~~ reserves the right to audit records related to urgent care claims.

VII. REFERENCES:

Accreditation Association for Ambulatory Health Care, Inc. criteria

VIII. DISTRIBUTION:

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

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

X. REVISION DATES:

Medi-Cal

03/18/96; 10/10/97 (name change only); 05/04/00; 10/17/01, 05/21/03, 10/20/04; 10/19/05, 10/18/06;

Policy/Procedure Number: MCUP3044 (previously UP100344)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Urgent Care Services		☒ External Policy ☐ Internal Policy	
Original Date: 04/03/1995		Next Review Date: 05/10/202408/13/2026 Last Review Date: 05/10/202308/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☐ <u>Partnership Advantage</u>

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

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

PREVIOUSLY APPLIED TO: N/A

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

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

The materials provided are guidelines used by **PHCPartnership** 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 **PHCPartnership**.

PHCPartnership'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

GUIDELINE / PROCEDURE

Guideline/Procedure Title: ~~MCUG3010~~ (previously <u>MCUG3010</u> , UG100310)			Lead Department: Health Services Business Unit: <u>Utilization Management</u>	
Guideline/Procedure Title: Chiropractic Services			☒ External Policy ☐ Internal Policy	
Original Date: 02/21/1995		Next Review Date: <u>09/11/2025</u> Last Review Date: <u>08/13/2026</u>		
Applies to:	☐ Employees	☒ Medi-Cal	☒ <u>Partnership Advantage</u>	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD	☐ COMPLIANCE	☐ FINANCE	☒ PAC
	☐ CEO	☐ ~~COO~~	☐ CREDENTIALING	☐ DEPT. DIRECTOR/OFFICER
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: <u>09/11/2024</u> <u>08/13/2025</u>	

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.)

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

IV. ATTACHMENTS:

- A. N/A

V. PURPOSE:

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.

Guideline/Procedure Number: ~~MP~~ UG3010 (previously ~~MC~~ UG3010, 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: ~~09/10/2025~~ 08/13/2026 Last Review Date: ~~09/11/2024~~ 08/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

1. ~~For Partnership Medi-Cal Members: as described in~~ Refer to the Medi-Cal Provider Manual/ Guidelines section on Chiropractic Services ([chiro](#)).

~~1.2.~~ **For Partnership Advantage 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.
 - a-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)
- ~~F.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

X. REVISION DATES:

Guideline/Procedure Number: ~~MP~~ UG3010 (previously <u>MCUG3010</u> , 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: ~~09/10/2025~~ 08/13/2026 Last Review Date: ~~09/11/2024~~ 08/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ <u>Partnership Advantage</u>

Medi-Cal

-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

Partnership Advantage (effective January 1, 2027)

N/A

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

PREVIOUSLY APPLIED TO: N/A

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPUP3014 (previously MCUP3014; UP100314)			Lead Department: Health Services	
			Business Unit: Utilization Management	
Policy/Procedure Title: Emergency Services			☒ External Policy ☐ Internal Policy	
Original Date: 06/20/2001		Next Review Date: ~~05/14/2026~~ 08/13/2026 Last Review Date: ~~05/14/2025~~ 08/13/2025		
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD	☐ COMPLIANCE	☐ FINANCE	☒ PAC
	☐ CEO	☐ COO	☐ CREDENTIALING	☐ DEPT. DIRECTOR/OFFICER
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~05/14/2025~~ 08/13/2025	

I. RELATED POLICIES:

- A. MCUP3124 – Referral to Specialists (RAF) Policy
- B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
- C. MCCP2018 – Advice Nurse Program

II. IMPACTED DEPTS:

- A. Health Services
- B. Claims
- C. Member Services

III. DEFINITIONS:

- A. Emergency Medical Condition is defined as a condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could result in:
 - 1. Placing the health of the member (or, in the case of a pregnant person, the health of the member and/or the unborn child) in serious jeopardy
 - 2. Serious impairment of bodily functions;
 - 3. Serious dysfunction of any bodily organ or part; or
 - 4. Death
- B. Partnership Advantage: Effective January 1, 2027~~6~~, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.
- C. Physician: Medical Doctor (MD) or Doctor of Osteopathy (DO)
- D. Provider: For the purposes of this policy, the provider is a physician, nurse practitioner or physician assistant.
- E. Triage evaluation is defined as a screening examination performed on a member where emergency or urgent services are not required in order to determine the appropriate location and time for the definitive evaluation of that member's problem.
- F. Urgent conditions are defined as a sudden onset of a medical condition or the worsening of an existing medical condition such that the patient is in mild distress, but without severe pain, significant loss of

Policy/Procedure Number: MPUP3014 (previously MCUP3014; UP100314)		Lead Department: Health Services Business Unit: Utilization Management	
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Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

function or threatened by loss of life and where urgent therapeutic intervention within 48 hours is needed to minimize the possibility of patient morbidity.

IV. ATTACHMENTS:

ADDENDA (See pages 6 -8)

- A. Non-Urgent Medical Conditions
- B. Urgent Medical Conditions
- C. Emergency Medical Conditions

V. PURPOSE:

To define the circumstances under which emergency services are covered.

VI. POLICY / PROCEDURE:

- A. Payment for Services and Prior Authorization
 - 1. Partnership HealthPlan of California may review claims submitted by facilities and practitioners to determine the appropriate payment level. Partnership reserves the right to monitor claims submitted to determine that the billing accurately reflects the level of services provided.
 - 2. Partnership covers emergency services without prior authorization for evaluation and treatment of an emergency medical condition.
- B. Referral of Triage Members and Follow-up
 - 1. Under Federal and State laws, a screening examination (triage services) is required to be performed on every patient presenting to the emergency department (24 hours a day). This will be reimbursed by Partnership. If a plan member is determined to not require emergency or urgent services, the facility will communicate with the Primary Care Provider (PCP) to determine the need for further medical attention.
 - 2. Partnership members may generally be referred by the treating Emergency Department (ED) provider for care to their PCP's office or an urgent care facility under the following circumstances:
 - a. The member is willing to be seen in the PCP's office or urgent care facility.
 - b. The member has transportation to the alternative site.
 - c. The Emergency Department staff arranges an appointment for the member at a time suitable and medically appropriate for the member.
 - d. The PCP or urgent care facility agrees to see the member at the appointed time.
 - 3. The emergency department or urgent care facility is expected to notify the PCP if follow-up care is required. The emergency department should send a copy of the ED record to the PCP or responsible provider within 48 hours of the ED visit. The emergency department provider should notify the PCP or the responsible provider at the time of the ED visit if urgent follow-up care by the PCP or responsible physician is required. Follow-up care by a specialist after an ED visit must have a Referral Authorization Form (RAF) from the PCP to be considered for payment (exception to this is for initial orthopedic or neurosurgery consult after ED referral and for certain capitated specialist services).
 - 4. Emergency department staff will determine if the patient also must be evaluated by an emergency department physician prior to referral to the PCP for treatment. For more information on post stabilization services, please refer to policy MCUP3041 Treatment Authorization Request (TAR) Review Process.
 - 5. Partnership has a dedicated after-hours local phone number (707) 430-4808 or toll free number (855) 798-8759 to receive calls from physicians and hospital staff for addressing post-stabilization care and inter-facility transfer needs 24 hours per day, 7 days per week. Calls are returned within 30 minutes of the time the call was received. Partnership's Chief Medical Director or physician designee is on call 24 hours per day 7 days per week to authorize medically necessary post-stabilization care services and to respond to hospital inquiries within 30 minutes. Partnership clinical

Policy/Procedure Number: MPUP3014 (previously MCUP3014; UP100314)		Lead Department: Health Services Business Unit: Utilization Management	
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Original Date: 06/20/2001		Next Review Date: 05/14/202608/13/2026 Last Review Date: 05/14/202508/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

staff are available 24 hours per day 7 days per week to coordinate the transfer of a member whose emergency medical condition is stabilized.

- C. Section 1882(c)(3) of the federal Social Security Act (as enacted by Section 4081(b)(2)(C) of the federal Omnibus Budget Reconciliation Act of 1987 (OBRA):
1. Pursuant to APL 21-015, OBRA services shall be billed and reimbursed through Medi-Cal FFS.
 - a. Every person who presents to an emergency department must receive a medical screening evaluation by a physician or provider under the supervision of a physician without prior authorization.
 - b. Medical screening must be performed prior to asking about the individual's ability to pay or before verifying Medicaid (Medi-Cal) eligibility.
 - c. Each person who presents to the ED must be stabilized by medical treatment, as needed.
 - d. The ED provider has the obligation to treat a patient in the emergency department if, in the provider's judgment, adequate care will not be obtained at another facility.
 - e. Transfers between emergency departments are appropriate only if the emergency physician at the second hospital accepts the transfer.
- D. Advice Nurse Program
1. Partnership maintains 24-hour emergency telephone availability with physician backup for Members through the Partnership Advice Nurse Line at (866) 778-8873. (See policy M CCP2018 Advice Nurse Program). If the Partnership Advice Nurse directs a member to the ED, Partnership will pay for the visit. The advice nurse faxes a copy of the Triage Call Documentation Report to the ED. This report is to be attached to the claim when it is submitted for payment.
- E. Coverage for Services Rendered Outside of the State of California, but within the ~~United States~~ S:
1. Medically necessary medical care outside of the State of California, within the limits of benefits as outlined in Title 22, is covered only when one of the following conditions is met:
 - a. An emergency arises from accident, injury or illness; or
 - b. The health of the individual would be endangered if care and services are postponed until it is feasible that the member return to California; or
 - c. The health of the individual would be endangered if travel were undertaken to return to California; or
 - d. It is customary practice in border communities for residents to use medical resources in adjacent areas outside California; or
 - e. The out-of-state treatment plan has been proposed by the member's attending provider, and the plan has been received, reviewed and authorized by Partnership before the services are provided AND the proposed treatment is not available from resources and facilities within the State of California.
 - f. Prior authorization is required for ALL out-of-state services, except:
 - 1) Emergency services as defined in Section 51056 – California Code of Regulations
 - 2) Services provided in border areas adjacent to California where it is customary practice for California residents to avail themselves of such services. Under these circumstances, program controls and limitations are the same as for services from providers within the state.
- F. Coverage for Services Rendered Outside of the United States:
1. For members enrolled in Partnership Advantage or with Medicare Part A coverage, no prior authorization is required for emergency services that require hospitalization in Canada or Mexico which meet the following qualified circumstances:
 - a. An emergency occurs, and a Canadian or Mexican hospital is closer to, or more accessible from, the site of the emergency than the nearest adequately equipped United States hospital that can provide emergency services, or
 - b. The emergency occurred in Canada while the beneficiary is traveling between Alaska and another State without unreasonable delay and by the most direct route, and a Canadian

Policy/Procedure Number: MPUP3014 (previously MCUP3014; UP100314)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Emergency Services		☒ External Policy ☐ Internal Policy	
Original Date: 06/20/2001		Next Review Date: 05/14/202608/13/2026 Last Review Date: 05/14/202508/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

hospital is closer to, or more accessible from, the site of the emergency than the nearest United States hospital. For this purpose, an emergency occurring within the Canadian inland waterway between the States of Washington and Alaska is considered to have occurred in Canada.

2.—For members with full scope Medi-Cal or Emergency-Only services.

3.2. nNo services are covered outside the United States, except for emergency services requiring hospitalization in Canada or Mexico.

F.G. Emergency Department Contracts

1. Certain in-plan Emergency Departments have voluntarily entered into contractual relationships with Partnership. Addenda A, B and C are samples of non-urgent, urgent & emergency medical conditions applicable to these contracted Emergency Departments.

G.H. Decisions Made on Medical Appropriateness

1. On an annual basis, Partnership distributes a statement to all its practitioners, providers, members and employees alerting them to the need for special concern about the risks of under-utilization. It requires employees who make utilization-related decisions and those who supervise them to sign a statement, which affirms that Utilization Management (UM) decision making is based only on the appropriateness of care and service. Furthermore, Partnership does not reward practitioners, or other individuals conducting utilization reviews, for issuing denials of coverage for services. Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization, and Partnership does not use incentives to encourage barriers to care and service. This does not preclude the use of appropriate incentives for fostering efficient, appropriate care.

H.I. Prescribed Medications Under Emergency Circumstances

1. When the course of treatment provided to a member under emergency circumstances requires the use of medication, a sufficient quantity shall be provided to the member to last until the member can reasonably be expected to have a prescription filled.

VII. REFERENCES:

- A. Omnibus Reconciliation Act (OBRA) regulations: Section 1882(c)(3) of the federal Social Security Act (SSA) as enacted by Section 4081(b)(2)(C) of OBRA, Public Law 100-203
- B. Title 22 California Code of Regulations (CCR)
- C. Title 22 CCR Sections [51056](#), [53855](#)
- D. Department of Health Care Services (DHCS) Contract Exhibit A, Attachment 1, Definitions and Exhibit A, Attachment III Section 3.3.16 Emergency Services and Post-Stabilization Care Services
- E. DHCS All Plan Letter ([APL](#)) [21-015](#) Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (CalAIM) (10/18/2021) [Attachment 1: Mandatory Managed Care Enrollment \(MMCE\) Requirements](#) (Revised 10/14/2022)
- F. Medicare Managed Care Manual 100-16: Chapter 4 Benefits and Beneficiary Protections, Section 20 Ambulance, Emergency, Urgently Needed and Post-Stabilization Services. Implementation date 01/01/2015 or any subsequent updates published by CMS.
- F.G. Medicare Claims Processing Manual Chapter 1 (Rev. 12909, Issued: 10-24-24), Section 10.2.1 FI Payment for Emergency and Foreign Hospital Services (Rev. 1, 10-01-03)

VIII. DISTRIBUTION:

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

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

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 20276)

Policy/Procedure Number: MPUP3014 (previously MCUP3014; UP100314)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Emergency Services		☒ External Policy ☐ Internal Policy	
Original Date: 06/20/2001		Next Review Date: 05/14/2026 Last Review Date: 05/14/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

N/A 05/14/25; 08/13/25

Medi-Cal

05/09/95; 10/10/97 (name change only); 06/21/00; 10/18/00; 08/15/01; 09/18/02; 10/20/04; 02/16/05, 10/18/06; 10/17/07, 08/20/08; 11/18/09; 05/18/11; 05/15/13; 01/20/16; 08/17/16; 08/16/17; *09/12/18; 09/11/19; 08/12/20; 08/11/21; 05/11/22; 04/12/23; 05/08/24; 05/14/25; 08/13/25

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

PREVIOUSLY APPLIED TO: N/A

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- 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

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Policy/Procedure Number: MPUP3014 (previously MCUP3014; UP100314)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Emergency Services		☒ External Policy ☐ Internal Policy	
Original Date: 06/20/2001		Next Review Date: 05/14/2026 Last Review Date: 05/14/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

ADDENDUM A

NON-URGENT MEDICAL CONDITIONS

Treatment for the following conditions requires non-urgent services with regard to payment to contracted facilities, unless extenuating circumstances necessitate urgent or emergency services and these needs are documented in the medical record. In these circumstances, Partnership reserves the right to review the record. (Note that this list is not exhaustive or definitive.)

- * Rash - minimally symptomatic
- * External parasites
- * First degree burns (small)
- * Insect bites (no systemic symptoms)
- * Minor puncture wounds (no evidence of infection or foreign object)
- * Uncomplicated diarrhea (no blood in stool, no vomiting or symptoms of dehydration)
- * Non-active but prior history of nausea/vomiting/diarrhea
- * Hemorrhoids – minimally symptomatic
- * Uncomplicated constipation
- * URI symptoms with no shortness of breath
- * Simple UTI – minimally symptomatic
- * Urethral or vaginal discharge without bleeding
- * Routine tetanus immunization
- * Suture removal
- * Routine dressing changes
- * Missed physician appointments
- * Prescription refills
- * Follow-up visits
- * Pre-employment physical examinations
- * Exposures to communicable diseases (e.g. hepatitis, TB, STD, except accidental exposure to blood)
- * Any other condition which appears uncomplicated and stable per judgment of ED staff.

Policy/Procedure Number: MPUP3014 (previously MCUP3014; UP100314)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Emergency Services		☒ External Policy ☐ Internal Policy	
Original Date: 06/20/2001		Next Review Date: 05/14/202608/13/2026 Last Review Date: 05/14/202508/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

ADDENDUM B

URGENT MEDICAL CONDITIONS

Treatment for the following conditions requires urgent services with regard to payment to contracted facilities, unless extenuating circumstances necessitate emergency services and these needs are documented in the medical record. In these circumstances, Partnership reserves the right to review the record. (Note that this list is not exhaustive or definitive.)

- * Chickenpox
- * Localized cellulitis
- * Abscess requiring I & D
- * Insect bites with systemic symptoms
- * Small second degree burns
- * Otitis media/Ear ache
- * Otitis externa
- * URI, complicated by abnormal vital signs
- * Bronchitis
- * Conjunctivitis
- * Pharyngitis
- * Sinusitis
- * Back pain not requiring parenteral analgesics
- * Stable Angina – not requiring diagnostic evaluation or parenteral therapy
- * Asthma without SOB and/not requiring nebulizer treatment and 80% or greater of predicted peak flow measurement
- * UTI-symptomatic
- * Vaginitis
- * Urethritis
- * Menstrual cramps
- * Dysfunctional Uterine Bleeding (DUB) without hemorrhage
- * Acute gastroenteritis
- * Hemorrhoids with bleeding
- * Mild abdominal pain
- * Minor contusion
- * Minor laceration - no suturing
- * Mild sprain/strain
- * Headache not requiring diagnostic evaluation or parenteral analgesic
- * Accidental Exposure to Blood with HIV risk
- * Chronic arthritis
- * Minor joint pain
- * Localized tooth pain (mild)

Policy/Procedure Number: MPUP3014 (previously MCUP3014; UP100314)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Emergency Services		☒ External Policy ☐ Internal Policy	
Original Date: 06/20/2001		Next Review Date: 05/14/202608/13/2026 Last Review Date: 05/14/202508/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

EMERGENCY MEDICAL CONDITIONS

ADDENDUM C

Treatment for the following conditions requires emergency services with regard to contracted facilities. This list is not intended to be all inclusive or definitive, and the ED physician may determine that emergency services were indicated for conditions other than those listed below. In these cases, Partnership reserves the right to review the record.

- *Chest pain - R/O cardiac problem
- *Angina - unstable
- *Myocardial Infarction
- *Congestive heart failure
- *Stroke
- *Significant abdominal pain with diagnostic work-up
- *Pyelonephritis
- *Acute GI bleed
- *Asthma requiring nebulizer treatment or peak flow less than 80% of expected measurement.
- *Pneumonia
- *Acute back pain requiring parenteral analgesics
- *Fractures or joint injury requiring splinting or reduction
- *Lacerations requiring suturing
- *Traumatic amputation
- *Pyrexia - R/O sepsis in children with diagnostic work-up
- *Hypovolemia/dehydration with IV treatment
- *Acute psychiatric conditions
- *Intoxication
- *Delirium
- *Hemorrhage in early pregnancy
- *PID
- *Genital tract hemorrhage
- *Rape/sexual assault
- *Labor/pre-term labor (to L & D)
- *Acute allergic reaction with therapeutic injection of medication
- *Acute seizure
- *Severe headache requiring therapeutic injection for pain or diagnostic evaluation (CT)
- *Uncontrolled epistaxis
- *Meningitis
- *Sepsis
- *Significant acute change in vision
- *Foreign body in eye
- *Corneal abrasion
- *Large first or second degree burn
- *Third degree burns
- *MVA
- *Gunshot/stabbing
- *Loss of consciousness
- *Poisoning
- *Overdose

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: ~~MCUP~~ UP3039 (previously ~~MCUP~~ UP3039, UP100339)			Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Direct Members			☒ External Policy ☐ Internal Policy	
Original Date: 04/25/1994		Next Review Date: ~~04/10/2025~~ 08/13/2026 Last Review Date: ~~04/10/2024~~ 08/13/2025		
Applies to:	☐ Employees	☒ Medi-Cal	☒ <u>Partnership Advantage</u>	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD	☐ COMPLIANCE	☐ FINANCE	☒ PAC
	☒ CEO ☐ COO	☐ CREDENTIALING	☐ DEPT. DIRECTOR/OFFICER	
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~04/10/2024~~ 08/13/2025	

I. RELATED POLICIES:

- A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
- B. MCCP2024 – Whole Child Model for California Children’s Services (CCS)
- C. MPCP2002 – California Children’s Services
- D. MCUP3104 – Transplant Authorization Process
- E. MCUP3020 – Hospice Service Guidelines
- F. MCUP3103 – Coordination of Care for Members in Foster Care
- G. MCUP3051 – Long Term Care SSI Regulation
- H. CGA024 – Medi-Cal Member Grievance System

II. IMPACTED DEPTS:

- A. Health Services
- B. Member Services
- C. Claims

III. DEFINITIONS:

- A. California Children’s Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
- B. Other Health Coverage (OHC): Where ~~PHC~~Partnership does not act as primary insurance.
- C. Partnership Advantage: Effective January 1, 2027, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.
- ~~C.D.~~ Whole Child Model (WCM): ~~In participating counties,~~ This program provides comprehensive treatment for the whole child and care coordination in the areas of primary, specialty, and behavioral health for Partnership HealthPlan of California (~~PHC~~Partnership) pediatric ~~member~~Members with a CCS-eligible condition(s).

IV. ATTACHMENTS:

- A. Direct Member/Health Conditions Category Designation Grid

Policy/Procedure Number: ~~MPCUP3039~~ (previously ~~MCUP3039~~ , UP100339)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Direct Members		☒ External Policy ☐ Internal Policy	
Original Date: 04/25/1994		Next Review Date: 04/10/202508/13/2026 Last Review Date: 04/10/202408/13/2025	
Applies to:	☒ Employees	☒ Medi-Cal	☒ <u>Partnership Advantage</u>

V. PURPOSE:

To define criteria for assigning ~~member~~Members to Direct Member status.

VI. POLICY / PROCEDURE:

- A. Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status is based on the ~~member~~Member's aid code, prime insurance, demographics, or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see ~~PHCPartnership~~ network providers and/or certified Medi-Cal providers (or Medicare providers as applicable for Partnership Advantage Members) willing to bill ~~PHCPartnership~~ for covered services. However, many specialists will still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP.
- B. ~~As of January 1, 2019, Under the Whole Child Model (WCM), PHCPartnership assumed is~~ responsible~~ibility~~ for authorizing and coordinating care for Members under age 21 with -California Children's Services (CCS) -eligible conditions ~~under the Whole Child Model (WCM) in participating counties.~~¹ To maximize the patient-provider relationship and to best coordinate care, these ~~member~~Members are assigned to a medical home and a "~~HealthWCMWhole Child Model~~" Direct Member status (as per Attachment A). The provider identified as the child's medical home is responsible for managing the child's primary care needs and coordinating specialty services.
- C. Services for Direct Members will be paid on a fee-for-service basis based upon prevailing ~~PHCPartnership~~ rates. The Treatment Authorization Request (TAR) system will be in place for all ~~PHCPartnership~~ services that require the use of a TAR. (Refer to policy MCUP3041 Treatment Authorization Request (TAR) Review Process)
- D. Generally, ~~member~~Members become eligible for Direct Member status either due to a specific clinical condition or due to a specific administrative service category (refer to Attachment A, Direct Member/Health Conditions Category -Designation Grid).
- E. Members, their authorized representative, or the primary care office they are assigned to, may request consideration for Direct Member status.
 1. Member requests will be processed through the Member Services department and reviewed by Health Services staff who will contact the ~~member~~Member's providers as necessary to obtain medical documentation.
 - a. Health Services staff will notify the ~~member~~Member and their assigned primary care office of the decision.
 - b. If the request is approved, an alternate provider (other than the previously assigned PCP) will be identified and informed of ~~PHCPartnership~~'s TAR procedures. The ~~member~~Member will be encouraged to obtain all care from the alternate provider.
 - c. If the request is denied, the reason(s) will be outlined in a letter to the ~~member~~Member.
1) Partnership Medi-Cal Members may appeal a Direct Member status decision according to

¹ ~~For Members under age 21 with a CCS-eligible condition, services and supplies for the CCS-eligible condition will either be authorized by PHCPartnership under the Whole Child Model program (see policy MCPP2024 Whole Child Model for California Children's Services (CCS), or by the State CCS program (see policy MPCP2002 California Children's Services). In PHCPartnership's service area, 14 counties participate in the Whole Child Model program (Del Norte, Humboldt, Lake, Lassen, Marin, Modoc, Mendocino, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo). As of January 1, 2024, the following 10 counties in PHCPartnership's service area are participants in the State's CCS program and are not participants in PHCPartnership's Whole Child Model program: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba.~~

Policy/Procedure Number: ~~MC~~ UP3039 (previously ~~MCUP3039~~ , UP100339)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Direct Members		☒ External Policy ☐ Internal Policy	
Original Date: 04/25/1994		Next Review Date: 04/10/202508/13/2026 Last Review Date: 04/10/202408/13/2025	
Applies to:	☒ Employees	☒ Medi-Cal	☒ <u>Partnership Advantage</u>

the process outlined in policy CGA024 Medi-Cal Member Grievance System.

~~1)2)~~ Partnership Advantage Members may appeal a Direct Member status decision according to the process outlined in Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (ODAG).

~~2)3)~~ For Members with a Continuity of Care health condition, requests (HP5 Direct Member status), appeals of decisions will go through the physician review process.

F. Other Considerations

1. Member assignment to Direct Member status is based on a time-limited or condition-limited (e.g., pregnancy) interval. After the interval has elapsed, the case will be reconsidered, and the ~~member~~Member removed from Direct Member status if circumstances warranting this status no longer exist.
2. The Chief Medical Officer or physician designee may review cases where the circumstances of a clinical condition warrant consideration of the status change by the HealthPlan and may consult with other specialty physicians as needed to complete the review.
3. The Health Services Department will encourage all Direct Members to utilize the ~~PHC~~Partnership network.
4. Members assigned to Direct Member status will receive a letter with a new ID card from the Member Services Department. The Member ID Card will reflect "Direct Member" in lieu of a PCP name.
5. Agencies/facilities will continue to administer their case management activities as mandated by state, federal and regulatory agencies.

VII. REFERENCES:

- A. Medi-Cal Aid Codes Master Chart
- B. Department of Health Services (DHCS) All Plan Letter ([APL 21-015](#) Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (CalAIM) (10/18/2021 with Attachments Revised 10/14/2022)
 1. [Attachment 1: Mandatory Managed Care Enrollment \(MMCE\) Requirements](#)
 2. [Attachment 2: Major Organ Transplant Requirements](#)
- 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. ~~PHC~~Partnership Department Directors
- B. ~~PHC~~Partnership Provider Manual

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

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2027)
08/13/25

Medi-Cal: 03/01/95; 10/10/97 (name change only); 6/14/00; 8/15/00; 11/20/00; 03/07/01; 10/17/01; 11/11/03; 03/10/04; 02/08/05; 10/10/06; 11/19/08; 08/18/10, 06/19/13; 03/18/15; 03/16/16; 01/18/17; *02/14/18; 03/13/19; 03/11/20; 09/09/20; 01/13/21; 03/09/22; 10/12/22; 11/08/23; 04/10/24; ~~(MPUP3039)~~
08/13/25

Policy/Procedure Number: ~~MP~~ CUP3039 (previously ~~MC~~ CUP3039, UP100339)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Direct Members		☒ External Policy ☐ Internal Policy	
Original Date: 04/25/1994		Next Review Date: 04/10/2025 Last Review Date: 08/13/2026	
Applies to:	☒ Employees	☒ Medi-Cal	☒ <u>Partnership Advantage</u>

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

PREVIOUSLY APPLIED TO: N/A

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

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

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

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

Partnership HealthPlan of California

Direct Member / Health Conditions Category Designation Grid

This grid has been updated to crosswalk the transition to Partnership's new core claims system, HealthRules Payer (HRP), which is estimated to occur in 2026. At that time, the previous Direct Member designation (shown in first column) will be replaced with one or more of the following four eligibility components (shown in 4th column):

Health Condition, Benefit Plan, User Defined Terms (UDT) and/or Pseudo PCP. (Members may qualify for more than one component at the same time.)

~~PHCP~~ Partnership Direct Member Designation	Direct Member Type	Criteria	HRP Categories and Eligibility Components (effective when HRP is active)
<u>D1</u>			<u>Transition to PCP</u> <u>Benefit Plan: Full Scope</u> <u>PCP: Pseudo0001</u>
Default1	New Member	Upon becoming eligible to ~~PHCP~~ Partnership, new Members will have up to 30 calendar days to select a primary care provider (PCP). During the interim, the Member will not be assigned to a PCP or a case managed pool unless the Member has selected a PCP in advance.	<u>Transition to PCP</u>
Default2	Member no longer eligible for a Health Services (HS) Direct Member designation.	Members who no longer qualify for a Health Services' approved Direct Member status such as WCM/CCS, LTC or H5 are placed in Default 2 for one month if the Member cannot be relinked, family-linked or assigned based on claims data.	<u>Transition to PCP</u>
Default4	Members who no longer have prime insurance status (H20, H21, H24)	Members who no longer qualify for prime insurance coverage status are placed in Default 4 for one month if the Member cannot be relinked, family linked or assigned based on claims data.	<u>Transition to PCP</u>
WELLNESS 0001	W&R Substance Use Treatment Services Only	Wellness & Recovery - Substance Use Treatment Services Only As of 7/1/2020 – Medi-Cal residents of Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, or Solano Counties. SUBSTANCE USE TREATMENT SERVICES ONLY Members will have a pseudo aid code of 99 (internal use only)	<u>Wellness and Recovery</u> <u>Benefit Plan: Wellness and Recovery</u> <u>PCP: No PCP</u>
WELLNESS 0011	W&R Deceased	Wellness & Recovery – Deceased W&R Member As of 7/1/2020 – Medi-Cal residents of Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, or Solano Counties.	

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<u>PHCP</u>Partnership Direct Member Designation	Direct Member Type	Criteria	<u>HRP Categories and Eligibility Components</u> (effective when HRP is active)
		Members will have a pseudo aid code of 99 (internal use only)	
WELLNESS 0026	W&R with SOC	Wellness & Recovery – with Share of Cost (SOC) As of 7/1/2020 – Medi-Cal residents of Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, or Solano Counties. Members will have a pseudo aid code of 99 (internal use only)	<u>Unmet Share of Cost Wellness and Recovery</u> <u>Benefit Plan: Unmet Share of Cost Wellness and Recovery</u> <u>PCP: No PCP</u>
HealthWCM 0001 – 0004	CCS Members Who Do Not Have a Medical Home	If a WCM child has not been assigned to a medical home, they will be assigned as follows: HEALTHWCM 0001- Solano, Marin and Sonoma Counties HEALTHWCM 0002- Lake, Mendocino and Northern and Eastern Region Counties HEALTHWCM 0003- Napa County HEALTHWCM 0004- Yolo County	<u>Whole Child Model (WCM)</u> <u>Health Condition: CCS</u> <u>Benefit Plan: Full Scope</u> <u>PCP: Yes, medical home is optional</u> <u>Historical CCS mbrs may be converted with No PCP</u>
<u>H1</u>	<u>Emergency & Pregnancy Only</u> <u>OBRA Aid codes</u>	<u>Effective January 1, 2022, as per APL 21-015 Attachment 1 “Mandatory Managed Care Enrollment (MMCE) Requirements,” OBRA beneficiaries transitioned from the Medi-Cal managed care delivery system to Medi-Cal Fee for Service (FFS).</u> <u>Beneficiaries receiving pregnancy-related Medi-Cal services prior to January 1, 2022, will remain in their current delivery system through the end of the individual’s postpartum period.</u>	<u>OBRA- Restricted Services</u> <u>Benefit Plan: ER and Pregnancy</u> <u>(Aid Codes ER, C5, C3, C7, 5F, 58, C9, C1)</u> <u>Benefit Plan: ER (Aid Code 5G)</u> <u>Benefit Plan: Pregnancy (Aid Code 5N)</u> <u>UDT: Aid Code - Benefit Plan Selection</u> <u>PCP: No PCP</u>
H3	Acquired Immune Deficiency Syndrome (AIDS)	Effective date of assignment is the day of <u>PHCP</u>Partnership notification. Members approved when the 2008 CDC criteria for AIDS is met.	<u>AIDS</u> <u>Health Condition: AIDS</u> <u>Benefit Plan: Full Scope</u> <u>PCP: No PCP</u>
H5 Continued	Continuity of Care, Transplants, and Sonoma Members approved	CONTINUITY of CARE: <u>PHCP</u>Partnership Medical Directors have the discretion to place Members with complex medical conditions into Direct Member status for continuity of care according to the following criteria:	<u>Transplant</u> <u>Health Condition: Transplant</u> <u>Benefit Plan: Full Scope</u> <u>PCP: No PCP</u>

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<u>PHCPartnership</u> Direct Member Designation	Direct Member Type	Criteria	<u>HRP Categories and</u> <u>Eligibility Components</u> <i>(effective when HRP is active)</i>
<i>Cont'd</i> H5	Continuity of Care, Transplants, and Sonoma Members approved	1. The Member's eligibility to <u>PHCPartnership</u> should be relatively recent. 2. The Member requires ongoing care from out-of-area specialist(s) for appropriate management of their complex medical condition(s) and discontinuation of this care from the out-of-area specialist(s) would be detrimental for the Member's health. 3. Referrals to specialty care by an in-network PCP do not meet the Member's health care needs. 4. The out-of-area specialist accepts the additional responsibility of Primary Care Provider. 5. Transgender Member or Member with gender dysphoria requiring primary care with clinician with expertise in this area. 6. The Member's need for Direct Member status under Health Plan 5 is generally required for 12 months or less. 7. Member will be removed when the Member's needs for continuity of care have been met. Transplants: <u>Solid Organ</u> Member is approved upon notification from a Medi-Cal designated transplant facility that the Member has completed the evaluation process and is currently listed and waiting a solid organ transplant. Exceptions: See H38. Members on dialysis awaiting a kidney will stay in H38 until transplanted. Heart transplant recipients are granted H5 for plan lifetime. <u>Bone Marrow (including CAR T-cell therapy and gene therapy)</u>	

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<u>PHCP Partnership</u> Direct Member Designation	Direct Member Type	Criteria	<u>HRP Categories and</u> <u>Eligibility Components</u> <i>(effective when HRP is active)</i>
		Member is approved upon notification from a Medi-Cal designated transplant facility that the Member has completed the evaluation process, a donor match has been found and is currently listed and waiting transplant. <u>Bone Marrow Transplant</u> Members becomes eligible for assignment to a PCP ~~one~~<u>two</u> years after receiving the transplant but may qualify for continued H5 based on continuity of care criteria above. Sonoma Members Approved for House Calls: Sonoma Members approved for “House Calls” (a St. Joseph’s System Provider Group). “House Calls” is a provider group that provides care for home bound patients.	
H6	Hospice	Effective date is the day the Member signs the hospice election form and continues in this category as long as their care is provided by a hospice program.	<u>Hospice</u> <u>Health Condition: N/A</u> <u>Benefit Plan: Hospice</u> <u>PCP: No PCP</u>
H7	Members in Foster Care, Adoption, or Members with aid code(s) from the Department of Developmental Services (DDS)	<u>Aid Codes:</u> Foster and Adoption: 03, 04, 06, 07, 2P, 2R, 2S, 2T, 2U, 40, 42, 43, 45, 46, 49, 4A, 4C, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4U, 4W, 5K, 5L DDS: 6V	<u>Developmental Disability</u> <u>Health Condition: Developmental</u> <u>Disabilities</u> <u>Benefit Plan: Full Scope</u> <u>UDT: Foster Member</u> <u>PCP: Yes, optional</u>
H8	Out of Area	Effective date is the day the Member <u>establishes residence</u> out-of-county for a 3-month period, except if the Member is an inpatient in an out-of-county hospital, then the Member can be placed in H8 the day after discharge. <u>Exception:</u> Members in a residential treatment facility for substance use disorders will be temporarily placed in H8 if the facility is out of the resident’s county for the length of their stay.	<u>Out of Area</u> <u>Benefit Plan: Full Scope</u> <u>PCP: Pseudo002</u>
H9	Long Term Care (LTC)	<u>LTC:</u> Effective date is the day of admission to SNF or LTC facility.	<u>Long Term Care (LTC):</u> <u>Health Condition: LTC – Admit</u> <u>Benefit Plan: Full Scope</u>

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<u>PHCPPartnership</u> Direct Member Designation	Direct Member Type	Criteria	<u>HRP Categories and</u> <u>Eligibility Components</u> <i>(effective when HRP is active)</i>
		LTC Psychiatric: Effective date is the date the Member is admitted to a long term care psychiatric facility. The Member is removed on the first day of the month following discharge and is re-linked to the previously assigned PCP at this time.	<u>PCP: No PCP</u>
H10	Retroactive Members	Effective date of assignment is the first day of the month the Member becomes retroactively eligible with <u>PHCPPartnership</u> . The Member is removed and assigned to a PCP on the first day of the month after the retroactive period.	<u>Retroactive Members</u> <u>Benefit Plan: Full Scope</u> <u>PCP: Pseudo003</u>
H11	Deceased	Effective date of assignment is the date of death plus one day.	<u>Deceased</u> <u>Benefit Plan: N/A</u> <u>UDT: Deceased Date</u> <u>PCP: No PCP</u>
H13	Newborn (mother assigned to a non-capitated PCP)	The effective date of H13 depends on the birth mother's <u>PHCPPartnership</u> enrollment status. The newborn period is defined as one of the following: • Date of birth through the second month following birth or • Second month following birth only	<u>Newborn</u> <u>Benefit Plan: Full Scope</u> <u>UDT: Newborn</u> <u>PCP: Optional (TBD)</u>
H14	Administrative	Members placed in H14 for any of the reasons below: • Have a Pope Valley, Potter Valley, or a Sea Ranch address or • Qualify for Direct Member status due to a state fair hearing decision, or • County expansion • Members that exceed a 30 mile radius from the nearest PCP	<u>Exempt from PCP</u> <u>Benefit Plan: Active</u> <u>UDT: Exempt from PCP</u> <u>PCP: No PCP at the same time -</u> <u>Mbr may select PCP</u>
H16	State Hospitals for Mental Health Services	Effective date of assignment is the date of admission to a State Hospital for Mental Health Services. The Member is removed on the first day of the month following discharge from the State Hospital.	<u>State Hosp for Mental Health</u> <u>Health Condition: Mental Health</u> <u>Benefit Plan: Active</u> <u>PCP: No PCP</u>
H18	Native Americans - Redding	Native American Indian – Redding Rancheria Liberty Site As of 9/1/2019:	<u>Native Americans</u> <u>Benefit Plan: Full Scope</u> <u>UDT: Native American Alaskan</u>

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<u>PHCPartnership</u> Direct Member Designation	Direct Member Type	Criteria	<u>HRP Categories and</u> <u>Eligibility Components</u> <i>(effective when HRP is active)</i>
	Rancheria Liberty site	- Healthrurl 0018 is used only for Native American Members and/or their family Members receiving services at Redding Rancheria Liberty site. - Assignment to Healthrurl 0018 requires Redding Rancheria approval.	<u>PCP: Yes, Pseudo-H18</u>
H19	General Member Service (GMS) AND Prenatal Care 28+ weeks	GMS: Effective date of this assignment is at the discretion of Member Services for the following circumstances: - The Member has an appointment with a physician for primary care services other than the Member's assigned PCP, and - The Member was assigned to a PCP inappropriately due to an error in the assignment process. - Other criteria approved by a Member Services Director and the Chief Medical Officer or physician designee. The Member is removed when the Member no longer qualifies, based on the criteria listed above. Prenatal Care: Effective date of this assignment is the first of the month that <u>PHCPartnership</u> is notified of eligibility with <u>PHCPartnership</u> under the following conditions: - The Member is 28 weeks pregnant or more on the date of eligibility with <u>PHCPartnership</u>, - The Member has been regularly cared for by an obstetrical provider prior to eligibility with <u>PHCPartnership</u>, and; - The Member wishes to continue care and requests during pregnancy to continue with their established obstetrical provider for the duration of their pregnancy. The Member is removed on the first day of the month following 60 calendar days from the delivery date. If the Member does not meet qualifications for Direct Member	<u>Access to Care</u> <u>Health Condition: Access to Care</u> <u>Benefit Plan: Full Scope</u> <u>PCP: No PCP at the same time - Mbr may select PCP</u>

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<u>PHC Partnership</u> Direct Member Designation	Direct Member Type	Criteria	<u>HRP Categories and Eligibility Components</u> (effective when HRP is active)
		status under made H19, the Member would be required to change OB providers due to PCP and hospital linkages.	
H20	Medi-Medi Members	Effective the date ~~member~~ Member has Medicare Part A or Part B or both Part A and Part B status. Moved out of H20 the day they no longer have any Medicare status.	<u>Medi-Medi Member</u> <u>Benefit Plan: Full Scope</u> <u>UDT: Dual Medicare/Medicaid</u> <u>PCP:</u> • <u>No PCP for A/B & Part B only member</u> • <u>Yes PCP for Part A only members</u>
H21	Continuous Insurance Premium Program (CIP)	Effective date of assignment is the first day of the month of notification that the Member is eligible for CIP and the Health Services Department determines that the Member's medical condition warrants continued eligibility for this program. If the Member is in H21, the Member's health insurance premium is paid by <u>PHC Partnership</u> . The HS Director monitors H21 Members periodically. The Member is removed on the first day of the month after the Member no longer meets criteria for eligibility.	<u>Health Ins. Payment Program</u> <u>Health Condition: OHC- CIP</u> <u>Benefit Plan: Full Scope</u> <u>PCP: No PCP</u>
H22	Genetically Handicapped Persons Program (GHPP)	Effective date of assignment is the date <u>PHC Partnership</u> is notified from the state that the Member has been included on the GHPP list. The Member is removed on the first day of the month that the Member is no longer eligible for GHPP.	<u>GHPP</u> <u>Health Condition: GHPP</u> <u>Benefit Plan: Full Scope</u> <u>PCP: Defer to CC</u>
H24	Other Insurance	Effective date of assignment is the first of the month of notification or identification that the Member has other health insurance. The Member is removed on the first day of the month that the other insurance ends. In this situation, since <u>PHC Partnership</u> is the "payer of last resort", the other insurance is always the primary payer. Members with an OHC code of C, F, H, K, P and have no Medicare (A and/or B) on the 834 file are placed in H24, effective the first of the current month or following depending on the 834 file information. <u>PHC Partnership</u> is the "payer of last resort."	<u>Other Health Coverage</u> <u>Benefit Plan: Full Scope</u> <u>PCP: No PCP</u>

08/13/2025

04/10/2024

<u>PHCP Partnership</u> Direct Member Designation	Direct Member Type	Criteria	HRP Categories and Eligibility Components <i>(effective when HRP is active)</i>
		Includes Members who have prime insurance and are placed in an LTC.	
H26	Unmet Share of Cost (SOC)	LTC aid code 13, 23, 63 with an unmet SOC may be placed in H26.	<u>Unmet Share of Cost</u> <u>Benefit Plan: Unmet Share of Cost</u> <u>PCP: No PCP</u>
H27	Long Term Care Resident with aid code 53	Effective date of assignment is the day the Member is admitted to a long term care facility. The Member is removed on the first day of the month that the Member is discharged from the LTC facility <u>or</u> the Member no longer has aid code 53.	<u>Long Term Care Residents –</u> <u>ER, Pregnancy, and LTC</u> <u>Benefit Plan: Limited to LTC (Aid Code 53)</u> <u>Benefit Plan: ER, Pregnancy, and LTC (Aid Codes 55, D2, D3, D4, D5, D6, D7)</u> <u>UDT: Aid Code - Benefit Plan Selection</u> <u>PCP: No PCP</u>
H28	Long Term Care aid code not in LTC (13, 23, 63)	Member with long term care (LTC) aid code and <u>PHCP Partnership</u> has not received information of an admit to an LTC facility.	<u>Long Term Care</u> <u>(Not in LTC facility) - 13, 23, 63</u> <u>Health Condition: LTC – Aid Code</u> <u>Benefit Plan: Full Scope (Aid Codes 13, 23, 63)</u> <u>PCP: No PCP</u>
H29	Duplicates	Effective date of assignment is the day the Member becomes eligible under more than one name or Membership number. <u>PHCP Partnership</u> pays for services under the valid Member number.	<u>Duplicates</u> <u>Health Condition: Missing</u> <u>Benefit Plan: Full Scope</u> <u>UDT: Duplicate Invalid Record</u> <u>PCP: No PCP</u>
H32	Holderman Patients	Effective date of assignment is the date of admission to Holderman facility. The Member is removed on the first day of the month following discharge from the Holderman facility.	<u>Holderman Patients</u> <u>Health Condition: Mental Health</u> <u>Benefit Plan: Active</u> <u>PCP: No PCP</u>
H38	End Stage Renal Disease (ESRD)	Members approved when the Medicare definition for ESRD is met. Effective date is the actual date of the first outpatient hemo/ peritoneal dialysis treatment. Exception: Member assigned to H9 who also meets the definition for ESRD will be assigned to H9 with special notation regarding ESRD status.	<u>End Stage Renal Disease (ESRD)</u> <u>Health Condition: ESRD</u> <u>Benefit Plan: Full Scope</u> <u>PCP: No PCP</u>
H39	Breast / Cervical Cancer	A Member is placed in H39 when the Member has Single aid code of: 0U, 0T, 0R or Member has multiple aid codes and	<u>Breast and Cervical Cancer</u> <u>Benefit Plan: BCCTP (Aid code 0T)</u> <u>Benefit Plan: BCCTP (Aid code 0R)</u> <u>Benefit Plan: ER, Pregnancy, LTC, and BCCTP (Aid code 0U)</u>

08/13/2025

04/10/2024

<u>PHCP Partnership</u> Direct Member Designation	Direct Member Type	Criteria	<u>HRP Categories and</u> <u>Eligibility Components</u> <i>(effective when HRP is active)</i>
		one of them is: 0U, 0T, 0R, , 0N, 0M, 0P 0W	<u>UDT: Aid Code - Benefit Plan Selection</u> <u>PCP: No PCP</u>
H40	Continuity of Care due to large PCP contract termination	- Used at the discretion of Health Services and Large Provider Term Workgroups. - As of 2/5/2020 only available for HEALTHYOLO 0040 & HEALTHRURL 0040	<u>Health Condition</u> <u>Health Condition: Health Condition</u> <u>Benefit Plan: Full Scope</u> <u>PCP: No PCP at the same time – Mbr</u> <u>may select PCP (check with CC)</u>
H41	Continuity of Care due to large PCP contract termination for WCM	- Used at the discretion of Health Services and Large Provider Term Workgroups. - As of 2/5/2020, only available for HEALTHYOLO 0041 & HEALTHRURL0041	<u>Continuity of Care</u> <u>Health Condition: Continuity of Care</u> <u>Benefit Plan: Full Scope</u> <u>PCP: No PCP at the same time – Mbr</u> <u>may select PCP</u>

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY/ PROCEDURE

Policy/Procedure Number: ~~MC~~ UP3111 (Previously ~~MC~~ UP3111)			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: ~~09/11/2025~~ 08/13/2026 Last Review Date: ~~09/11/2024~~ 08/13/2025		
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD		☐ COMPLIANCE	☐ FINANCE
	☐ CEO	☐ COO	☐ CREDENTIALS	☒ PAC
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~09/11/2024~~ 08/13/2025	

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

~~A-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:

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. Pulmonary rehabilitation is defined as an evidence-based, multidisciplinary, and comprehensive intervention for patients with chronic respiratory diseases who are symptomatic and often have decreased daily life activities. The primary goal of pulmonary rehabilitation is to restore the patient to the highest level of independent function,

Policy/Procedure Number: ~~MCPUP3111~~ MPUP3111 (previously ~~MCPUP3111~~)		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: 09/11/2025 Last Review Date: 09/11/2024	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

~~of which they are capable, by helping patients become more physically active and learn more about their disease, treatment options, and how to cope. This primary goal has the purpose of improving quality of life and preventing relapses of the chronic respiratory condition.~~

~~A.~~

~~A.B.~~ All requests for pulmonary rehabilitation requires 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]
6. 94626 - Physician or other qualified health care professional* services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring [per session]

**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.*

D. Partnership Advantage Criteria:

1. Partnership Advantage covers pulmonary rehabilitation for Members 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. For pulmonary rehabilitation to be covered for Partnership Advantage Members, 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.

~~D.E.~~ Partnership covers pulmonary rehabilitation for Members who have ~~with~~ a diagnosis ~~as~~ listed in

Policy/Procedure Number: ~~MCPUP3111~~ MPUP3111 (previously ~~MCPUP3111~~)		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: 09/11/202508/13/2026 Last Review Date: 09/11/202408/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ <u>Partnership Advantage</u>

~~ED.1.or ED.2 below or who meet and also meeting~~ the criteria listed in ~~ED.3. are eligible for this benefit.~~
A completed Pulmonary Rehabilitation Questionnaire (Attachment A) must be submitted with the TAR.

1. Chronic pulmonary conditions eligible for pulmonary rehabilitation include the following:
 - a. Chronic Obstructive Pulmonary Disease (COPD) – chronic bronchitis or emphysema
 - b. Interstitial lung disease or idiopathic pulmonary fibrosis
 - c. Alpha-1-antitrypsin deficiency
 - d. Asbestosis
 - e. Asthma
 - f. Bronchiectasis
 - g. Chronic airflow obstruction
 - h. Cystic fibrosis
 - i. Fibrosing alveolitis
 - j. Lung Reduction Surgery
 - k. Pneumoconiosis
 - l. Pulmonary alveolar proteinosis
 - m. Pulmonary hemosiderosis
 - n. Radiation pneumonitis
2. Other chronic conditions affecting pulmonary function which may be eligible for pulmonary rehabilitation include ~~the following~~:
 - a. Ankylosing spondylitis
 - b. Bronchopulmonary dysplasia
 - c. Guillain-Barre syndrome or other infective polyneuritis
 - d. Lung cancer
 - e. Muscular dystrophy
 - f. Myasthenia gravis
 - g. Pulmonary Arterial Hypertension (PAH)
 - h. Paralysis of the diaphragm
 - i. Sarcoidosis
 - j. Scoliosis
3. A ~~Member~~ will also qualify for pulmonary rehabilitation if they must meet ALL the following criteria (See detailed in -Attachment A) and have at least moderate to qualify for functional pulmonary disability, with appropriate medical management, as demonstrated by one of the following within 12 months prior to the TAR -rehabilitation (unless there are special considerations as noted in Section VI.~~FE~~):
 - ~~a. Reduction in exercise tolerance that restricts the ability to perform activities of daily living~~
 - ~~b. Symptoms that persist despite appropriate medical management~~
 - ~~c. No longer smoking or vaping any products (including marijuana) or at least actively quitting by evidence of use of a cessation protocol.~~
 - ~~d. Have at least moderate functional pulmonary disability, with appropriate medical management, as demonstrated by one of the following within the last 12 months:~~
 - ~~e. Obstructive disorders: Moderate to very severe COPD (defined as GOLD classification II, III, IV) Pulmonary function tests showing FEV1/FVC less than 70%~~
 - ~~a. Restrictive/fibrotic disorders FEV1, FVC, TLC, or DLCO less than 60% of predicted~~
 - ~~b. 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)~~
 - ~~h. The member is physically able, motivated and willing to participate and is a candidate for self-care post-program.~~

Policy/Procedure Number: ~~MCPUP3111~~ MPUP3111 (previously ~~MCPUP3111~~)		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: 09/11/202508/13/2026 Last Review Date: 09/11/202408/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ <u>Partnership Advantage</u>

- ~~i. 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, congestive heart failure [CHF], recent (6 months) myocardial infarction, dysrhythmia, active joint disease, claudication, malignancy).~~
- ~~j. Member has had no pulmonary exacerbation within the past four weeks.~~

E-F. 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.

1. Members eligible for lung transplantation are eligible for pulmonary rehabilitation without demonstration of chronic lung disorders or dysfunction beginning at the time the ~~member~~ **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.
2. Members with post-COVID-19 pulmonary sequelae may also be eligible for pulmonary rehabilitation without demonstration of chronic lung disorders or dysfunction.

G. Limits on Coverage:

1. **Partnership Medi-Cal** Members **and Partnership Advantage Members** who meet the criteria will initially be approved up to a maximum of 36 ~~visits~~ **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 has a lifetime limit of 72 sessions of pulmonary rehab**ilitation**, 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](https://doi.org/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/>
- F.** 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.** Title 42 Code of Federal Regulations (CFR) Section § 410.26 Services and supplies incident to a physician's professional services: Conditions.
- ~~**D.** 42 CFR § 410.47 Pulmonary rehabilitation program: Conditions for coverage.~~
- ~~**H.**~~

VIII. DISTRIBUTION:

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

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

X. REVISION DATES:

Policy/Procedure Number: ~~MP~~ CUP3111 (previously MCPUP3111)		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: 09/11/2025 Last Review Date: 08/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ <u>Partnership Advantage</u>

Partnership Advantage (Program effective January 1, 2027)

N/A

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

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

PREVIOUSLY APPLIED TO:

Partnership Advantage:

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.

08/10/2022 08/13/2025

A

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.	☐	☐

Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the June 18, 2025 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>i.e.</i> , NCQA, APL, Medi-Cal guidelines, clarification, <i>etc.</i>)	External Documentation (Notice required outside of originating department)
Policy Owner: Care Coordination – Presenter: Shannon Boyle, RN, Manager of Care Coordination Regulatory Performance			
MCCP2036 – Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities (NEW Policy)	235 – 239	NEW Policy - To describe and define the intent of the Memorandum of Understanding (MOUs) required to be entered into by Partnership HealthPlan of California (as the Medi-Cal Managed Care Plan [MCP]) and Third Party Entities. This policy outlines that Partnership shall negotiate in good faith and execute an MOU with Third Party Entities as required under the Medi-Cal Managed Care Contract (MCP Contract) with the Department of Health Care Services (DHCS). MOU Policy includes the following: 1. A designated point of contact responsible for the oversight and supervision of the terms of all MOUs. 2. All Subcontractors, Downstream Subcontractors, and Network Providers are required to comply with any applicable provisions. 3. MOU parties must work collaboratively to ensure Members are referred to appropriate programs and/or services and coordinate Members' access to care and services that incorporate all the requirements noted in the MOU. 4. MOUs must be reviewed annually for any needed modifications or renewal of responsibilities and obligations. For each MOU Partnership will hold regular meetings with the MOU parties, at least quarterly, to address policy and practical concerns. 5. The MOU parties may develop Quality Improvement (QI) activities specifically for the oversight of the requirements of the MOU. 6. The MOU parties must support the timely and frequent exchange of Member information and data. 7. The MOU parties must develop policies and procedures to mitigate the effects of disaster and emergency preparedness 8. Partnership and MOU parties shall negotiate in good faith and execute MOUs to ensure coordination of Medi-Cal services, delineate the responsibilities of each respective party, and afford for a dispute resolution process. 9. Partnership or the MOU parties may seek to remedy a dispute informally through discussion and dialogue.	Administration Compliance Health Services Grievance and Appeals Member Services Provider Relations

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, <i>i.e.</i> , NCQA, APL, Medi-Cal guidelines, clarification, <i>etc.</i>)	External Documentation (Notice required outside of originating department)
		Updates made at June 10, 2025 Internal Quality Improvement (IQI) Committee Definition added: Behavioral Health Plan (BHP) is a county behavioral health plan that is responsible for providing behavioral health services outlined in Title 9 CCR and Title 22 CCR. VI.A.7 added: All executed MOU's are available on the Partnership website at: https://www.partnershiphp.org/About/Pages/MOU-Documents.aspx References added: Partnership External Website Memoranda of Understanding (MOU) Documents: https://www.partnershiphp.org/About/Pages/MOU-Documents.aspx	
Policy Owner: Utilization Management – Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations			
MCUP3041 – Treatment Authorization Request (TAR) Review Process	241 – 260	Section I: Two Relate Policies were added J. MPUP3139 – Criteria and Guidelines for Utilization Management K. MCUP3064 – Communication Services Section V. An outdated reference to processing of RAFs was deleted from the Purpose section. This policy now describes only TAR processing. Section VI.A.2. In the description of criteria used for review decisions, we added a reference to our policy MPUP3139 Criteria and Guidelines for Utilization Management. Section VI.A.5 was removed. This paragraph discussed records retention which is the topic of another policy, CMP30 Records Retention and Access Requirements, which is listed in Section I. as a Related Policy. Section VI.B.2.b. This paragraph was added per DHCS request to state that requests for DME for dually eligible Medi-Cal/ Medicare Members are exempt from the requirement to submit a TAR with written verification from Medicare that the benefits have been exhausted. This is because Medicare does not issue denials and Explanations of Benefits (EOBs) for non-covered DME services. Section VI.B.2.b. Added language to say TARs are not required for “certain” services because the list has been growing and we did not want to limit services to only those specified. Section VI.B.4. Removed “diagnostic imaging” from the list of services limited to a 6-month authorization period because we are no longer requiring a TAR for CT or MRI Section VI.F. Removed the entire Communication Services section because all of the language is duplicate in policy MPUP3064 Communication Services which has been listed at the top in Section I. as a Related Policy. Attachment A: Policy numbers updated throughout.	Health Services Claims Member Services Provider Relations

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, <i>i.e.</i> , NCQA, APL, Medi-Cal guidelines, clarification, <i>etc.</i>)	External Documentation (Notice required outside of originating department)
		H. Diagnostic Studies; Paragraphs 1. CT Scans and 2. MRI: were both deleted as we no longer require a TAR for these services.	
MPUP3139 – Criteria and Guidelines for Utilization Management – <i>previously MCUP3139</i>	261 – 265	This policy has been updated for Partnership Advantage (Medicare) applicability, effective Jan. 1, 2027. Section VI.B.2.a. 2) Added description of Medicare standards that may be used for UM decisions including NCDs and LCDs. Section VII.B and C. Added two new references for “Contractual obligations with the Department of Health Care Services (DHCS)” and “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)” Attachment A: Added Criteria for Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance	Health Services Compliance Provider Relations
Policy Owner: Population Health – Presenter: Greg Allen Friedman, Project Coordinator II, Pop Health			
MPND9001 – Population Health Management Strategy & Program Description – <i>previously MCND9001</i>	267 – 322 <i>clean copy pp. 323-370</i>	Changed to MPND9001 to reflect applicability also to the coming D-SNP program. Annual update includes revisions and additional contract and APL references to further align the document with NCQA and state requirements. Many small changes for grammar, clarity, and/or readability. Highlights below: P. 5 Introduction: new paragraph explaining Partnership’s Medi-Cal and D-SNP services, and Partnership Advantage. P. 6 Data Analysis and Strategy: fine-tuned explanations of PHM processes, its Work Plan, and other analysis and policies. P. 8-11 under Data Analysis and Strategy: updated the graphic showing the relationship of PHM and county CHA/CHIP activities, moved PNA Committee explanation from p. 11 to p. 14. P. 13 under Population Needs and Community Needs Assessments: added language about Community Advisory Committee (CAC). P. 16-17 under Social Drivers of Health and Community Needs: added language about covered behavioral health services for Medicare Advantage members. P. 22 Basic Population Health Management: added language mentioning Community Health Worker services, and reports being reviewed for members who may be at risk of diabetes.	Grievance, Member Services, Pharmacy, Utilization Management, Communications

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, <i>i.e.</i> , NCQA, APL, Medi-Cal guidelines, clarification, <i>etc.</i>)	External Documentation (Notice required outside of originating department)
		P. 36 Practitioner Education and Training; Health Education Interventions: rewritten to reflect DEI offerings for providers, and eliminated references to the QIHETP/C&L Work Plan in the context of Health Education. P. 39-42 under Community Engagement and Coordination of PHM Programs: updated explanation of Partnership systems, including its case management system and plans to switch to JIVA later in 2025. Updated vendor names and terminology, and added qualifiers for possible different services for Medi-Cal and Partnership Advantage members. Updated list of organizations with MOUs effective January 2025. P. 47 Population Health and Health Education Delegation Oversight and Monitoring: added details explaining Partnership’s monitoring of performance for delegates. P. 48-51 under Team Roles and Responsibilities: updated descriptions of various roles, including Chief Medical Officer, Director of Population Health, Health Educator, Healthy Living Coach, and others.	
Policy Owner: Population Health – Presenter: Christine Smith, Community Health Needs Liaison, Pop Health			
MPND9002 – Cultural & Linguistic Program Description – <i>previously MCND9002</i>	371 – 416 <i>clean copy pp. 417-444</i>	Changed to MPND9002 to reflect applicability also to the coming D-SNP program. This policy was updated to align with DHCS APL 25-005 Review Tool and other organizational changes. Due to the timing of APL 25-005, additions were needed since the previous April approvals: Alignment with DHCS Review Tool • Added reference to the regulatory required notices Attachment A & Attachment B (p. 8). • Added details around written information in either traditional, simplified Chinese characters (p. 11). • Updated details on the content of the Nondiscrimination notice to include information on how to file discrimination grievance with the with Partnership, DHCS’ OCR, and HHS’ OCR (p. 9). • Added details on the use of quick response codes, otherwise known as QR codes alongside printed notices however cannot be replaced or to be used in lieu of the regulatory required notices (p.9). • Clarified that Members with limited English proficiency (LEP) or disabilities are not required to provide or pay for their own interpreters, nor rely on unqualified staff for interpretation (p. 12). • Included language affirming Members' right to free interpreter services, and that interpreter use will not affect service quality or confidentiality (p. 14).	Grievance & Appeals, Health Equity, Member Services, Pharmacy, Utilization Management, Communications, Quality Improvement

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, <i>i.e.</i> , NCQA, APL, Medi-Cal guidelines, clarification, <i>etc.</i>)	External Documentation (Notice required outside of originating department)
		- Added provisions requiring documentation in the medical record when a Member refuses free interpreter services and requests a family member, friend, or minor to interpret (p. 14). DSNP Language - Changed policy name from MCND9002 to MPND9002 throughout document - Updated the list of member correspondence items to include “Notices of Organization and Coverage Determinations to encompass DSNP notices” (pg.9) Attachments A-E updated with new “MPND” policy coding. Other specifics below. Updating Attachment D: Process for Translation Services - Document from our translations vendor updated with branding reflecting that they are now owned by Propio. Updating Attachment E: Community Advisory Committee - Name changed from “<i>Consumer</i>” to “<i>Community Advisory Committee</i>.” - More detailed diversity statement added. - Edits made to include the committee’s feedback on the subject of CHA/CHIP work with counties. - Added members who receive Long-Term Supports Services (LTSS), and/or individuals representing those members to list of examples of how CAC members may reflect Partnership’s member population. - Added detail about representation ratios. - Added a new paragraph explaining responsibilities of the CAC Coordinator, Facilitators, and CAC selection committee. - Updated member responsibilities, adding a qualifier for members with ADA-qualifying disabilities allowing remote attendance. - Responsibilities for choosing replacement members now shared between the CAC Coordinator, Facilitators, and CAC selection committee. - Removed a sentence which described how regional representatives reporting to the Partnership Board of Commissioners would be rotated from region to region. - Updated references to DHCS’s Medi-Cal Member Advisory Committee (MMAC). - Updated Partnership office addresses.	

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY / PROCEDURE

Policy/Procedure Number: MCCP2036			Lead Department: Health Services Business Unit: Care Coordination	
Policy/Procedure Title: Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities			☒ External Policy ☐ Internal Policy	
Original Date: 08/13/2025 Effective Date: 01/01/2024		Next Review Date: 08/13/2026 Last Review Date: 08/13/2025		
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD		☐ COMPLIANCE	☐ FINANCE
	☐ CEO	☐ COO	☐ CREDENTIALS	☒ PAC
Approval Signature: Robert Moore, MD MPH MBA			Approval Date: 08/13/2025	

I. RELATED POLICIES:

- A. MCCP2035 – Local Health Department (LHD) Coordination
- B. MPBP8005 – Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services
- C. ADM41 - PHC's Community Emergency Response Plan
- D. MPBP8003 - Mental Health Services
- E. MPUP3047 - Tuberculosis Related Treatment
- F. MCCP2024 - Whole Child Model For California Children's Services (CCS)
- G. MPNP9008 - Women, Infants and Children (WIC) Supplemental Food Program
- H. MPCP2034 - Transitional Care Services (TCS)
- I. MCUP3103- Coordination of Care for Child Welfare-Involved Members

II. IMPACTED DEPTS:

- A. Administration
- B. Compliance
- C. Health Services
- D. Grievance and Appeals
- E. Member Services
- F. Provider Relations

III. DEFINITIONS:

- A. Behavioral Health Plan (BHP): A county behavioral health plan that is responsible for providing behavioral health services outlined in Title 9 CCR and Title 22 CCR.
- B. Closed loop referral: A closed loop referral means bidirectional information sharing between two or more parties to communicate requests for services and the associated outcomes of the requests. The frequency and format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and /or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required.
- C. Managed Care Plan (MCP): Partnership HealthPlan of California (Partnership) is contracted as a Department of Health Care Services (DHCS) Managed Care Plan (MCP). MCPs are required to provide and cover all medically necessary physical health and non-specialty mental health services.
- D. Memorandum of Understanding (MOU): A formal written agreement between two or more

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governmental entities or community-based organizations to outline and define roles and responsibilities. MOUs do not constitute a provider contract.

- E. Mental Health Plan (MHP): A county Mental Health Plan in Partnerships' service area. MHPs are required to provide and cover all medically necessary SMHS in accordance with their contracts with DHCS.

IV. ATTACHMENTS:

- A. [Base Memorandum of Understanding Template](#)
- B. [In Home Supportive Services Memorandum of Understanding Template](#)
- C. [Regional Center Memorandum of Understanding Template](#)
- D. [Specialty Mental Health Services Memorandum of Understanding Template](#)
- E. [Substance Use Disorder Treatment Services Memorandum of Understanding Template](#)
- F. [Local Health Department Memorandum of Understanding Template](#)
- G. [County Social Services Programs and Child Welfare Memorandum of Understanding Template](#)
- H. [Women, Infant, & Children Memorandum of Understanding Template](#)
- I. [County-Based Targeted Case Management Memorandum of Understanding Template](#)
- J. [Drug Medi-Cal State Plan Memorandum of Understanding Template](#)
- K. [First 5 Memorandum of Understanding Template](#)
- L. [California Children's Services \(CCS\) Whole Child Model Program Memorandum of Understanding Template](#)

V. PURPOSE:

To describe and define the intent of the Memorandum of Understanding (MOUs) required to be entered into by Partnership HealthPlan of California (as the Medi-Cal Managed Care Plan [MCP]) and Third Party Entities as defined below under the Medi-Cal Managed Care Contract with the Department of Health Care Services (DHCS).

VI. POLICY / PROCEDURE:

A. MOU OVERSIGHT & COORDINATION

1. Partnership HealthPlan of California (Partnership) shall negotiate in good faith and execute an MOU with Third Party Entities as required under the Medi-Cal Managed Care Contract (MCP Contract) with the Department of Health Care Services (DHCS).
 - a. Partnership will submit all executed MOUs to DHCS as required by the DHCS-MCP Contract Exhibit A, Attachment III, Subsection 5.6.1 (MOUs with Third Party Entities and County Programs).
 - b. To the extent the plan does not execute an MOU required by the DHCS-MCP contract within four months of the effective date of the contract, Partnership must submit quarterly reports to their DHCS contract manager documenting the plan's continuing good faith efforts to execute the MOU, until such time as the MOU is executed. Documentation of good faith efforts to execute the MOU must include a justification for why the MOU has not been executed.
 - c. Partnership is responsible for authorizing medically necessary covered services and coordinating care for Members provided by Partnership's Network Providers and other providers of carved-out programs, services, and benefits.
2. Partnership has a designated point of contact responsible for the oversight and supervision of the terms of all MOUs entered into by the plan.
 - a. The appropriate level of leadership for both the parties to the MOU must be present at all engagements when defining the terms of the MOU.
 - b. Partnership will notify the Third Party Entities of any changes to Partnership's designated MOU

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Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

- point of contact in writing as soon as reasonably practical but no later than the date of change.
 - c. Partnership will notify DHCS within five working days of any change in the designated MOU point of contact.
- 3. All Partnership Subcontractors, Downstream Subcontractors, and Network Providers are required to comply with any applicable provisions for all MOUs entered into by the plan.
 - a. Partnership provides training and orientation for its employees who carry out responsibilities under an MOU and on any provisions applicable to Subcontractors, Downstream Subcontractors, and Network Providers in any MOUs entered into by the plan, on an annual basis, at a minimum. The training must include information on MOU requirements, what services are provided or arranged for by each of the MOU parties, and policies and procedures outlined in the MOU.
 - b. Partnership and Third Party Entities will work together to develop training and educational materials that covers services provided or arranged for by the MOU parties.
- 4. The MOU parties must work collaboratively to ensure Members are referred to appropriate programs and/or services. Referrals must be facilitated among the MOU parties for Members who potentially meet criteria or quality for such programs and/or services.
- 5. The MOU parties will coordinate Members' access to care and services that incorporate all the requirements noted in the MOU. Partnership would need to maintain collaboration with Third Party Entities and to identify strategies to monitor and assess the effectiveness of the MOU in place.
- 6. At a minimum, the plan must review its MOUs annually for any needed modifications or renewal of responsibilities and obligations outlined within.
 - a. Partnership will submit evidence of the plan's annual review of MOUs to their DHCS contract manager, along with copies of any MOUs that have been modified or renewed as a result.
- 7. All executed MOU's are available on the Partnership website at:
<https://www.partnershiphp.org/About/Pages/MOU-Documents.aspx>
- B. MOU Meetings
 - 1. For each MOU entered into by the plan, Partnership will hold regular meetings with the MOU parties, at least quarterly, to address policy and practical concerns that may arise between MOU parties.
 - a. For each regular meeting, appropriate representatives from both parties to the MOU, who are knowledgeable about the topics to be discussed, must:
 - 1) Be present, and
 - 2) Include at least one individual who directly interacts with the Member population being served.
 - b. At each regular meeting, there will be an opportunity to discuss and address care coordination and MOU-related issues directly with county executives, when applicable.
 - c. Partnership will report to DHCS updates from each regularly held MOU meeting in a manner and frequency specified by DHCS.
- C. Quality Improvement (QI)
 - 1. The MOU parties may develop QI activities specifically for the oversight of the requirements of the MOU, including, without limitation, any applicable performance measures and QI initiatives, including those to prevent duplication of services, as well as reports that track referrals, Member engagement, and service utilization. Partnership must document these QI activities in its policies and procedures or the MOU parties may agree to additional requirements that involves adopting joint policies and procedures to establish and address QI activities for coordinating the care and delivery of services for Members.
- D. Data Sharing, Exchange, and Confidentiality
 - 1. The MOU parties must ensure that the minimum necessary Member information and data for

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Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

accomplishing the goals of the MOU are exchanged timely and maintained securely and confidentially.

2. The MOU parties must support the timely and frequent exchange of Member information and data, which may include behavioral health and physical health data; for ensuring the confidentiality of exchanged information and data; and, if necessary, for obtaining Member consent.
- E. Disaster and Emergency Preparedness
1. The MOU parties must develop policies and procedures to mitigate the effects of natural, man-made, or war-caused disasters involving emergency situations and/or broad health care surge events greatly impacting the MOU parties' health care delivery system to ensure the continued coordination and delivery of the Third Party Entities programs and services and Partnership's Covered Services for impacted Members.
 2. Refer to Partnership policy ADM41 PHC's Community Emergency Response Plan for more details.
- F. Dispute Resolution Process
1. Partnership and MOU parties shall negotiate in good faith and execute memoranda of understanding (MOUs) to ensure coordination of Medi-Cal services, delineate the responsibilities of each respective party, and afford for a dispute resolution process.
 2. MOUs shall be entered into and maintained, consistent with any future-related DHCS guidance as communicated in writing.
 3. Emphasis on Timely, Collaborative Resolution
 - a. The provision of medically necessary services for Members will not be delayed during the pendency of any dispute.
 - b. Partnership and the MOU party staff will make a good faith effort to agree to resolutions that are in the best interest of Members and are agreeable to all parties involved.
 - c. Proactive and timely communication is expected between Partnership and the MOU party.
 4. Partnership or the MOU parties may seek to remedy a dispute informally through discussion and dialogue. If this fails to resolve the dispute, either party may request, in writing, a formal meeting between the two parties to identify issues and possible solutions. The receipt of the written request will initiate the Plan Level Dispute timeline.
 - a. A Request for Plan Level Dispute Resolution can be submitted via secure email to any of Partnership's respective MOU liaisons, Directors, Behavioral Health Administrator, or Chief Health Services Officer as applicable.
 - b. Within 10 business days, the meeting will be conducted at a mutually agreeable time. Representatives from both Partnership and the MOU parties must participate in the meeting.
 - c. Within 5 business days from the date of the meeting, Partnership will issue to the MOU party a written final position on the matter in dispute signed by the CEO or their designee.
 - d. Partnership will maintain records of Plan Level Dispute Resolutions consistent with applicable Partnership record retention policy.
 5. Refer to Partnership policy MPBP8005 Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services for more details on dispute resolution between Partnership and Behavioral Health Plans (BHPs) in delivery of mental health services. The receipt of the written request will initiate the Plan Level Dispute timeline in which the dispute must be resolved within 15 business days.

VII. REFERENCES:

- A. DHCS Contract, Exhibit A, Attachment III, Section 5.6 (MOUs with Third Party Entities and County Programs)
- B. DHCS All Plan Letter ([APL](#)) 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (01/08/2025)

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- [Base Memorandum of Understanding Template](#)
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 - [Drug Medi-Cal State Plan Memorandum of Understanding Template](#)
 - [First 5 Memorandum of Understanding Template](#)
- C. Title 9, California Code of Regulations (CCR) Sections §1810.370, §1850.505, §1850.520, §1850.525, and §1850.530
- D. [Template for Memorandum of Understanding between \[MCP\] Medi-Cal Managed Care Plans and \[County\] California Childrens Services \(CCS\) Whole Child Model Program](#) (07/2024)
- E. Partnership External Website Memoranda of Understanding (MOU) Documents:
<https://www.partnershipphp.org/About/Pages/MOU-Documents.aspx>

VIII. DISTRIBUTION:

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

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

X. REVISION DATES: N/A

PREVIOUSLY APPLIED TO: N/A

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY / PROCEDURE

Policy/Procedure Number: MCUP3041 (previously UP100341)			Lead Department: Health Services Business Unit: <u>Utilization Management</u>	
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~~ <u>08/13/2026</u> Last Review Date: ~~06/12/2024~~ <u>08/13/2025</u>		
Applies to:	☐ Employees	☒ Medi-Cal	☐ <u>Partnership Advantage</u>	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD	☐ COMPLIANCE	☐ FINANCE	☒ PAC
	☐ CEO	☐ COO	☐ CREDENTIALS <u>SING</u>	☐ DEPT. DIRECTOR/OFFICER
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~06/12/2024~~ <u>08/13/2025</u>	

I. RELATED POLICIES:

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

Policy/Procedure Number: MCUP3041 (previously UP100341)		Lead Department: Health Services Business Unit: Utilization Management	
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Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

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 ~~Referral Authorization Forms (RAFs) and~~ 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 internally developed and approved guidelines. Determinations also take into account individual member 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 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 and includes all member information and all attachments noted on the TAR are received. When completing information fields for the provider of service and 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

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Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

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.

~~5. Since 2014, all TARs and related materials including worksheets, letters, and other documentation, are scanned and stored electronically. Electronic files are maintained and archived with appropriate backup both on and off site. Paper records prior to 2014 are archived and stored offsite. Records are maintained as noted:~~

~~a. For Members age twenty one (21) and over, archived materials are kept for a minimum of 10 years.~~

~~b. For Members under the age of twenty one (21), archived materials are kept until the Member reaches the age of twenty one (21) or for ten (10) years, whichever is longer.~~

B. SERVICES REQUIRING TREATMENT AUTHORIZATION

1. Certain procedures, services, and medications require prior authorization from Partnership before reimbursement is made. Those services requiring a Treatment Authorization Request (TAR) are listed as attachments to this policy. The attachment consists of:

- a. Partnership TAR Requirements List
- b. HCPCS Codes Requiring a TAR
- c. Outpatient Surgical Procedures Requiring TAR
- d. Pain Management CPTs Requiring TAR

2. 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.

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.

a.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 (~~diagnostic imaging~~, dental anesthesia, sleep studies, surgical procedures, interventional pain management procedures, genetic testing, and laboratory studies) will be limited to a 6-month authorization period. Services excluded from this limit will 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

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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

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. Requests for an urgent determination should be submitted by the provider and clearly marked "Urgent" or "Expedited" and should indicate reason there is an urgent need for authorization. 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. 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. 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. If the patient's condition necessitates hospitalization beyond the pre-approved timeframe, Partnership will perform concurrent review on the remainder of the stay.
- 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 not 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 section 50763, "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.

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- d. Once a Medicare determination of denial of coverage is received, Partnership will 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 require a TAR ONLY for inpatient services (i.e. acute or skilled nursing facility [SNF]/LTC facility.) However, 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).
 6. Long Term Care/Skilled Nursing Services
All Skilled Nursing or Long Term 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.
 - 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 member 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 themselves to the provider as a Partnership Member by deliberate concealment or because of physical or mental incapacity to so identify themselves.
 - 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 Nurse Coordinator can approve, modify, defer (pend) or deny the TAR for non-medical necessity determinations. 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. Requests that do not meet review guidelines and require clinician review

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

2. Chief Medical Officer / Physician Designee Review
 - a. The Chief Medical Officer or Physician Designee must be available physically or by telephone during business hours to assist with evaluating TAR requests.
 - b. The Chief Medical Officer or 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 Physician Designee reviews all TARs referred to him/her, taking the action deemed appropriate.
 - c. The 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 Chief Medical Officer or Physician Designee documents the rationale for any decision on the Medical Director Worksheet. Once the 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 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 Physician Designee.
 - e. Partnership makes a physician reviewer available (Chief Medical Officer or 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

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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 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. The decision will be rendered no later than 72 hours from the original date of receipt of the request. For urgent concurrent denials, Partnership may inform the hospital Utilization Review (UR) department staff of the decision, with the understanding that staff will inform the attending/treating prescriber.
 - 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.
 - 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.

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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 (5) business 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 (5) business 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.

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- 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 audits as outlined in policy MPUP3026 Inter-Rater Reliability Policy, at least biannually on both physician and nurse reviewers.
 - 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 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.
- ~~F.— COMMUNICATION SERVICES~~
- ~~G.— Partnership provides access to staff for members and practitioners seeking information about the UM process and the authorization of care in the following ways:~~
- ~~H.— Calls from Members are triaged through Member Services staff who are accessible to practitioners and Members to discuss UM issues during normal working hours when the health plan is in operation (Monday—Friday 8 a.m.—5 p.m.).~~
- ~~I.— Members and Providers may contact the Partnership voice mail service to leave a message which is communicated to the appropriate person on the next business day. Calls received after normal business~~

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~~hours are returned on the next business day and calls received after midnight on Monday—Friday are returned on the same business day.~~

- ~~J. After normal business hours, Members may contact the advice nurse line at (866) 778-8873 for clinical concerns.~~
- ~~K. Practitioners both in-network and out-of-network, may contact UM staff directly either through secure email or voicemail. Each voice mailbox is confidential and will accept messages after normal business hours. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday—Friday are returned on the same business day.~~
- ~~L. Partnership has a dedicated after-hours local phone number (707) 430-4808 or toll-free number (855) 798-8759 to receive calls from physicians and hospital staff for addressing post-stabilization care and inter-facility transfer needs 24 hours per day, 7 days per week. Calls are returned within 30 minutes of the time the call was received. Partnership's Chief Medical Officer or physician designee is on call 24 hours per day 7 days per week to authorize medically necessary post-stabilization care services and to respond to hospital inquiries within 30 minutes. Partnership clinical staff are available 24 hours per day 7 days per week to coordinate the transfer of a Member whose emergency medical condition is stabilized.~~
- ~~M. For information on utilization management procedures (prior authorization requirements, Clinical Protocols and Practice Guidelines) refer to Partnership's Provider Manual, Section 5: Health Services at www.partnershiphp.org. For information on how to submit claims, refer to Partnership's Provider Manual, Section 3: Claims at www.partnershiphp.org.~~
- ~~N. Partnership has a toll-free number (800) 863-4155 that is available to either members or practitioners.~~
- ~~O. UM staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues. For a list of UM Program Staff and Assigned Responsibilities, please refer to policy MPUD3001 Utilization Management Program Description.~~
- ~~P. Linguistic services to discuss UM issues are provided by Partnership to monolingual, non-English speaking or limited-English proficiency (LEP) Medi-Cal beneficiaries for population groups as determined by contract. These services include the following:~~
- ~~Q. No-cost linguistic services~~
- ~~R. Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries~~
- ~~S. Written informing materials (to include notice of action, grievance acknowledgement and resolution letters) are fully translated into threshold languages in accordance with regulatory timeframes and into other languages or alternative formats as indicated in the Member's record or upon request. Material formats include audio, large print and electronically for Members with hearing and/or visual disabilities. Braille versions are available for members with visual disabilities. The organization may continue to provide translated materials in other languages represented by the population at the discretion of Partnership, such as when the materials were previously translated or when translation may address Health Equity concerns.~~
- ~~T. Use of California Relay Services for hearing-impaired [TTY/TDD: (800) 735-2929 or 711].~~
- ~~U. Partnership regularly assesses and documents member cultural and linguistic needs to determine and evaluate the cultural and linguistic appropriateness of its services. Assessments cover language preferences, reported ethnicity, use of interpreters, traditional health beliefs and beliefs about health and health care utilization.~~

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VII. REFERENCES:

- A. DHCS Contract Exhibit A, Attachment 5 Utilization Management
- B. DHCS All Plan Letter [\(APL\) 21-011](#) Grievance and Appeals Requirements, Notice and “Your Rights” Templates (08/31/2021)
- C. DHCS All Plan Letter [\(APL\) 22-012 Revised](#) Governor’s Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx (12/30/2022)
- 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](#) and Title 28 California Code of Regulations (CCR) Section [1300.71.4](#)
- F. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 2025⁵⁴) 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

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](#)

*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

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

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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 ~~MP~~UG3002 *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. **Allergy Injections** – A TAR is required when services exceed Medi-Cal frequency limit of eight (8) allergy injections in any 120-day period for code 95115 or four (4) allergy injections in any 120-day period for code 95117. (For codes 95115 and/or 95117 in any combination, a maximum of eight (8) allergy injections in any 120-day period is reimbursable to any provider for the same recipient without authorization.)
- C. **Cardiac Rehabilitation** – Phase II and pediatric (see policy MCUP3128 *Cardiac Rehabilitation*)
- D. **Chiropractic Services** (see policy ~~MP~~UG3010 *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 MCCP2033 *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 ~~MCUP3142~~ ~~MCAP7003~~ CalAIM Community Supports (CS) and ~~MCUP3143~~ ~~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**
 - ~~1. CT Scans: TARs are required for all CT scans for Members under age 21 years. For adults age 21 years and older, TARs are required for CT scans of the chest, abdomen, and/or pelvis. No TARs are required for other CT scans of the extremities, head, neck, or spine, for CT angiograms, or for screening CT colonograms—effective 7/1/2024~~
 - ~~2. MRI: TARs are required for all MRIs for Members under age 21 years. For adults age 21 years and older, TARs are required for MRIs of the chest (including Cardiac MRI 05561), abdomen, and/or pelvis. No TARs are required for other MRI scans of the extremities, head, neck, or spine, for MR elastography, or for breast MRIs—effective 7/1/2024~~
 - 3.1. MRA (MR Angiogram)
 - 4.2. MSI ([Magnetic source imaging](#))
 - 5.3. MEG ([Magnetoencephalography](#))
 - 6.4. PET scan [see policy MPUP3116 *Positron Emission Tomography Scans (PET Scans)*]
 - 7.5. Transcranial Doppler
 - 8.6. 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 MCUG3110 *Evaluation and Management of Obstructive Sleep Apnea in Adults (Medi-Cal)*)
 - 9.7. Non-specific radiology codes for X-rays and ultrasound including 76497, 76380, 76506
- I. **Doula Services** (see policy MCNP9006 *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*)

PARTNERSHIP TAR REQUIREMENTS

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

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 MCUG3019 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-Cal 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*)
9. **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 CalAIM Enhanced Care Management (ECM) and [MCUP3143-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)** A TAR is required for all procedures related to fecal microbiota transplant. (*see policy [MCUP3136 Fecal Microbiota Transplant](#)*)
- 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. **Home Health Care** (*see policy [MCUP3011 Criteria for Home Health Services](#)*)

PARTNERSHIP TAR REQUIREMENTS

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

Q. **Home Infusion Therapy**

R. **Hysterectomy**

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

T. **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.

U. **Hyperbaric Oxygen Pressurization**

V. **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 Long Term Care (LTC) Facilities.

W. **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 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](#).

X. **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 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.

Y. **Medications Administered in a Medical Setting, and Billed as a Medical Claim [Physician**

PARTNERSHIP TAR REQUIREMENTS

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

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.

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

AA. **Occupational Therapy** (see policy MPEUP3114 Physical, Occupational and Speech Therapies)

- 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.)

- A TAR is required for all OT services provided as Home Health or by Non-contracted Providers

BB. **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.)

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

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

EE. **Phototherapy** for dermatological condition

FF. **Physical Therapy** (see policy MPEUP3114 Physical, Occupational and Speech Therapies)

- 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.)

- A TAR is required for all PT services provided as Home Health or by Non-contracted Providers

GG. **Pulmonary Rehabilitation** (see policy MPEUP3111 Pulmonary Rehabilitation)

HH. **Speech Therapy** (see policy MPEUP3114 Physical, Occupational and Speech Therapies)

- Partnership members age 21 and over 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.)

- A TAR is required for all ST services provided as Home Health or by Non-contracted Providers

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

JJ. **ANY UNLISTED OR MISCELLANEOUS CODE**

PARTNERSHIP TAR REQUIREMENTS

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

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

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
37700	Ligation And Division of Long Saphenous Vein at Saphenofemoral Junction, Or Distal Interruptions
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

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
43999	Stomach Surgery Procedure
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

Pain Management CPTs Requiring TAR

PARTNERSHIP TAR REQUIREMENTS

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

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	Discography, Lumbar (62290) and Cervical/Thoracic (62291)
62360, 62362	Implantable or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
63650, 63655, 63662, 63664, 63685	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	Cervical and Thoracic Discography
72295	Lumbar discography

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY / PROCEDURE

Policy/Procedure Number: ~~MCUP3139~~ <u>MPUP3139</u> (previously <u>MCUP3139</u>)			Lead Department: Health Services Business Unit: <u>Utilization Management</u>	
Policy/Procedure Title: Criteria and Guidelines for Utilization Management			☒ External Policy ☐ Internal Policy	
Original Date: 08/12/2020		Next Review Date: ~~08/14/2025~~ <u>08/13/2026</u> Last Review Date: ~~08/14/2024~~ <u>08/13/2025</u>		
Applies to:	☐ Employees	☒ Medi-Cal	☒ <u>Partnership Advantage</u>	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD		☐ COMPLIANCE	☐ FINANCE
	☐ CEO	☐ COO	☐ CREDENTIAL <u>SING</u>	☒ PAC
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~08/14/2024~~ <u>08/13/2025</u>	

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, 2027~~6~~, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

A.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 criteria and guidelines to assist in making decisions to approve, modify or deny service authorization requests. It is important that the criteria and guidelines used in this process be known and accessible and reflective of well accepted

Policy/Procedure Number: ~~MCUP3139~~ MPGUP3139 (previously ~~MCUP3139~~)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Criteria and Guidelines for Utilization Management		☒ External Policy ☐ Internal Policy	
Original Date: 08/12/2020		Next Review Date: 08/14/2025 Last Review Date: 08/14/2024	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

standards of care. This policy will establish the process of Criteria and Guideline review and approval for use by the Partnership network of providers.

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.
 - 2) Industry accepted guidelines that are used by a variety of other managed care organizations (e.g. InterQual® and National Comprehensive Cancer Network [NCCN]).
 - 3) Guidelines developed through government agencies (e.g. Center for Disease Control [CDC])

Policy/Procedure Number: ~~MCUP3139~~ <u>MPGUP3139</u> (previously <u>MCUP3139</u>)		Lead Department: Health Services Business Unit: Utilization Management	
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Applies to:	☐ Employees	☒ Medi-Cal	☒ <u>Partnership Advantage</u>

or Agency for Healthcare Research and Quality [AHRQ]).

~~4~~5) Policies developed by Partnership.

- b. There should be few circumstances where these groups of guidelines conflict. In situations where there is a conflict, the use of the guidelines should favor the patient first.
- c. The guidelines that are required by statute or contract should 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, 202~~5~~4) UM 2 Clinical Criteria for UM Decisions Elements A
- B. Contractual obligations with the Department of Health Care Services (DHCS)
- A.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, 2027~~6~~)
N/A08/13/2025

Medi-Cal

08/11/21; 08/10/22; 08/09/23; 08/14/24; 08/13/25

PREVIOUSLY APPLIED TO: N/A
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 <i>Example:</i> Medi-Cal Guidelines Pathology: Molecular Pathology (<i>path molec</i>)	--
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 <i>Example:</i> 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) <i>with hyperlink</i> <i>Example:</i> 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) <i>with hyperlink</i> <i>Example:</i> 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 <i>with hyperlink</i>	AHRQ
Centers for Disease Control and Prevention	Centers for Disease Control and Prevention (CDC): then guideline or article used <i>with hyperlink</i> <i>Example:</i> Centers for Disease Control and Prevention (CDC): Epigenetics, Health, and Disease	CDC
National Comprehensive Cancer Network	National Comprehensive Cancer Network (NCCN): then guideline used <i>with hyperlink</i> <i>Example:</i> 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 <i>with hyperlink</i> <i>Example:</i> United States Preventive Services Taskforce (USPSTF): Cervical Cancer: Screening	USPSTF
Up-To-Date	<u>UpToDate</u> : Author(s), Article Title, publishing date <i>with hyperlink</i> or <u>UpToDate</u> : Search Term or Title of Article <i>Example:</i> <u>UpToDate</u> : D. Kline, Lewis R. MD et al. Clinical Presentation and Diagnosis of OSA in Adults ; published online 9 August 2019. or <u>UpToDate</u> : Obstructive Sleep Apnea	UTD
Other government or specialty society guidelines as noted in ~~PHG~~ Partnership policies	Varies	--

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PARTNERSHIP



HEALTHPLAN
of CALIFORNIA

A Public Agency

Population Health Management Strategy & Program Description

MPND9001
(previously MCND9001, MCCD2027)

June ~~2024~~2025

Original Date: ~~11/13/2019~~11/13/2019 11/13/2019 11/13/2019 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 8/13/2025

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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, 2027~~6~~, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member 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, ~~and outlines a plan for addressing and mitigating these disparities.~~ In addition, as part of DHCS' updated PNA requirement, Partnership collaborates with Local Health Jurisdictions (LHJs), and ~~Public Hospitals~~ other community stakeholders as

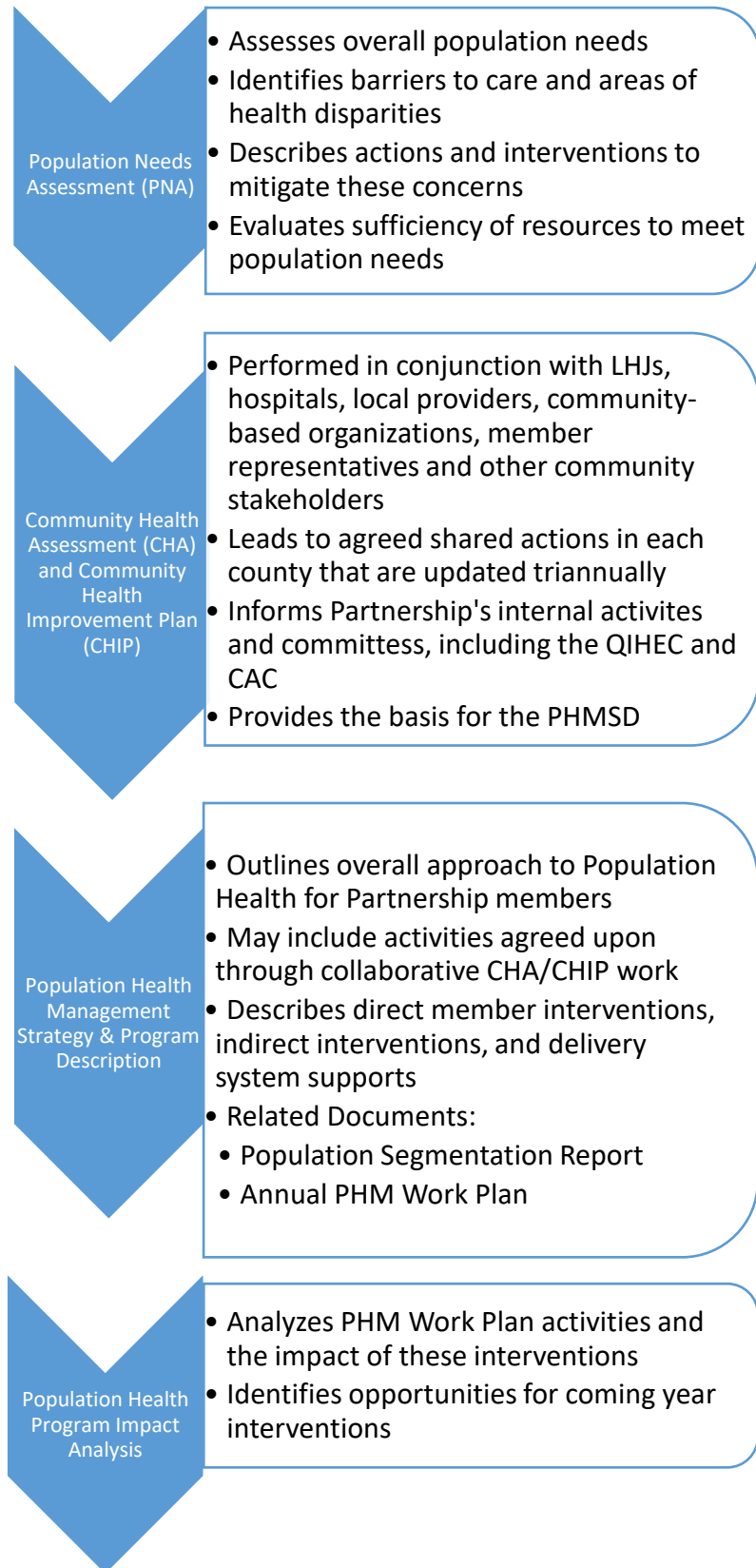
appropriate, on their Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs), documenting the shared work in accordance with each of the LHJ reporting cadences in all Partnership's counties of operation.

Data Analysis and Strategy

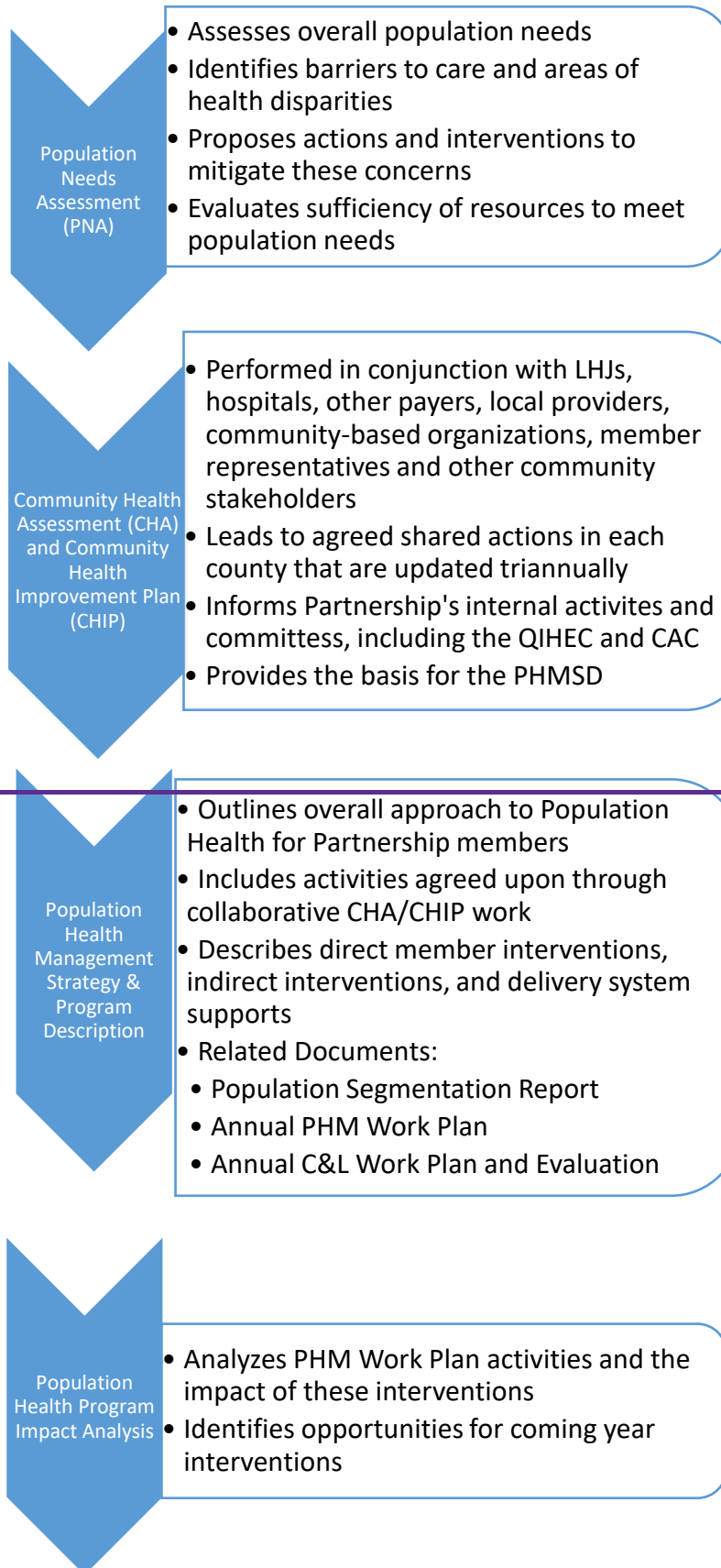
Partnership uses several methods to identify member needs, and to strategize the best means ~~best~~ to meet them. Both the annual PNA and county CHAs/CHIPs describe the overall health, social, health education, and cultural and linguistic needs of Partnership's membership, including members who are 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 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 in support of the population. The PNA and county CHA/CHIP findings inform Partnership's overall PHM strategies and are electronically submitted to the appropriate governing bodies perby their respective reporting timelines. Key stakeholders within Partnership review the PNA and CHA/CHIP findings and from there, develop which are used to complete the annual PHM Work Plan, DHCS PHM Strategy Deliverable (PHMSD), and the annual PHM Work Plan, Segmentation Report, Cultural & Linguistics (C&L) Work Plan, and appropriate health education and shared community interventions; findings may also be used to update Partnership's Strategy and Program description as appropriate. These work plans outline specific interventions to mitigate health disparities both on a member and system level. (MCND9001) as appropriate. An impact analysis of the previous year's activities is also drafted.

The PHM Strategy & Program Description (MCND9001) provides a high-level overview of Partnership's approach to improving the health and wellbeing of the population we serve. The 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. Similarly, the C&L Work Plan identifies specific health equity concerns and provides a strategy for how Partnership will address them through annual activities. The PHM Impact Analysis report evaluates 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”. The following diagram shows the relationship of these activities:



Quality Improvement and Health Equity Committee (QIHEC)



~~The~~ 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 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 Meetings occur on a quarterly 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 between Partnership and each of the LHJs in Partnership's service. This committee also meets annually to review and make recommendations for the Population Needs Assessment (PNA) used to fulfill NCQA requirements. The PNA Committee activities and recommendations will be shared with the Quality Improvement and Health Equity Committee (QIHEC), Internal Quality Committee (IQI), Quality/Utilization Advisory Committee (Q/UAC), Physician Advisory Committee (PAC) and Partnership's Board of Commissioners.

~~Quality Improvement and Health Equity Committee (QIHEC)~~

Following each PNA committee meeting, the proceedings and recommendations from the written PNA, and/or updates from the CHA/CHIP efforts, are ~~forwarded~~presented to Partnership's QIHEC for ~~deliberation and approval~~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 ~~is also~~ responsible for reviewing reviews the PNA, regular CHA/CHIP updates, 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 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 ~~data provided by Health Plan sponsors or~~ other sources such as local community needs assessments. ~~Partnership's Health Analytics and Health Education teams analyze~~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, health inequities, social and structural barriers to care, and more. The PNA proposes actions to address identified disparities and promote health equity. The PNA also analyzes language preferences (including limited English proficiency [LEP]), reported ethnicity, ~~traditional health beliefs~~, and beliefs about health and health care utilization.

~~The Manager of Population Health provides a~~ summary report of the NCQA PNA findings ~~is prepared for discussion with the Community Advisory Committee (CAC) (formerly known as the Consumer Advisory Committee (CAC) session and the Family Advisory Committees (FAC).)~~ (see MCND9002 for more information on these committees). Members of both committees are given an opportunity to provide input and advice on ~~selecting~~ Partnership's targeted, priority health education, and cultural and linguistic strategies and outreach programs. The NCQA PNA and its proposed actions also undergo review by Partnership's PNA Committee, the QIHEC, Internal Quality Improvement Committee, Quality/Utilization Advisory Committee, Physician Advisory Committee, ~~and by the Board of Directors~~ and other committees before submission ~~to NCQA and DHCS~~ 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.

In addition to the annual PNA, and in alignment with DCHS's Population Health Management Policy Guide¹ and 2024 Contract, Partnership works collaboratively with LHJs, hospitals, community providers, other payers, community-based organizations, member representatives, and other community stakeholders on each county's CHA and CHIP ~~report process~~. This collaborative work has replaced DHCS's historically mandated PNA. The county CHAs/CHIPs represent the overall community needs and priorities; ~~and provide~~ 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. The PNA committee, CAC, ~~FAC~~, and QIHEC receive regular updates on the CHA/CHIP collaborative work and are provided with an opportunity to

¹ [2024 PHM Policy Guide](#)

give feedback as appropriate. CHA/CHIP updates are sent to providers via Partnership's quarterly provider newsletter and corresponding fax blast notice.

Each As of 2025, each county has its own schedule for CHA/CHIP work, and; Partnership will align its reporting with each county as needed until timelines are standardized in 2028. The shared action plans and findings from county collaborations lead to the development of Partnership's annual PHM Strategy Deliverable (PHMSD) that demonstrates commitment to the implementation of prioritized actions and responses to community needs. The PHMSD is submitted to DHCS annually, along with an NCQA-approved version of this document (MCND9001) and the annual NCQA-approved PNA. An overview of the PHMSD is shared with Partnership committees as needed.

Findings from these collaboratives are also 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 on how to use findings from the CHAs/CHIP collaborative work. The CAC is a committee that acts as a liaison between Partnership and its members (see MCND9002 for more information). As appropriate, feedback may be used to influence:

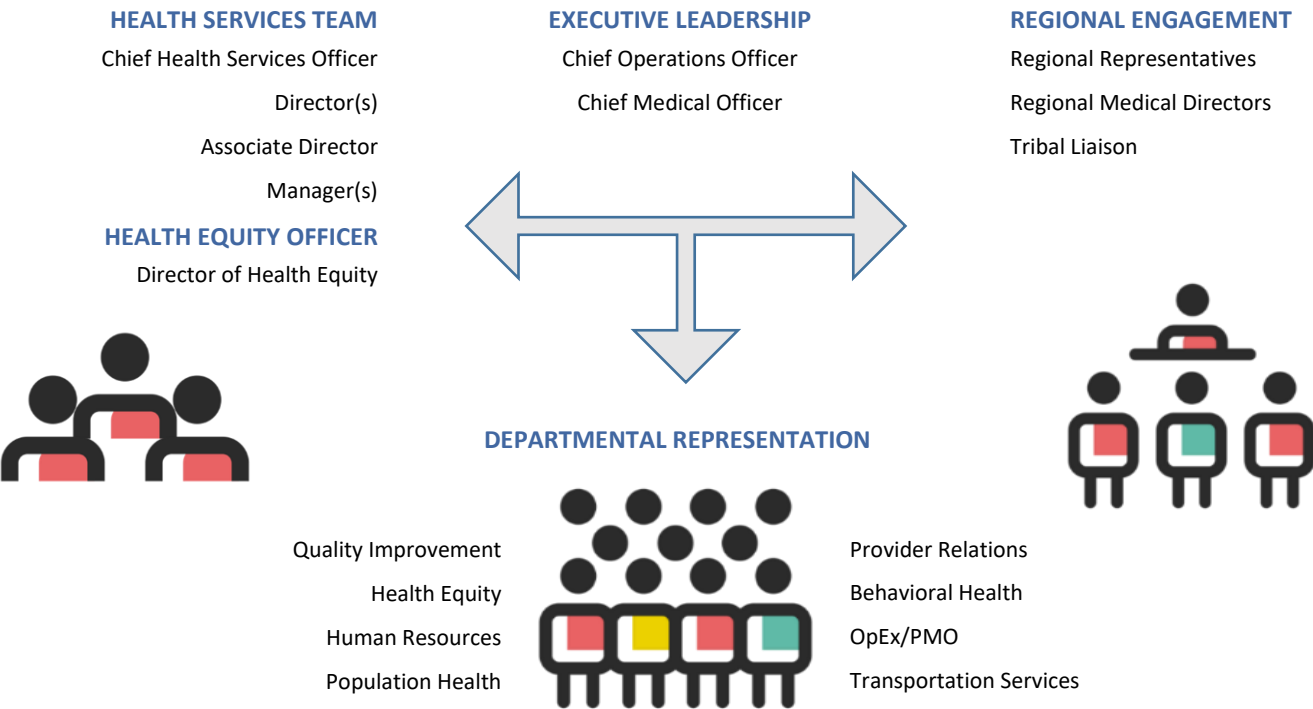
- Partnership's strategies and workstreams related to the Bold Goals defined in the PHM policy guide,
- wellness and prevention
- health equity needs
- health education needs, and
- cultural and linguistic needs

Partnership also publishes the CHAs/CHIPs of all LHJ's in its Service Area on Partnership's website, along with a description of Partnership's collaboration on the report.

~~Similar to the Population Needs Assessment (PNA) review described above, the annual PHMSD will be shared with members (through CAC and FAC sessions as well as through key informant interviews), with the 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 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 Meetings occur on a bi-monthly basis to review requests from the Quality Improvement Health Equity Committee (QIHEC), 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 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 Improvement Committee (IQI), Partnership's Quality-/Utilization Advisory Committee (Q/UAC), Partnership's and Physician Advisory Committee (PAC), and by Partnership's Board of Directors. These documents will be posted on Partnership's external website as they are updated, and provider newsletters will prompt providers when new versions are available.)~~

Population Needs Assessment Committee



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 with the 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 [havinghave](#) either a Senior or Person with Disability (SPD) aid 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 or serious emotional disturbance (SMI/SED) receive 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 17-018All Plan Letter 22-006: Medi-Cal Managed Care Health Plan Responsibilities For Non-Specialty Mental Health ServicesMedi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services²](#)).

In July 2020, Partnership began administering 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. [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, 2027, Partnership will also covers behavioral health services for PartnershipMedicare 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](#)

² [All Plan Letter 17-018All Plan Letter 22-006: Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services](#)

covered service in Partnership Advantage provided by Opioid Treatment Programs (OTPs).

In addition, Partnership's disease registry flags members with SMI/SED 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 leverages this data to ensure members with SMI/SED receive care for comorbid medical conditions.

Population Risk Stratification & Segmentation

Currently, Partnership analyzes and segments the ~~entire~~ population by need and appropriate intervention(s), as described in the Population Segmentation Report.

[Partnership also assesses and reassesses member risk scores on a monthly basis.](#)

Once DHCS has launched the PHM Service and associated Risk Stratification and Segmentation methodology, Partnership will incorporate those data 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.](#)

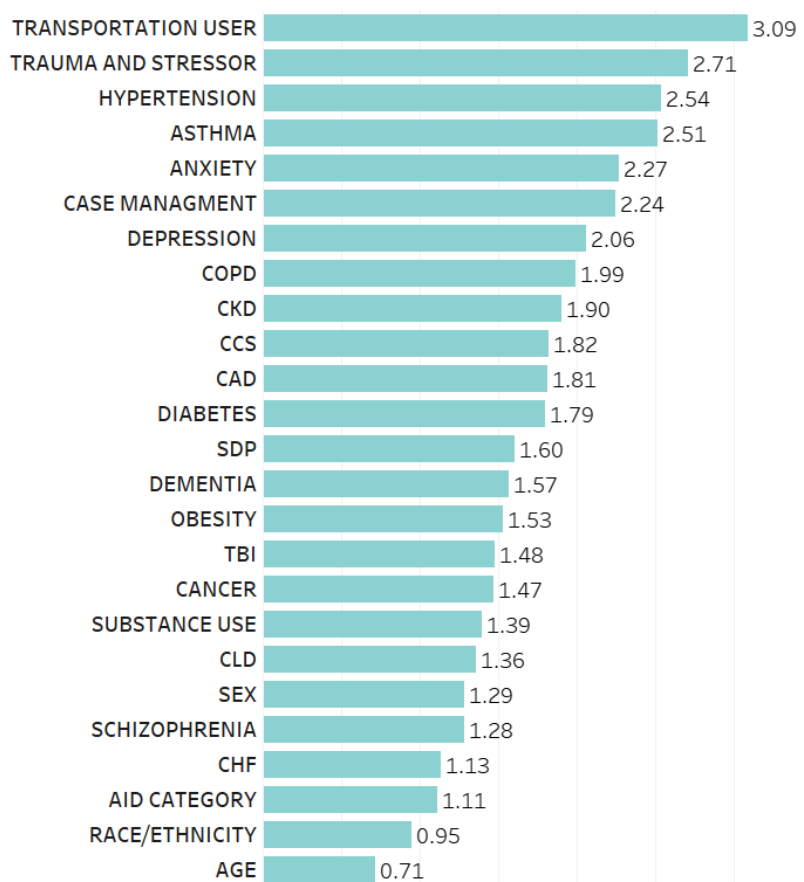
Partnership's Risk Stratification Process

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: (a) five or more ED visits, (b) one or more acute hospital admission, (c) fifteen or more distinct drug prescriptions, or (d) total 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 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 on members having gaps in care, and this information is shared with providers to help members obtain preventive and chronic care.

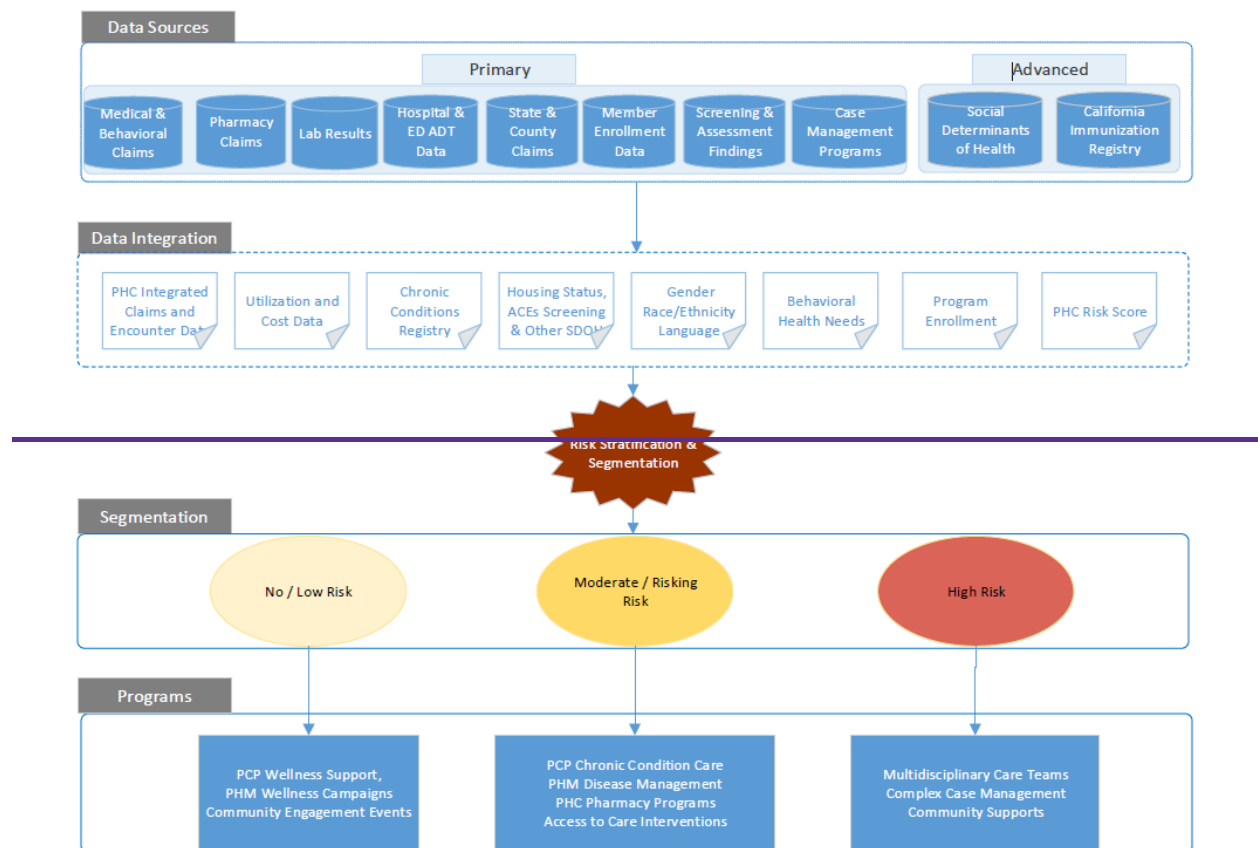
Partnership's Population Health team uses monthly has various member-facing campaigns that are designed to positively impact various HEDIS measures. The care gap reports to perform outreach gaps report allows the team to members, explaining their benefits and connecting them with providers be better informed on where focuses for campaigns should be.

The PNA Partnership's PNA and the Annual Reducing Health Disparities report describes how Partnership analyzes 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

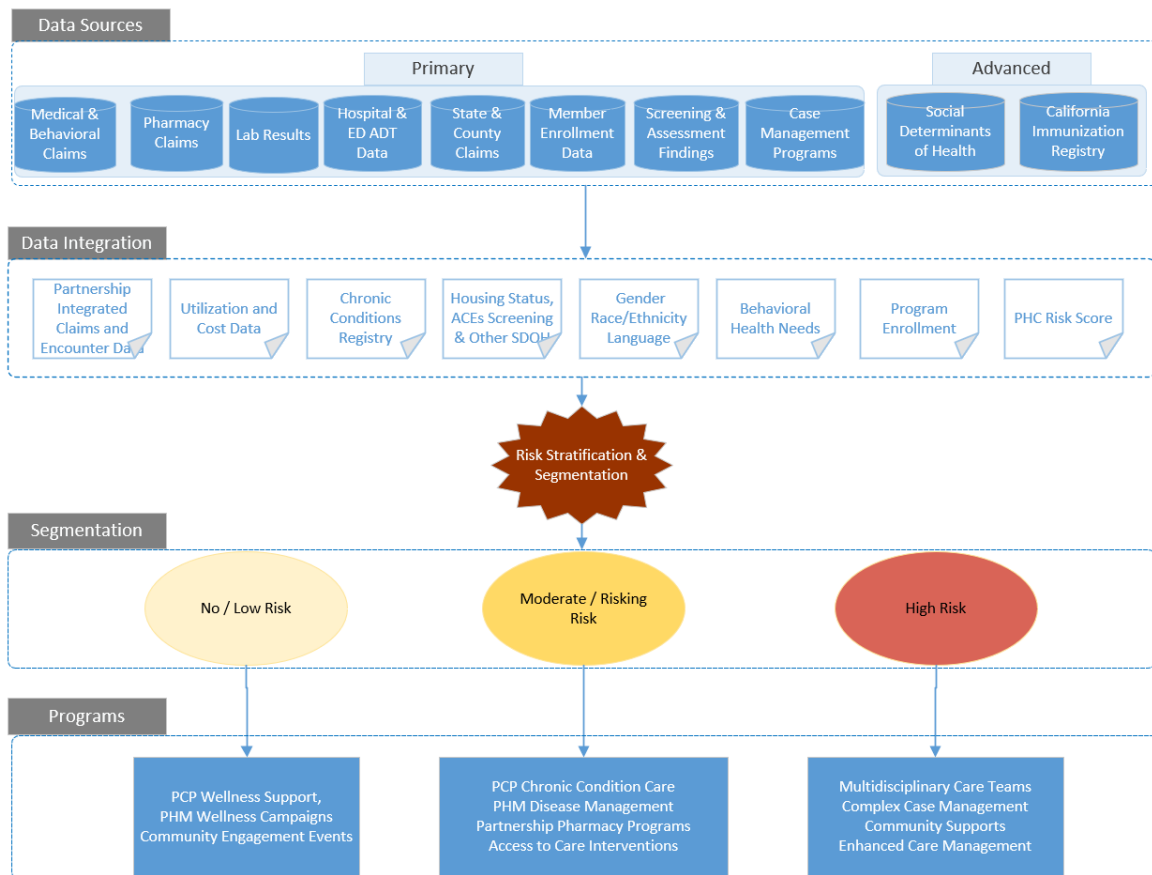
may benefit from intervention regardless of risk score. Partnership recognizes that cost and utilization data is insufficient to identify the needs of all racial, language, and gender groups. Therefore, Partnership mitigates the impact of racial bias that could result from risk stratification based solely 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

After the release of the DHCS PHM Service's RSST methodologies, [through the Medi-Cal Connect platform \(estimated late 2025\)](#), 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 [cullfind](#) 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 potentially changes a member's needs.

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 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 ~~and communities we serve.~~ 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 PHM policy guide, Partnership's BPHM is for all members. BPHM includes services such as having ensuring members have an ongoing source of care, Care Coordination, and care coordination, navigation and referrals across health and social services, sharing resources ~~and,~~ providing education to improve the health of members ~~and to access resources and/or services available to members, Community Health Worker services, and more.~~³

~~Each~~ 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~~ ensures members are engaged with their assigned PCP, and receive all needed preventive services. Member utilization reports are reviewed to identify members ~~not using primary care. At minimum, reports are~~ 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. Strategies are then developed to address differences in utilization to promote health equity for all members as needed.

³ 2024 Contract, Exhibit A, Attachment III, section 4.3.8

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 ~~needed~~the services needed including but not limited to:

- Care coordination
- Navigation and referrals to services that address a ~~members'~~member's developmental, physical, mental health, substance use disorder, dementia, long-term services and supports, palliative care, and oral health needs
- ~~Help~~Assist with making appointments
- ~~Help~~Assist with arranging non emergency or medically appropriate transportation
- Health education on the importance of Primary Care when disengaged with their ~~Primary Care Provider~~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, delivery systems, and programs (e.g., Targeted Case Management, Specialty Mental Health Services), with external entities outside of ~~Contractor's Network~~Partnership's network, and with Community Supports and other community-based resources, even if they are not Covered Services. Referrals are coordinated to ensure Care Coordination with public benefits programs. Members, and 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 provided to a member is communicated to the members' parents, family members, legal guardians, ARs, caregivers, or authorized support persons as appropriate. Partnership maintains processes to ensure there is no duplication of services.

Members are further provided with resources and education about how to access the various programs and services offered by organizations Partnership has established relationships with or by agencies and third-party entities with whom Partnership has or will have an executed ~~MOU~~Memorandum of Understanding (MOU). Members are also provided with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes. All services are delivered in a culturally and linguistically competent manner that promotes 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 Programs

In alignment with the DHCS 2024 contract and 2024 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 ~~access to~~ culturally and linguistically appropriate health education materials available to them.

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 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
- ~~Programs aimed at helping Members set and achieve wellness goals.~~

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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 Strategy. Please see the Health Education section for additional programs.

On an annual basis, Partnership's DHCS PHMSD reports how community-specific information and stakeholder input from the CHA/CHIP collaborations are used to design

~~and implement evidence-based~~inform wellness and prevention strategies- and other Partnership programs, as applicable. Findings from the NCQA Population Needs Assessment ~~are 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 ~~area~~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 and its~~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 ~~Review~~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 ~~member's~~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 ~~Case~~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
<i>No/Low Risk:</i> Pregnant members with no complications;	<i>Keeping Members Healthy</i> 1) <i>Healthy Babies Growing Together</i>	<i>Member Needs:</i> To understand benefits and how to access them; universal prenatal care and perinatal case management; identify and access

DHCS Risk Segment	NCQA Program/Services	Organizational Support
Members with no known risk of disease or for whom we have no claims data; focus on supporting wellness.	2) Healthy Kids Growing Together 3) Health Care Transitions 4) Medi-Cal for Kids and Teens (EPSDT) Awareness campaign 5) Routine Member Newsletters 6) Community Resource Connections 7) Mobile Mammography Clinics 8) School-Based Vaccination Education & Clinics 9) Community Outreach / Engagement Events 10) Health Equity Community Outreach Events	providers for primary care; help with prescriptions or DME; access to non-Partnership services (Denti-Cal, In Home Support Services, etc.). <i>Population Health Interventions:</i> 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; promote local community resources on Partnership's external website. <i>Health Education Interventions:</i> 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. <i>Member Services Interventions:</i> Explain benefits and how they may be accessed; connect members to providers. <i>Quality Interventions:</i> 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 engaged and receive services; share

DHCS Risk Segment	NCQA Program/Services	Organizational Support
		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).
<i>Moderate / Rising Risk</i> 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.	<i>Managing Members with Emerging Risk</i> 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	<i>Member Needs:</i> 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. <i>Population Health Interventions:</i> 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 clinics. <i>Care Coordination Interventions:</i> 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,

DHCS Risk Segment	NCQA Program/Services	Organizational Support
		who need basic case management support. <i>Grievance Interventions:</i> 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. <i>Health Education Interventions:</i> 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. <i>Quality Interventions:</i> Develop reports that identify members with chronic conditions showing gaps in HEDIS measures specific to monitoring chronic disease management. Member Services 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 (POC) devices to address or diagnosis chronic disease earlier.

DHCS Risk Segment	NCQA Program/Services	Organizational Support
<i>Transitional Care Services:</i> Members going through transitions in their care.	<i>Outcomes Across Settings</i> 1) <i>Transitional Care Services</i>	<i>Member Needs:</i> Assistance with transitions between settings, such as acute care to home or skilled nursing facility to home. <i>Member Services Interventions:</i> Support members who contact Partnership post hospital discharge who may need to establish care with a PCP. If necessary, refers members to Care Coordination to assess the needs of the member and whether a primary care assignment is appropriate. <i>Utilization Management Interventions:</i> 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. <i>Care Coordination Interventions:</i> 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 care; and provide medication reconciliation.

DHCS Risk Segment	NCQA Program/Services	Organizational Support
<i>High Risk:</i> Members with 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.	<i>Managing Members with Multiple Chronic Conditions</i> 1) <i>Complex Case Management</i> 2) <i>High Risk Pregnancies</i>	<i>Member Needs:</i> 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. <i>Care Coordination Interventions:</i> 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 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/materials as needed to help members improve their health. The Health Education Team promotes a variety of strategies and methods to deliver ~~evidence-based~~ 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; ~~and~~ 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. Select written Health Education 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 ~~and~~, social media, and through targeted outreach.

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, 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. Programs can include: smoking and tobacco cessation; managing stress; injury prevention; ~~prevention of sexually transmitted diseases~~ 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 ~~obesity~~, 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).⁴

Material Development

In collaboration with Population Health, Care Coordination, Communications, Pharmacy, Quality Improvement, and other 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 assesses member health care needs and barriers to care by consulting regularly with the ConsumerCommunity Advisory Committee (CAC), the Family 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.

~~The~~In alignment with APL 18-016,⁵ 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 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

⁴ [Section 1557, HHS, 2020](#)

⁵ [APL 18-016](#)

audience with special attention to concept, density, tone, key messages, including format, page design and graphics, and that documents are up-to-date. HealthMember facing materials (which includes health education materials) are made available in Partnership's threshold languages, large font, ~~and~~ 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 large font or audio are also available upon request (see MNCD9002 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. The qualified Senior Health Educator will provide oversight of the field-testing of all materials. 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 member, and/or review during ConsumerCommunity Advisory Committee and Family Advisory Committee meetings. The health education 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 website requirements). They are approved when:
 - A majority of the Readability and Suitability Checklist provisions are met.
 - 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 health educator/health education specialist 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 health educator" 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 16-005,⁶ Non-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 healthy 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 ~~that~~ 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
- Non-monetary member incentives ~~that~~ 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 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.

⁶ APL 16-005 Requirements for Use of Non-Monetary Member Incentives for Incentive Programs, Focus Groups, And Member 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 [identification process assessment](#) of any needs for preventive screens or services, referrals to health education where appropriate, [physical examination 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).

Members can also identify their own needs for health education. Partnership makes educational materials, resource information, and other tools (such as training, and programs) available to help network providers provide health education services. 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)
- 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

- Injury Prevention
- Weight Management & Exercise

Practitioner Education and Training

Partnership's Health Education team supports network providers through trainings on the unique cultural needs of Partnership's member populations. The PNA and CHA/CHIP collaborative serves as guidance for provider trainings highlighting Partnership members' beliefs about illness and health, their cultural health behaviors, and their preferences for interacting with providers and the health care system. The trainings are designed to support network providers and their staff in providing effective health education in a manner that respects the cultural and linguistic diversity of patients and promotes health equity.

Starting in 2025, Partnership will offer trainings to providers in its network on topics of health equity, including cultural competency, bias, diversity or inclusion training. Some of the trainings will include information about relevant health inequities and identified cultural groups in the Partnership's service area. Topics may include, but are not limited to: seniors and persons with disabilities awareness and sensitivity, preventive health care for children, alcohol misuse screening and counseling, and other concerns as appropriate for the population. Other trainings may also include PHM program requirements, including referrals, health education resources, and provider and member incentive programs. Trainings may be delivered in person, virtually, and made available on the external website. 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. Partnership staff will receive the staff-specific DEI training on an annual basis. For more information on these trainings, please see MCND9002 Cultural and Linguistic Program Description and the forthcoming policy on Diversity, Equity, and Inclusion Training Program Requirements for External Practitioners.

Health Education Interventions

The CHA/CHIP efforts, PNA, and other regulatory requirements serve as vehicles for the basis of setting the Health Education Program goals, which are documented in the Quality Improvement and Health Equity Transformation Program (QHETP)/Cultural & Linguistic (C&L) Work Plan as appropriate activities. The annual QHETP/C&L Work Plan and C&L Evaluation report describes the methodology for evaluating intervention outcomes to ensure Partnership is effective in delivering high-quality health education and culturally and linguistically appropriate interventions for our members to promote

~~health equity and reduce disparities. The written~~ PNA ~~findings~~ and conclusions drawn from CHA/CHIP efforts ~~are used to~~ evaluate and make recommendations for appropriate allocation of health education resources ~~based on needs assessment findings~~, provider ~~training result~~ ~~trainings~~, Partnership staff ~~training results, trainings, and~~ intervention evaluation ~~results, and other data efforts~~. The departments responsible for ~~each~~ specific ~~intervention~~ ~~interventions~~ monitor their outcomes 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
<i>Partnership Provider Population Reports</i>	An automated list of members with missing services supplied to providers that are specific to low-performing HEDIS measures and immunization status updates. 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.
<i>Outreach/ Scheduling Calls</i>	Based on the list of care gaps provided by Partnership, provider offices call members to remind them about scheduling needed services.
<i>Scheduling Block</i>	Clinic days at provider sites or health centers where blocks of appointment time are scheduled for Partnership members to receive missing services. Incentives are provided to add operational days / hours to expand access to members.
<i>Poster Campaign, School Engagement</i>	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.

Initiative Type	Definition
<i>Provider Newsletters</i>	Monthly Medical Director Newsletter to Primary Clinician Leaders, as well as a quarterly publication by the Provider Relations Department (Provider Newsletter) with dedicated space for Quality Improvement and Member Engagement articles for providers to consider applying to their patients.
<i>Provider Education</i>	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.
<i>Provider Fax Blast (email or fax)</i>	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).
<i>Partnership Website</i>	Changing banners to communicate health information to providers, community-based organizations, as well as to members.
<i>Point of Service Interaction</i>	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.
<i>Media Campaign</i>	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 telephonically through Partnership's Care Coordination, Population Health, and Member Services departments. 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.

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 ~~new~~ 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 [fivesix](#) 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) came together to respond to 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. 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 [effortefforts](#), any department planning or implementing programs affecting our members has ~~read-only access to Essette, Partnership's case-management software system. A move to a new system is planned after mid-2024. Member-facing campaigns are logged~~[the ability to log their member-](#)

member-facing campaign in the Population Health Campaign Tracker ~~and shared with the entire~~ within Partnership's internal SharePoint sites. This campaign tracker is a central location for anyone in the organization, ~~ensuring to ensure~~ staff are aware of current interventions. ~~Monthly~~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. 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 ~~effort~~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 CaseCare 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, along with the cloud-based Collective MedicalPointClickCare

Platform to facilitate real-time data sharing between Partnership and ECM or other community providers of services (see Partnership Policy MCCP2032). 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~~[DHCS'](#) 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 [CaseCare](#) 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 Member.](#)

Partnership also 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 [including](#):
 - ~~California Children's Services (CCS);~~
 - ~~Maternal and Child and Adolescent Health; and~~
 - ~~Tuberculosis Direct Observed Therapy;~~
- 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 ~~around~~ Substance Use Disorder Treatment for Specialty Mental Health Services in Medi-Cal Mental Health Plans and SUD Services in Drug Medi-Cal State Plan Organized Delivery System (ODS) Counties

Other MOUs with the following organizations ~~will be~~ became effective ~~on~~ January 1, 2025:

- ~~HCBS Waiver Agencies~~ LGA/California Department of Corrections and Programs
- ~~LGA/Rehabilitation, County Jails, Juvenile Facilities and Probation Departments~~ Youth
- ~~Continuum of Care~~
- First 5 Programs
- ~~Area Agencies on Aging~~
- ~~California Caregiver Resource Centers~~
- Local Education Agencies (LEAs)
- ~~Indian Health Services/Tribal Entities~~

By ~~January 1, mid-~~2025, Partnership ~~must~~ will also ~~have a process~~ work to implement DHCS guidance regarding Closed Loop Referrals to applicable ~~Community Supports, ECM benefits~~ services, and ~~or community-based resources~~ in certain MOUs, as needed. Partnership ~~must~~ also ~~work~~ 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.

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 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 ~~cost of services and programs~~, utilization results in aggregate and by subpopulation, and data supporting the tracking measures identified in specific initiatives. Data gathered to perform this analysis ~~includes~~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 ConsumerCommunity 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 ~~is meeting~~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 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 evaluates reviews the impact of PHM's programs, identifies opportunities for improvement, and selects 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.

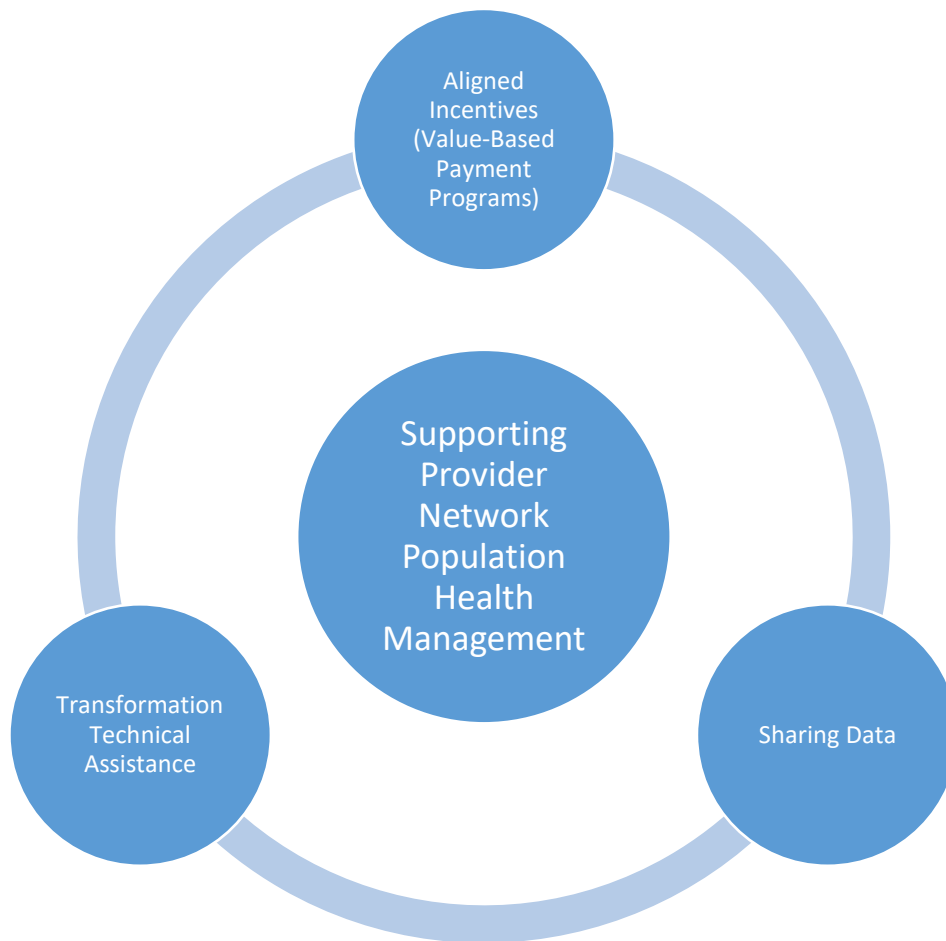
Value-Based Payment Programs

Partnership has a number of value-based payment programs through which contracted provider organizations can qualify for a financial bonus incentives for quality-related performance. There are separate incentive programs for primary care providers, hospitals, pharmacies, perinatal providers, behavioral health, palliative care, and other specialty ECM providers, and other. 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 [ana publicly available](#), annual data report with County Public Health Departments in alignment with DHCS' PHM requirements.⁷

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

⁷ [DHCS Population Health Management Policy Guide, 2024](#)

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 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).

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:

<i>Measure-Specific Data</i>	PQD tracks provider performance on all Primary Care Provider Quality Improvement Program and HEDIS measures relevant to targets.
<i>Trended Data</i>	Providers can track their performance on the measures throughout the measurement periods (i.e. monthly rates).
<i>Comparative Data</i>	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 displaysdisplay 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., 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 Academy offerings include the ABCs of QI (QI basic methodology for the model for improvement) 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 ~~delegates activities for both~~ may delegate Population Health, Health Education, and Cultural and Linguistics functions. A Prior to assigning delegated responsibility, Partnership ensures the entity's capacity to perform. Once confirmed, the parties enter into a formal agreement ~~is maintained and~~ inclusive of all delegated ~~functions-responsibilities~~. Partnership conducts an audit of all delegated entities no less than annually to ensure the appropriate that the delegate is performing consistent the delegation agreement, applicable Partnership policies and procedures are in place, 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, identifying/partnering with other departments to identify the health disparities and wellness needs of Partnership's members, implement DHCS' 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 Health Services~~Medical Officer:

~~Provides overall direction to the Health Services (HS) Care Coordination/Population Health/Utilization Management Leadership Team. This position~~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 Health Equity (Health Equity Officer)

~~In collaboration with other Partnership leaders, develops and drives forward the key strategies helping Partnership be a diverse, equitable, and inclusive organization. Works to raise awareness of health inequities within Partnership's staff, providers, and membership, and creates concrete plans for addressing them. Works closely with the Senior Director of Health Services, Quality, Human Resources, Provider Relations and Population Health departments toward shared goals, and with other internal and external Partnership stakeholders to ensure high standards of equitability.~~

Director of Population Health

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.

Manager of Population Health

~~The Manager of Population Health gives~~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 supervisors, 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.

Supports 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.

Community Health Needs Liaison

Supports the coordination and implementation of Partnership's Population Needs Assessment (CHA/CHIP) activities through active and meaningful engagement in identified community ~~workgroup~~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. ~~Makes these resources available on Partnership's external website, and shares with appropriate stakeholders as needed. Supports the development of the DHCS annual PHMSD and the NCQA annual Population Needs Assessment report.~~

Senior Health Educator

A masters-prepared (or MCHES-certified) professional who ensures the delivery of health education resources for both members and primary care providers. ~~Supports the creation of trainings for contracted providers and internal Partnership staff to promote cultural competency, health equity, and member wellness. Assists with preparation and implementation of the PNA. 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 the Health Education ~~Program. Assesses~~Programs, including the health education needscreation of internal staff, leadshealth education materials and sessions/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, ~~and evaluates member discrimination grievances.~~ Serves as a resource to internal staff and providers to ensure compliance with state requirements for educational member materials.

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.
~~Engages Partnership members to identify barriers to care, member concerns, and resources needed.~~ Leads Lead member wellness campaigns and support support members using Partnership's Healthy Living Tools. Participates in health fairs and other activities where Partnership members congregate; shares learning 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 (e.g., pregnant members, members impacted by natural disasters, etc.) 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 database/tracking case management system, per prescribed protocols. When applicable, refers members to culturally and linguistically appropriate community services, and DHCS-approved health education materials.

Project Manager

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.

Project Coordinator

Oversees timelines and deliverables for department projects. 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, meeting minutes, and the file retrieval system.

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.

Note: Staffing and staff job descriptions are subject to change based upon program needs and organizational growth.

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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

	06/18/2025

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

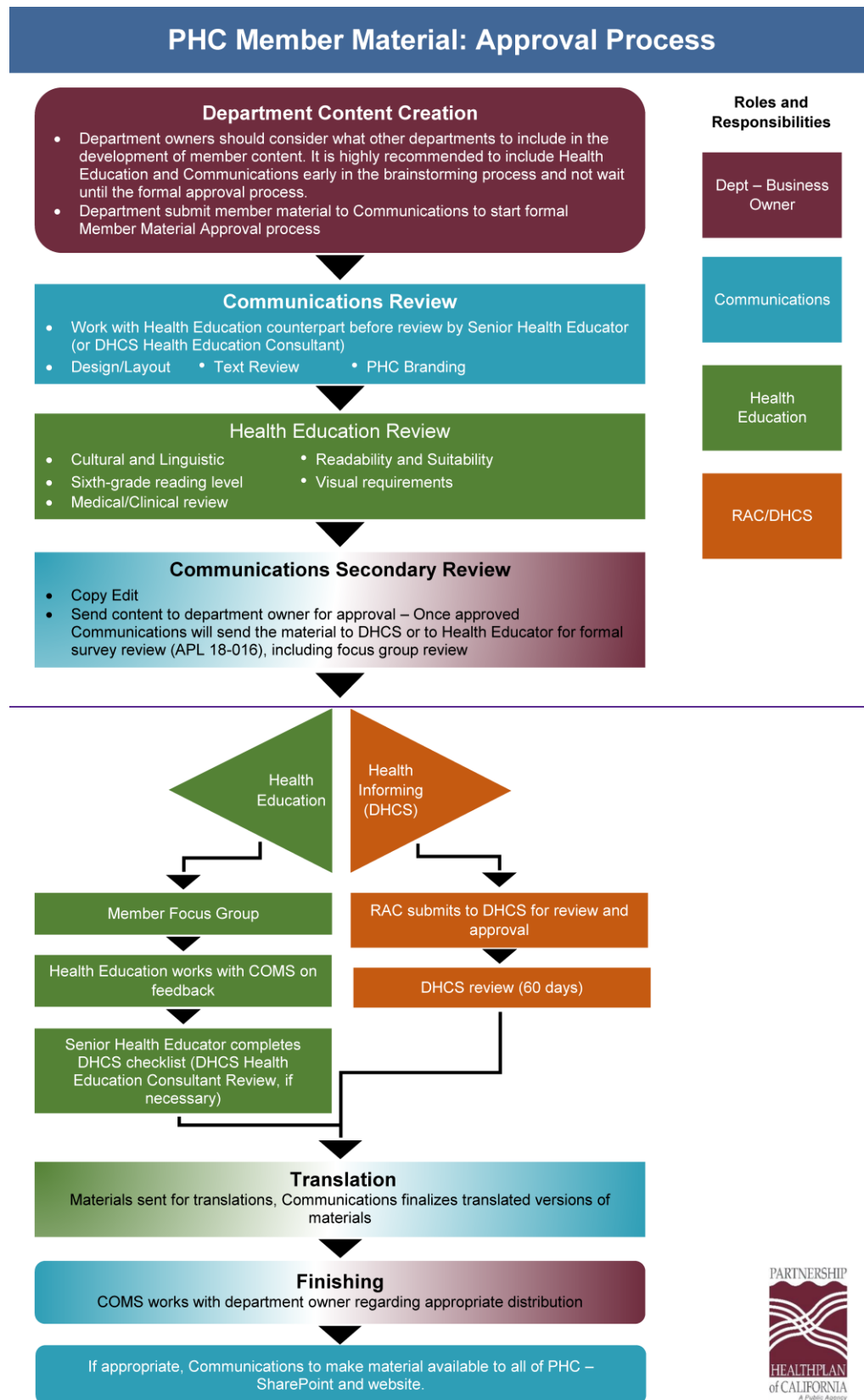
	08/13/2025

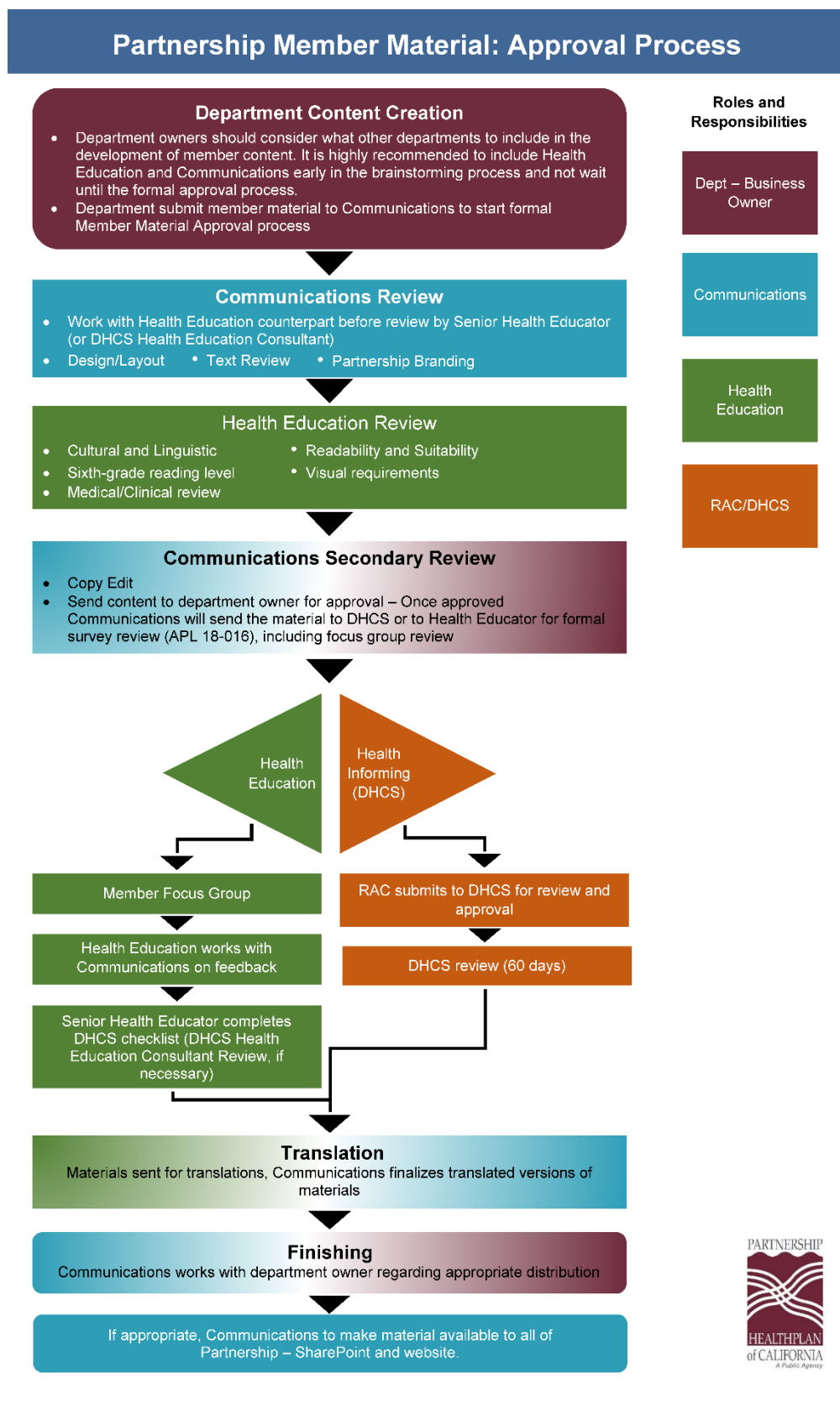
Angela Brennan, DO
Physician Advisory Committee Chairperson
Date Approved

	08/27/2025

Kim Tangermann
Board of Commissioners Chairperson
Date Approved

Appendix A





PARTNERSHIP



HEALTHPLAN
of CALIFORNIA
A Public Agency

Population Health Management Strategy & Program Description

MPND9001
(previously MCND9001, MCCD2027)

June 2025

Original Date: 11/13/2019 11/13/2019 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 8/13/2025

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

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.

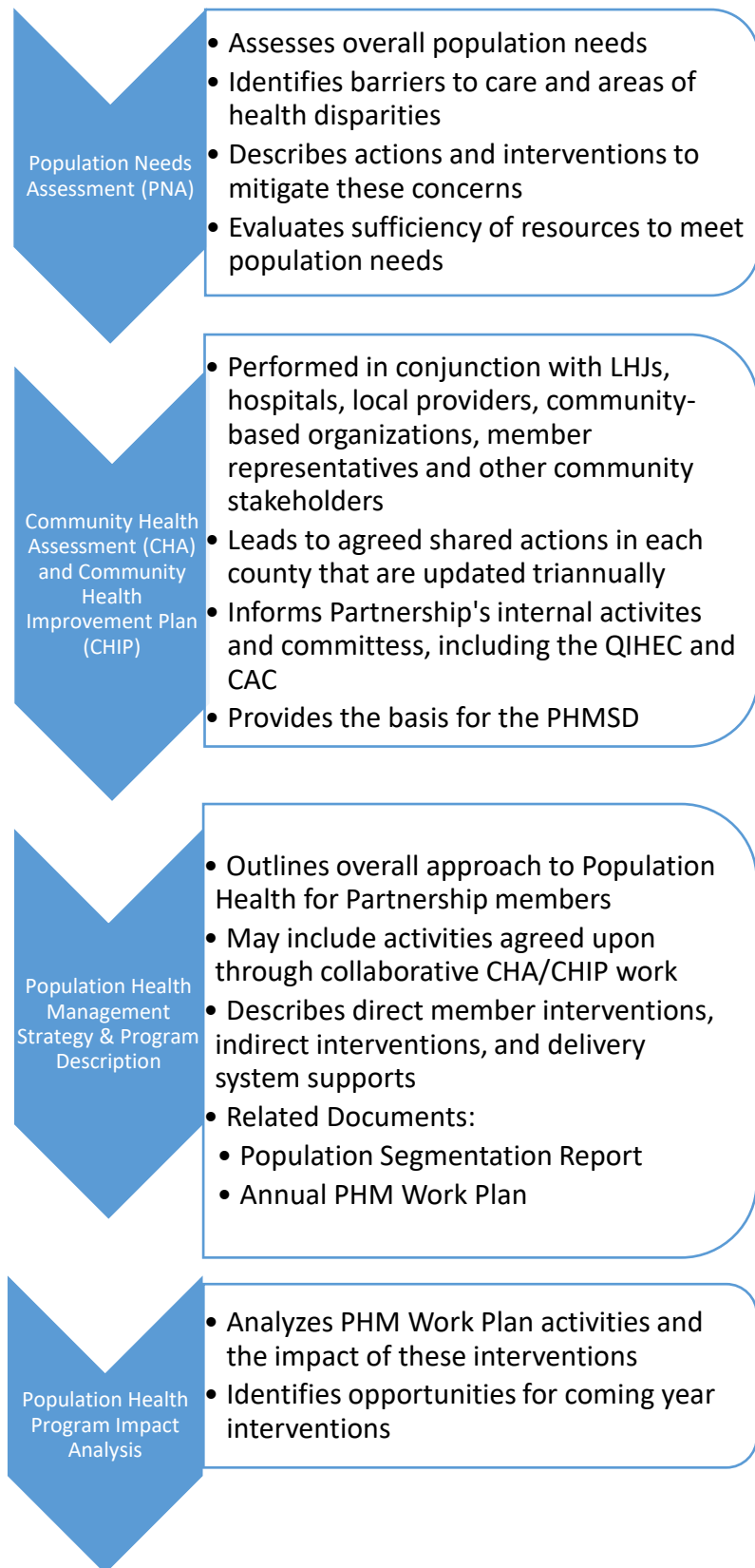
As part of NCQA requirements, Partnership performs an annual Population Needs Assessment (PNA), which identifies factors leading to health disparities for Partnership subpopulations. In addition, as part of DHCS' updated PNA requirement, Partnership collaborates with Local Health Jurisdictions (LHJs), 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 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 in support of the population. The PNA and county CHA/CHIP findings inform Partnership's overall PHM strategies 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 which are used to complete the annual DHCS PHM Strategy Deliverable (PHMSD), 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 (MCND9001) as appropriate. An impact analysis of the previous year's activities is also drafted.

The PHM Strategy & Program Description (MCND9001) provides a high-level overview of Partnership's approach to improving the health and wellbeing of the population we serve. The 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. The PHM Impact Analysis report evaluates 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". The following diagram shows the relationship of these activities:



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, 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 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, health inequities, social and structural barriers to care, and more. The PNA proposes actions to address identified disparities and promote 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 MCND9002 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. The NCQA PNA and its proposed actions also undergo review by Partnership's PNA Committee, the QIHEC, Internal Quality

Improvement Committee, Quality/Utilization Advisory Committee, Physician Advisory Committee, 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.

In addition to the annual PNA, and in alignment with DCHS's Population Health Management Policy Guide¹ and 2024 Contract, Partnership works collaboratively with LHJs, hospitals, community providers, other payers, community-based organizations, member representatives, and other community stakeholders on each county's CHA and CHIP process. This collaborative work has replaced DHCS's historically mandated PNA. 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. The PNA committee, CAC, and QIHEC receive regular updates on the CHA/CHIP collaborative work 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, each county has its own schedule for CHA/CHIP work; Partnership will align its reporting with each county as needed until timelines are standardized in 2028. The shared action plans and findings from county collaborations lead to the development of Partnership's annual PHM Strategy Deliverable (PHMSD) that demonstrates commitment to the implementation of prioritized actions and responses to community needs. The PHMSD is submitted to DHCS annually, along with an NCQA-approved version of this document (MCND9001) and the annual NCQA-approved PNA. An overview of the PHMSD is shared with Partnership committees as needed.

Findings from these collaboratives are 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 on how to use findings from the CHAs/CHIP

¹ [2024 PHM Policy Guide](#)

collaborative work. The CAC is a committee that acts as a liaison between Partnership and its members (see MCND9002 for more information). As appropriate, feedback may be used to influence:

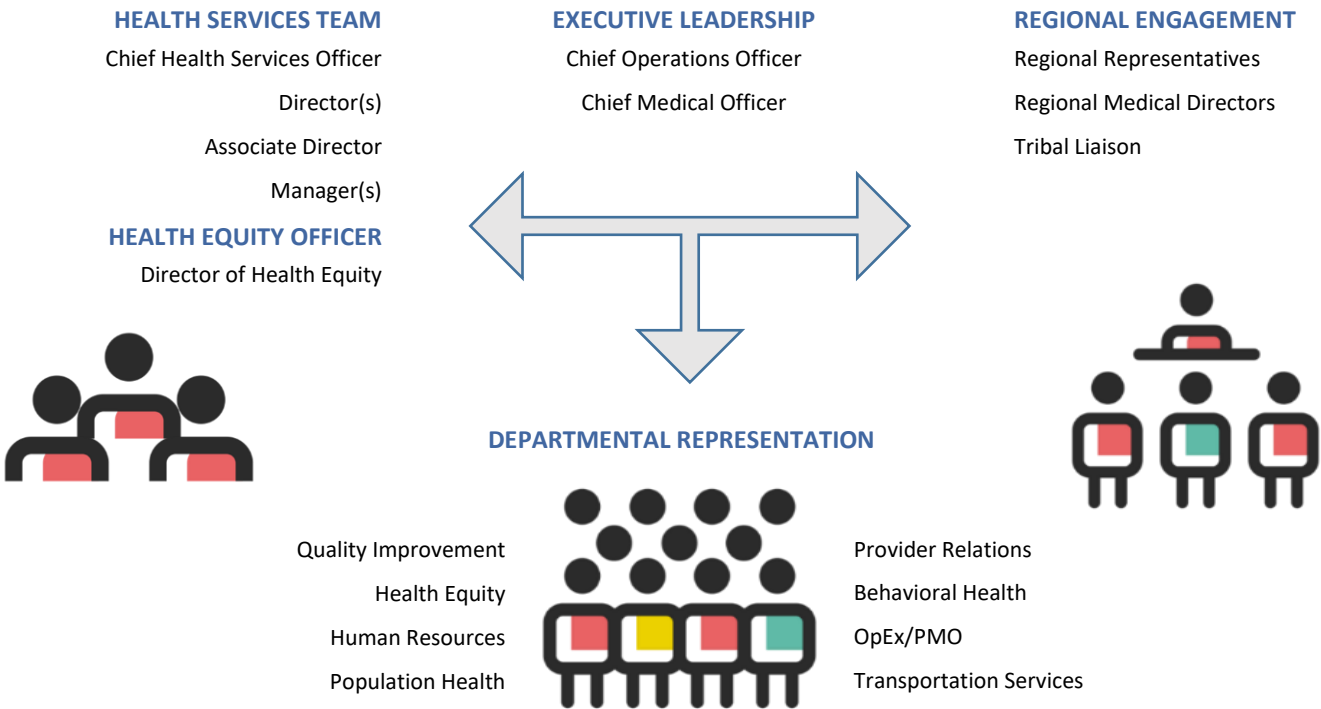
- Partnership's strategies and workstreams related to the Bold Goals defined in the PHM policy guide,
- wellness and prevention
- health equity needs
- health education needs, and
- cultural and linguistic needs

Partnership also publishes the CHAs/CHIPs of all LHJ's in its Service Area on Partnership's website, along with a description of Partnership's collaboration on the report.

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 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 Meetings 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 between Partnership and each of the LHJs in Partnerships 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).

Population Needs Assessment Committee



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 with the 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 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 or serious emotional disturbance (SMI/SED) receive 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: Medi-Cal Managed Care Health Plan Responsibilities For Non-Specialty Mental Health Services](#)²).

In July 2020, Partnership began administering 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. 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, 2027, 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

² [All Plan Letter 22-006: Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services](#)

covered service in Partnership Advantage provided by Opioid Treatment Programs (OTPs).

In addition, Partnership's disease registry flags members with SMI/SED 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 leverages this data to ensure members with SMI/SED 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 in the Population Segmentation Report. Partnership also assesses and reassesses member risk scores on a monthly basis. Once DHCS has launched the PHM Service and associated Risk Stratification and Segmentation methodology, Partnership will incorporate those data 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.

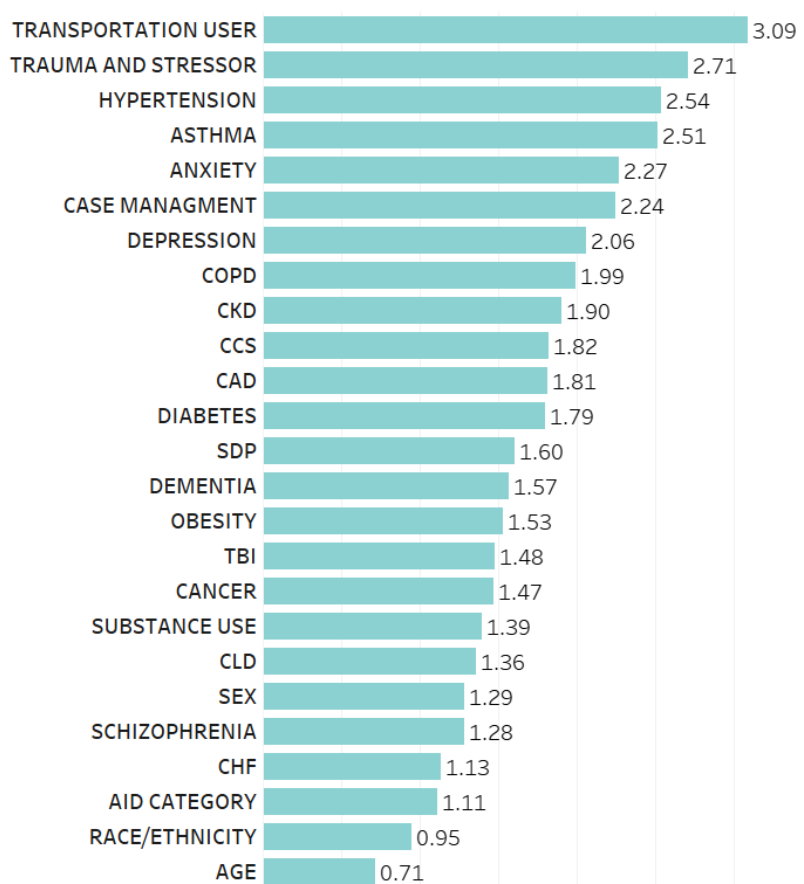
Partnership's Risk Stratification Process

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: (a) five or more ED visits, (b) one or more acute hospital admission, (c) fifteen or more distinct drug prescriptions, or (d) total 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 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 on members having gaps in care, and this information is shared with providers to help members obtain preventive and chronic care.

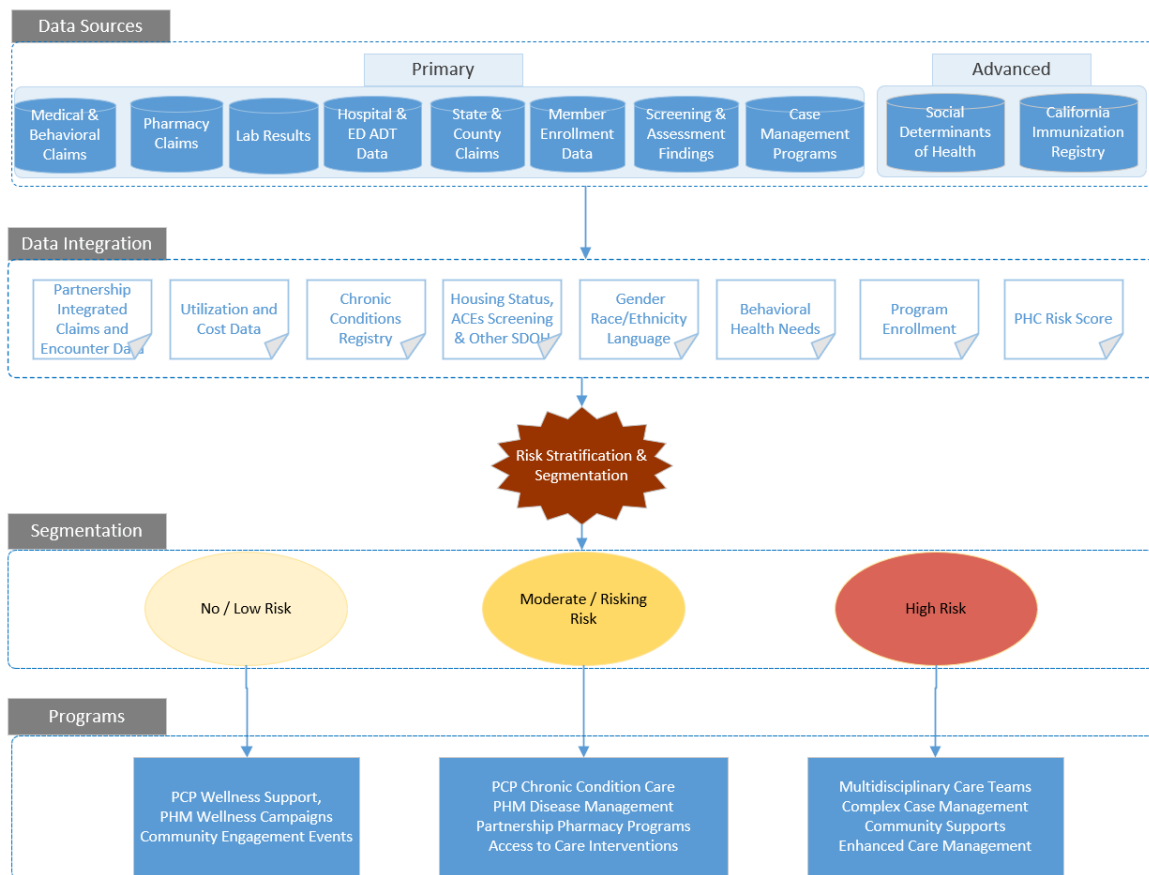
Partnership's Population Health team has various member-facing campaigns that are designed to positively impact various HEDIS measures. The care gaps report allows the team to be better informed on where focuses for campaigns should be.

Partnership's PNA and the Annual Reducing Health Disparities report describes how Partnership analyzes 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

Future Risk Stratification and Segmentation and Risk Tiering

After the release of the DHCS PHM Service's RSST methodologies through the Medi-Cal Connect platform (estimated late 2025), 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 potentially changes a member's needs.

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 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 PHM policy guide, Partnership's BPHM is for all members. 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, and more.³

³ 2024 Contract, Exhibit A, Attachment III, section 4.3.8

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 ensures 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. Strategies are then developed to address differences in utilization to promote health equity for all members as needed.

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 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, delivery systems, and programs (e.g., Targeted Case Management, Specialty Mental Health Services), with external entities outside of Partnership's network, and with Community Supports and other community-based resources, even if they are not Covered Services. Referrals are coordinated to ensure Care Coordination with public benefits programs. Members, and 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 provided to a member is communicated to the members' parents, family members, legal guardians, ARs, caregivers, or authorized support persons as appropriate. Partnership maintains processes to ensure there is no duplication of services.

Members are further provided with resources and education about how to access the various programs and services offered by organizations Partnership has established relationships with or by agencies and third-party entities with whom Partnership has or will have an executed Memorandum of Understanding (MOU). Members are also provided with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes. All services are delivered in a culturally and linguistically competent manner that promotes 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 Programs

In alignment with the DHCS 2024 contract and 2024 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 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 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

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 Strategy. Please see the Health Education section for additional programs.

On an annual basis, Partnership's DHCS PHMSD reports 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 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
<i>No/Low Risk:</i> Pregnant members with no complications; Members with no known risk of disease or for whom we have no claims data; focus on supporting wellness.	<i>Keeping Members Healthy</i> 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 6) Community Resource Connections 7) Mobile Mammography Clinics 8) School-Based Vaccination Education & Clinics 9) Community Outreach / Engagement Events 10) Health Equity Community Outreach Events	<i>Member Needs:</i> 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.). <i>Population Health Interventions:</i> 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; promote local community resources on Partnership's external website. <i>Health Education Interventions:</i> 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. <i>Member Services Interventions:</i> Explain benefits and how they may be accessed; connect members to providers. <i>Quality Interventions:</i> Provide HEDIS-based gap reports to providers, showing which members are missing well care visits, timely immunizations, and cancer

DHCS Risk Segment	NCQA Program/Services	Organizational Support
		prevention screenings; 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 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).
<i>Moderate / Rising Risk</i> 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.	<i>Managing Members with Emerging Risk</i> 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	<i>Member Needs:</i> 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. <i>Population Health Interventions:</i> 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 clinics. <i>Care Coordination Interventions:</i> Outreach to CCS members who have not had an annual well-child visit to

DHCS Risk Segment	NCQA Program/Services	Organizational Support
	7) BPHM Depression Management Program	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. <i>Grievance Interventions:</i> 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. <i>Health Education Interventions:</i> 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. <i>Quality Interventions:</i> Develop reports that identify members with chronic conditions showing gaps in HEDIS measures specific to monitoring chronic disease management. Member Services 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

DHCS Risk Segment	NCQA Program/Services	Organizational Support
		Care (POC) devices to address or diagnosis chronic disease earlier.
<i>Transitional Care Services:</i> Members going through transitions in their care.	<i>Outcomes Across Settings</i> 1) <i>Transitional Care Services</i>	<i>Member Needs:</i> Assistance with transitions between settings, such as acute care to home or skilled nursing facility to home. <i>Member Services Interventions:</i> Support members who contact Partnership post hospital discharge who may need to establish care with a PCP. If necessary, refers members to Care Coordination to assess the needs of the member and whether a primary care assignment is appropriate. <i>Utilization Management Interventions:</i> 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. <i>Care Coordination Interventions:</i> 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 care; and provide medication reconciliation.

DHCS Risk Segment	NCQA Program/Services	Organizational Support
<i>High Risk:</i> Members with 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.	<i>Managing Members with Multiple Chronic Conditions</i> 1) <i>Complex Case Management</i> 2) <i>High Risk Pregnancies</i>	<i>Member Needs:</i> 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. <i>Care Coordination Interventions:</i> 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 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/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. Select written Health Education 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.

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, 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. 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).⁴

Material Development

In collaboration with Population Health, Care Coordination, Communications, Pharmacy, Quality Improvement, and other 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 assesses member health care needs and barriers to care by consulting regularly with the Community Advisory Committee (CAC), the Family 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 18-016,⁵ 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 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

⁴ [Section 1557, HHS, 2020](#)

⁵ [APL 18-016](#)

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 large font or audio are also available upon request (see MNCD9002 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. The qualified Senior Health Educator will provide oversight of the field-testing of all materials. 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 member, and/or review during Community Advisory Committee and Family Advisory Committee meetings. The health education 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.
 - 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 health educator/health education specialist 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 health educator" 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 16-005,⁶ Non-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 healthy 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
- 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 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.

⁶ [APL 16-005 Requirements for Use of Non-Monetary Member Incentives for Incentive Programs, Focus Groups, And Member Surveys](#)

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).

Members can also identify their own needs for health education. Partnership makes educational materials, resource information, and other tools (such as training, and programs) available to help network providers provide health education services. 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. Partnership staff will receive the staff-specific DEI training on an annual basis. For more information on these trainings, please see MCND9002 Cultural and Linguistic Program Description and the forthcoming policy on Diversity, Equity, and Inclusion Training Program Requirements for External Practitioners.

Health Education Interventions

The CHA/CHIP efforts, PNA, 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 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 specific interventions monitor their outcomes 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
<i>Partnership Provider Population Reports</i>	An automated list of members with missing services supplied to providers that are specific to low-performing HEDIS measures and immunization status updates. 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.
<i>Outreach/ Scheduling Calls</i>	Based on the list of care gaps provided by Partnership, provider offices call members to remind them about scheduling needed services.

Initiative Type	Definition
<i>Scheduling Block</i>	Clinic days at provider sites or health centers where blocks of appointment time are scheduled for Partnership members to receive missing services. Incentives are provided to add operational days / hours to expand access to members.
<i>Poster Campaign, School Engagement</i>	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.
<i>Provider Newsletters</i>	Monthly Medical Director Newsletter to Primary Clinician Leaders, as well as a quarterly publication by the Provider Relations Department (Provider Newsletter) with dedicated space for Quality Improvement and Member Engagement articles for providers to consider applying to their patients.
<i>Provider Education</i>	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.
<i>Provider Fax Blast (email or fax)</i>	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).
<i>Partnership Website</i>	Changing banners to communicate health information to providers, community-based organizations, as well as to members.
<i>Point of Service Interaction</i>	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.

Initiative Type	Definition
<i>Media Campaign</i>	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 telephonically through Partnership's Care Coordination, Population Health, and Member Services departments. 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.

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) came together to respond to 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. 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. 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, along with the cloud-based PointClickCare Platform to facilitate real-time data sharing between Partnership and ECM or other community providers of services (see Partnership Policy MCCP2032). 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' 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 Member.

Partnership also 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
- Local Education Agencies (LEAs)

By mid-2025, Partnership will also work to implement DHCS guidance regarding Closed Loop Referrals to applicable services, and in certain MOUs, as needed. 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.

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 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 ϵ , 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 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

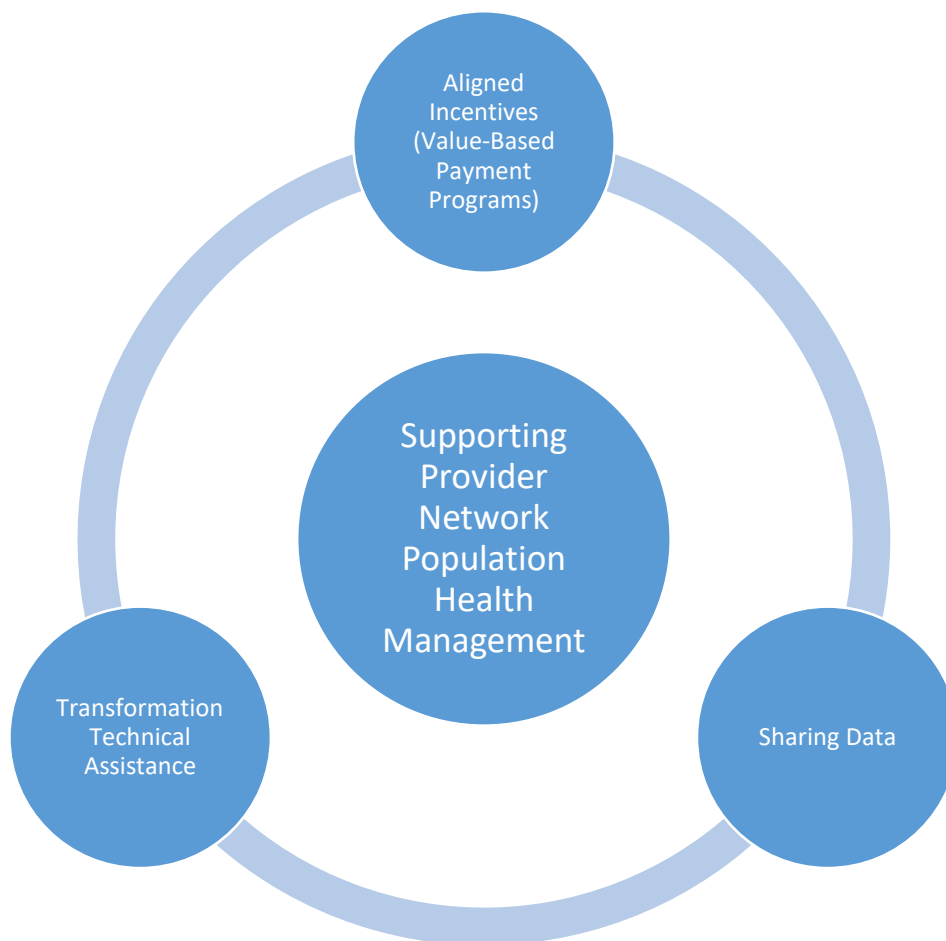
Through PHM, Partnership acts to support providers by working intentionally and collaboratively with the provider community. The Quality Improvement department outlines strategies for the coming year in the Quality Improvement Program Description (See Policy MPQD1001) and annual Work Plan, addressing how providers will be made aware of population needs, and how they will be supported in addressing them.

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 care, ECM providers, and other. 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' PHM requirements.⁷

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

⁷ [DHCS Population Health Management Policy Guide, 2024](#)

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 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).

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:

<i>Measure-Specific Data</i>	PQD tracks provider performance on all Primary Care Provider Quality Improvement Program and HEDIS measures relevant to targets.
<i>Trended Data</i>	Providers can track their performance on the measures throughout the measurement periods (i.e. monthly rates).
<i>Comparative Data</i>	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., 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 Academy offerings include the ABCs of QI (QI basic methodology for the model for improvement) 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. 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 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' 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

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.

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 supervisors, 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. Supports 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.

Community Health Needs Liaison

Supports the coordination and implementation of Partnership's Population Needs Assessment (CHA/CHIP) 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 DHCS annual PHMSD and the NCQA annual Population Needs Assessment report.

Senior Health Educator

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 the Health Education Programs, including the creation of health education materials and sessions/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. Serves as a resource to internal staff and providers to ensure compliance with state requirements for educational member materials.

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.

Project Manager

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.

Project Coordinator

Oversees timelines and deliverables for department projects. 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, meeting minutes, and the file retrieval system.

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.

Note: Staffing and staff job descriptions are subject to change based upon program needs and organizational growth.

References

DHCS APL 22-006 [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

	06/18/2025

Robert Moore, MD, MPH, MBA
Quality/Utilization Advisory Committee Chairperson

Date Approved

	08/13/2025

Angela Brennan, DO
Physician Advisory Committee Chairperson

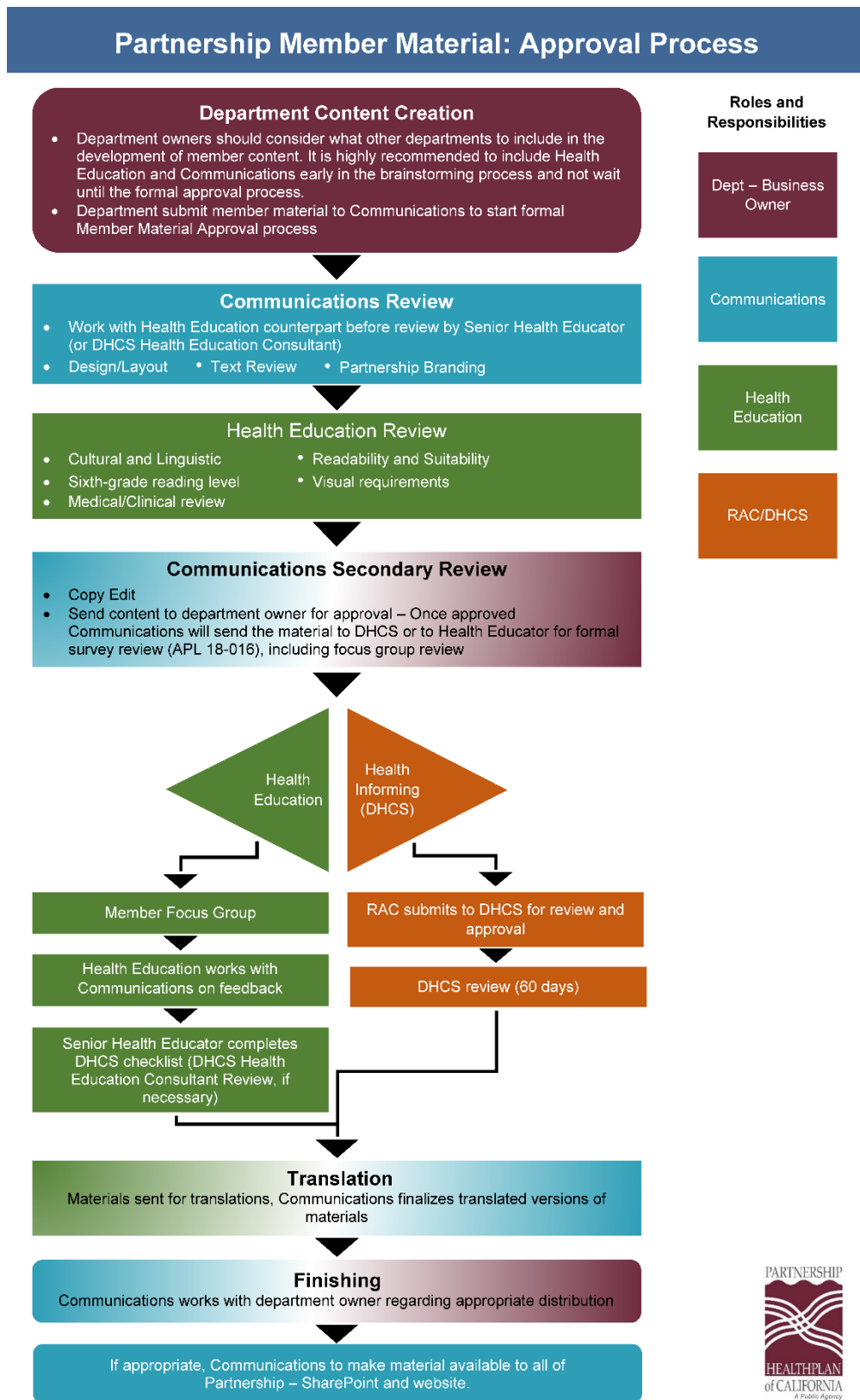
Date Approved

	08/27/2025

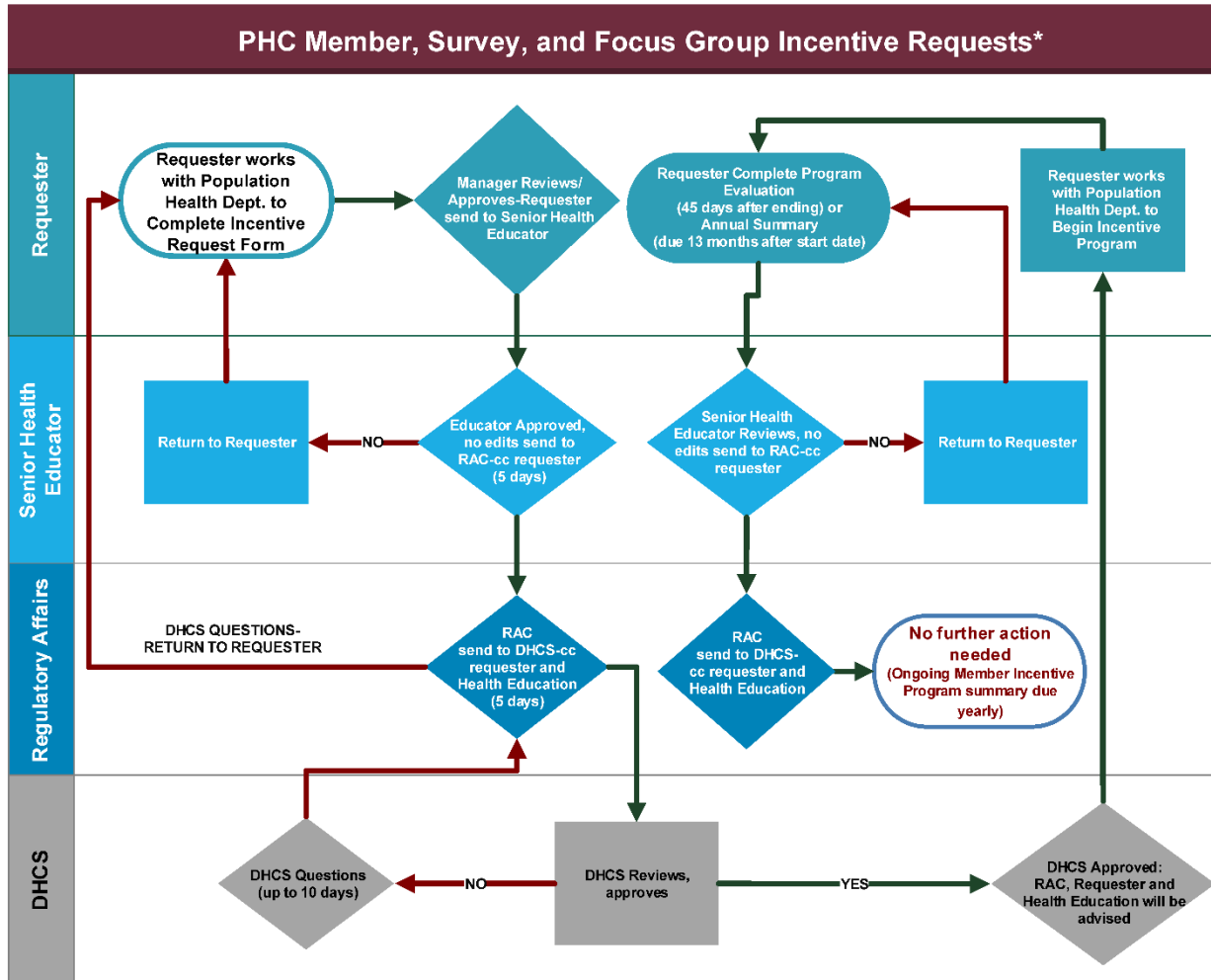
Kim Tangermann
Board of Commissioners Chairperson

Date Approved

Appendix A



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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Cultural & Linguistic Program Description

[MPND9002](#)

August 2025

Original Date: 02/19/2014

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Program Purpose

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

Introduction

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

Partnership works to ensure there is equal access to the provision of high quality interpreter and linguistic services for LEP members and potential members, and for members and potential members with disabilities, in compliance with federal and state law, and APL 25-005.² Partnership makes this commitment to the availability and accessibility of these C&L services, along with a commitment to nondiscriminatory treatment of members regardless of sex, race, color, national origin (including LEP and primary language), religion, ancestry, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or group as defined in Title VI of the Civil Rights Act of 1964³ or Section 1557 of the Affordable Care Act of 2010,⁴ the Americans with Disabilities Act of 1990,⁵ or as specified in APL 25-005. Partnership maintains, continually monitors, improves, and evaluates cultural and linguistic services that support covered services for all members, including members less than 21 years of age.

All covered services, member-facing programs, member facing (including health education) and/or outreach material are provided in a culturally and linguistically appropriate manner that promotes health equity for all members. Member facing

¹ [National Culturally and Linguistically Appropriate Services Standards](#)

² [All Plan Letter 25-005 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services](#) and [Threshold and Concentration Languages](#)

³ [Penal Code 422.56](#)

⁴ [ACA 1557](#)

⁵ [Americans with Disabilities Act of 1990](#)

materials are routinely distributed in all of Partnerships threshold languages, meet the requirements of APL 18-016 Readability and Suitability of Written Health Education Materials,⁶ and are available in accessible formats upon member request. Partnership also ensures that members receive all Member Information in a language or alternative format of their choice.

Objectives

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

- Collecting and updating data on the race/ethnicity, language, sexual orientation and gender identity of Partnership members and sharing this information with providers. This effort is part of Partnership's goal to monitor and evaluate how CLAS may impact health equity and outcomes, which can better inform service delivery. Members will be advised of the intent to share their data and will be given the right to opt out of data sharing in accordance with their privacy rights.
- Ensuring Partnership's staff, providers' and delegates' Cultural and Linguistic services comply with the Department of Health Care Services (DHCS) and Federal regulations without limitations, particularly relating to communication assistance requirements and access for members with disabilities.^{7,8,9,10,11}
- Continually assessing, monitoring, improving, and evaluating Partnership's C&L services that support covered services for members, including members under the age of 21.
- Addressing deficiencies and gaps in Partnership's C&L services.
- Communicating Partnership's C&L Services and Standards to staff, providers, delegates, and community members.

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

⁶ [APL 18-016 Readability and Suitability of Written Health Education Materials](#)

⁷ 22 CCR 53876; 21202.5; 51202.5; 51309.5(a)

⁸ 28 CCR 1300.67.04(c)(2)(A)-(B); 1300.67.04(c)(2)(G)(v)-(c)(4)

⁹ 42 CFR 438.206(c)(2); 438.10; 438.404

¹⁰ W&I Code 14029.91

¹¹ Medi-Cal Managed Care Plans, Exhibit A, Scope of Work 5.2.10

Programs and Services

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

Language Data Collection

At least every three years, DHCS gathers language information for individuals enrolled in Medi-Cal and shares this information with Managed Care Plans (MCPs) to address potential changes to threshold and concentration standard languages (see [MCND9002MPND9002](#) attachment C for threshold languages) as well as any changes in state and/or federal law. Partnership reviews overall language prevalence per state-published data every three years in order to identify emerging language patterns that may impact Partnership members or potential members. This data is also used to assess languages in a way that aligns with DHCS requirements as outlined in APL 25-005 as well as aligns with NCQA requirements for threshold languages of five (5) percent or 1,000 individuals, as well as languages spoken by one (1) percent or 200 individuals (whichever is less). According to APL 25-005 and its attachments, MCPs must provide translated written member information to specific groups in the MCP's service area as identified by DHCS in the Threshold and Concentration Language dataset.¹² Partnership also routinely collects and maintains records of member language preferences spoken by one (1) percent of the member population or less.

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

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

¹² [APL 25-005](#) and [Threshold and Concentration Languages](#)

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

Partnership distributes a written notice in English and other languages spoken by 1 percent of the members served by the organization or by 200 individuals (whichever is less), informing members that the organization provides language assistance services and how they can obtain it at no cost to the member. Non-speaking or Limited English Proficient (LEP) members can also request language and/or interpretation services, or even refuse interpreter services; this request is then documented in Partnership's member record.¹³ Partnership may use or disclose the member's preferred language with Partnership network practitioners/providers, subcontractors, or other covered entities for the purposes of ensuring communication and care delivery are in a culturally sensitive and linguistically appropriate manner. Members are informed that their language preferences may be shared when language information is directly collected.

Partnership also assesses and collects data on the cultural and linguistic needs of the member population through the written Population Needs Assessment (PNA). Each year, Partnership assesses the overall environment, specific community needs, and the factors that influence the health and well-being of the assigned member population. This information is collected from its member population data and integrated into the PNA, which helps drive the goals of Partnership's Population Health Management Strategy, the Cultural & Linguistics Program, and their associated work plans. Both of these work plans are the driving force by which Partnership responds to the cultural and linguistic diversity and needs of Partnership's member population. The report is written in accordance with the requirements of the National Committee for Quality Assurance (NCQA) Health Plan Accreditation Standards for an annual Population Needs Assessment (PNA).

Finally, in alignment with DHCS's Population Health Management Policy Guide, Partnership collects information on language needs as part of its collaboration with each Local Health Jurisdiction in its service area.¹⁴ This collaborative work is referred to as the Community Health Assessment (CHA) and Community Health Improvement Plan

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

¹⁴ [DHCS Basic Population Health Management Policy Guide](#)

(CHIP) process. Based on this collaborative work, and input from various stakeholders, including Partnership's Community Advisory Committee (CAC) (formerly known as the Consumer Advisory Committee), Partnership annually reviews, and updates as needed, its strategies and work streams related to the DHCS Bold Goals, health equity, health education materials, wellness and prevention programs, and cultural and linguistic and quality improvement strategies to address identified health and social needs in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy.¹⁵ Findings from both the PNA and CHA/CHIP work are shared with our providers and other stakeholders as needed on a regular basis.

Language Assistance Services

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

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

In alignment with APL 25-005¹⁶ and other DHCS requirements, Partnership provides nondiscrimination notices and Language Assistance Notice of Availability.

Nondiscrimination notices are provided and inform Members, Potential Members, and the public about nondiscrimination, protected characteristics, accessibility requirements, and information on how to file a grievance. A Language Assistance Notice of Availability is also provided in a visible font size in English and the top 18 non-English languages spoken by Limited English Proficient (LEP) individuals in the state; they inform members, potential members, and the public of all available language assistance services at no cost to them as well as how to access them— [\(including written translation and interpretation\)](#). [To see these two notices in detail please refer to attachment A & B in MCNP9004 Regulatory Required Notices and Notice of Availability.](#)

The Language Assistance Notice of Availability and nondiscrimination notices are provided in a font size no smaller than 12-point and are available in all Threshold

¹⁵ [DHCS Comprehensive Quality Strategy](#)

¹⁶ [APL 25-005](#)

Languages/Concentration Standard Languages and in an ADA-compliant, accessible format. Alternative formats available to members includes Braille, large-size print font that is no smaller than 20-point, accessible electronic format, or audio format, and Auxiliary Aids-at no cost to the member, and upon request. Consideration is also given for the special needs of members with disabilities or LEP members. [Although quick response codes, otherwise known as QR code may be used alongside the nondiscrimination notice and notice of availability, they are not to be replaced by the use of QR codes.](#)

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

- Partnership Member Handbook/Evidence of Coverage (EOC)
- Partnership Provider Directory
- Form letters and notices critical to obtaining services
- Notices of Action
- Notice of Appeal Resolution Letters
- Notices of Adverse Benefit Determination
- Grievance and Appeals letters
- Welcome Packets
- Marketing Information
- Preventive health reminders
- Member surveys
- Notices advising of the availability of free language assistance services
- Newsletters
- [Notices of Organization and Coverage Determinations](#)
- All member information, informational notices, and materials critical to obtaining services targeted to members, potential enrollees, applicants, and members of the public
- Other written communications and/or informational notices for members, Potential Members, and the public as applicable.

~~The~~ [In alignment with APL 25-005, Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services and Alternative Formats, the](#) nondiscrimination notice and the ~~Language Assistance~~ Notice of Availability includes Partnership's toll-free and/or Telephone Typewriters (TTY)/Telecommunication Devices for the Deaf (TDD) telephone number for obtaining these services ~~and~~. [The nondiscrimination notice also includes information on how to file a discrimination grievance directly with Partnership , DHCS' OCR, and HHS' OCR.](#)

[The regulatory notices](#) are posted in the following places in a clear and prominent manner:¹⁷

- a) In the Member Handbook/EOC and other electronic and written communications,
- b) In all physical locations in 20-point font sans serif where Partnership interacts with the public and where members seeking health programs or activities would be able to read or hear the notice;
- c) In a location on Partnership's website that is accessible on the home page, and in a manner that allows Members, Potential Members, and members of the public to easily locate the information; and
- d) In all Member information and other informational notices, in accordance with federal and state law and this APL.

In alignment with DHCS requirements, all member facing material and correspondences (member informing and health education) are created using simple language, are culturally and linguistically appropriate, are provided at a 6th grade reading level, are in a format that is easily understood, in a font size no smaller than 12-point, are translated and sent in the member's preferred language (including Partnership's threshold languages) and format; member informing materials are approved by DHCS before distribution, while health education materials are approved by a Qualified Health educator as defined by APL 18-016.¹⁸ Translation of member facing materials are provided to members at no cost to them.

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

¹⁷ [APL 25-005](#)

¹⁸ [APL 18-016 Readability and Suitability of Written Health Education Materials](#)

Translation Service

Partnership utilizes United Language Group (ULG) as the certified translation service of all member-facing materials (including vital written materials) for LEP Members and Potential Members who speak Partnership's Threshold or Concentration Standard Languages. Partnership translates all member facing materials into its designed threshold and concentration standard languages or other languages as requested. Members can inform Partnership of their preferred language to receive written translations of member materials in the identified Threshold Language, or other languages as necessary, at no cost to the member from a qualified translator. [If a member has requested to receive translated written information in either traditional or simplified Chinese characters, Partnership must provide written information in the member's preferred characters. If member does not indicate a preference, Partnership will provide translations in Simplified Chinese characters. Only upon member request, Partnership is required to provide translated written information in Traditional Chinese characters.](#)

Member requests are fulfilled in a timely manner. ULG services are provided at no cost to the member. Partnership aims to have written member information translated within 2-5 business days depending on the complexity and rarity of the language requested; threshold and concentration languages are defined by DHCS APL 25-005. All translations are verified by separate, additional ULG translators to ensure cultural and linguistic accuracy as well as appropriate grammar and context (see [MCND9002MPND9002](#) attachment D Process for Culturally and Linguistically Appropriate Translations for further translation explanation).

Partnership has adopted the definition of a qualified translator/vendor as delineated in APL 25-005.¹⁹ Per this APL, a translator interpreting for Partnership member must:

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

¹⁹ [APL 25-005](#)

Partnership has requirements for their translator certification process, as set forth by ULG Translations in [MCND9002MPND9002](#) D Process for Culturally and Linguistically Appropriate Translations.

Interpreter Services

Partnership provides equal and timely access to high quality, oral and non-oral interpretation services to members who are monolingual, non-English-speaking, or LEP from a qualified interpreter on a 24-hour, 7 days a week basis at all key points of contact and at no cost to all members and potential members. Points of contact include the medical care setting, such as telephone, advice, Urgent Care, and other outpatient encounters with providers; and non-medical care settings, such as a member services, orientations, and appointment scheduling. Oral interpreter services are available for any language spoken by the member (see [MCND9002MPND9002](#) attachment A for criteria and authorization requirements for interpreting services). Interpreter services are available in all of Partnership's threshold languages, and over 140 additional languages are available upon member request through Partnership's contracted language service provider. The member's preferred language (if other than English) is also prominently noted in their medical record, as well as their request or refusal of language/interpretation services (including refusal of interpreter services from members with disabilities) in accordance with APL 25-005.²⁰ As described in the translation services section above, Partnership offers written translation services of member facing materials in its threshold and concentration languages and upon member request; however, sight translation (oral interpretation) of written information can also be provided upon member request.

Partnership will not require Members with LEP or members with a disability to provide their own interpreters or pay for the cost of their own interpreter or rely on staff who are not qualified interpreters or qualified bilingual/multilingual staff. Any Partnership staff member who provides interpreter services to members in a non-English language is tested for proficiency through Human Resources before engaging members in that language. Partnership has also contracted with AMN HealthCare as their language interpretation service provider. Partnership ensures that timely access to care will not be delayed due to lack of interpretation services. Language services through AMN Healthcare are available for any member in need of an interpreter, member facing staff, and providers working with Partnership members. Member-facing delegates are also required to provide interpreter services for members, however, workflows vary per delegate.

²⁰ [APL 25-005](#)

Partnership uses the definition provided by APL 25-005 in vendor selection and to define a qualified interpreter as an interpreter who:

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

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

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

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

When providing Video Remote Interpreter (VRI) services, Partnership provides real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection. The connection is delivered through high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular

pauses in communication; and provide a sharply delineated image that is large enough to display the interpreter's face, arms, hands, and fingers, and the participating individual's face, arms, hands, and fingers, regardless of body position. Partnership provides clear, audible transmission of voices, and adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the VRI.

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

- As a temporary measure when there is an emergency involving an imminent threat to the safety or welfare of the Member or the public and a qualified interpreter is not immediately available; or,
- If the LEP Member or member with a disability specifically requests that an accompanying adult interpret or facilitate communication. This request must be done in private with a qualified interpreter present and without an accompanying adult present. Additionally, the accompanying adult must agree to provide that assistance, the request and agreement is documented, and reliance on that accompanying adult for that assistance is appropriate under the circumstances.

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

Auxiliary Aids and Services

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

opportunity to participate in, or enjoy the benefits of, the MCP's services, programs, and activities. Auxiliary aids and services include

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

Please see [MCND9002MPND9002](#) attachment B to learn more about how Partnership provides auxiliary aids and services for persons with disabilities.

Alternate Formats

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

In alignment with APL 22-002, when a member contacts Partnership about electronic alternative formats, Partnership also informs the member that, unless they request a password-protected format, the requested member information will be provided in an electronic format that is not password protected. Partnership then communicates to the member that they may request an encrypted electronic format with unencrypted instructions on how the Member can access the encrypted information.²¹

Trainings

In alignment with APL 24-016, Partnership provides Diversity, Equity, and Inclusion (including sensitivity, communication skills, cultural competency/humility training, health equity, and related trainings) for practitioners of our network providers, Partnership staff, and subcontractors and downstream subcontractors. Contracted network providers, contractors, and subcontractors are eligible to submit their own diversity, equity, and inclusion training for review and approval by Partnership's Director of Health Equity in consideration of DHCS regulatory requirements. Separately, Partnership educates contracted network providers, contractors, subcontractors, and staff on Partnership-specific policies, practices, and guidelines for Partnership-specific cultural and language assistance services.

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

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

Also in alignment with APL 24-016, Partnership's Director of Health Equity reviews and oversees the evidence-based DEI trainings and program. The training content will be delivered as digital training modules via an electronic Learning Management System (LMS) to allow asynchronous training delivery throughout Partnership's 24 counties of

²¹ [APL 22-002 Alternative Format Selection for Members with Visual Impairments](#)

service. It will review 3 three major themes to ensure coverage of Partnership member demographics including, but not limited to, members' sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other person or groups defined in Penal Code section 422.56 within specific regions. For details on the 3 three themes described in the training, see the forthcoming policy Diversity, Equity, and Inclusion Training Program Requirements for External Practitioners.

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

Partnership's State Hearing Representative is working towards becoming a certified ADA Coordinator, who advises Partnership on how and when accommodation requests should be honored.

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

- Staff
- Leadership
- Governing bodies
- Committees
- Providers

Assessment and Evaluation

Cultural and Linguistic Program Evaluation

On an annual basis, Partnership writes an evaluation report detailing the Cultural and Linguistic (C&L) program structure and interventions performed in accordance with PHM and other Partnership efforts of the given year. [This report is drafted using elements and findings from this program description and the annual C&L/QIHETP workplan.](#) Key elements in this annual evaluation include program structure/processes, goals for completed activities, review of the Community Advisory Committee (CAC) feedback, overall program effectiveness, and opportunities for improvement.

Linguistic Capacity Assessments

Partnership identifies and tracks the language capabilities of clinicians and other provider office staff during the credentialing process. When available, Partnership

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

Annually, Partnership performs an audit of its delegated cultural and linguistic services providers to ensure their services meet the needs of our members, including members under 21 years of age as well as their parents, guardians, and authorized representatives. Identified gaps are addressed as needed.

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

Member-facing Departments include:

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

Administrative Oversight & Compliance Monitoring

Internal Oversight

Within Partnership's Population Health department, the Senior Health Educator (a masters-prepared or MCHES-certified professional) monitors and oversees regulatory requirements related to Cultural & Linguistics programs and requirements for compliance purposes and to ensure the delivery of culturally and linguistically appropriate health care services. Partnership also created the Population Needs Assessment Committee to review findings and strategies, as needed, to address C&L needs identified in the collaborative work referred to as the CHA and CHIP (please refer to MCND9001 for more detail). To protect the privacy of members, Partnership treats race/ethnicity, language, sexual orientation and gender identity as protected health information (PHI). Member PHI data cannot be used for denial of services, nor for coverage and benefits.

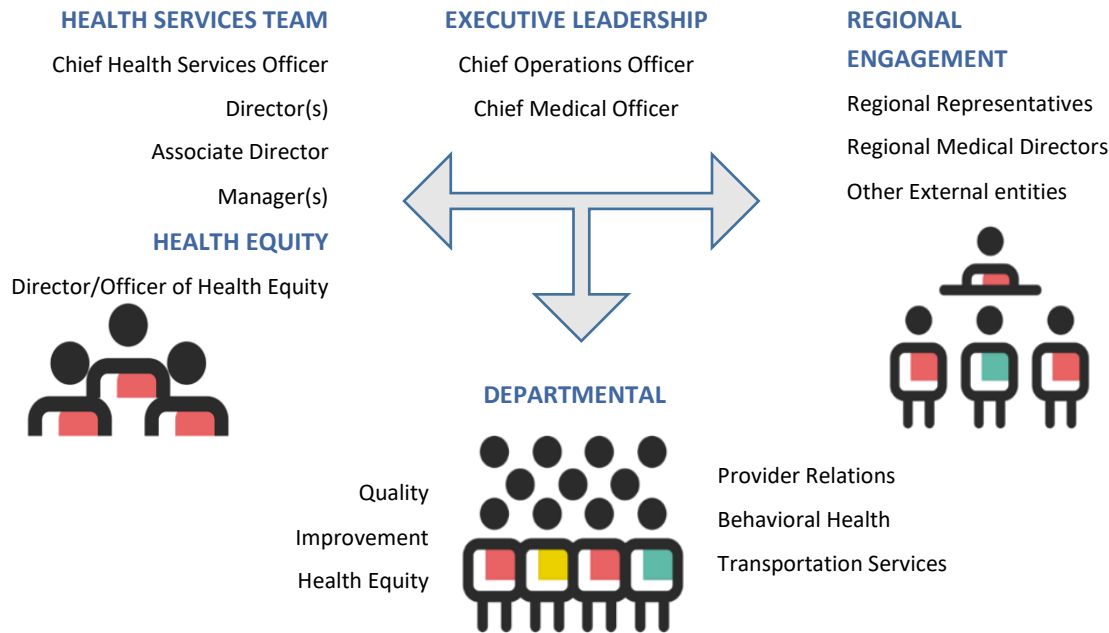
Partnership also houses the Quality Improvement Health Equity Transformation Program (QIHETP). The QIHETP is designed to develop, implement, monitor, and maintain a health equity transformation system. The goal of this system is to address improvements in the quality of care delivered by all of its providers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

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

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

As part of the QIHETP, in accordance with MCND9001 and MCEP6002, the Quality Improvement Health Equity Committee (QIHEC) is responsible for analyzing and evaluating the results of quality improvement and health equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and findings and activities of internal PHC specific committee. This committee is also responsible for developing actions to address performance deficiencies and ensuring appropriate follow-up of identified performance deficiencies. Furthermore, the QIHEC meets bi-monthly to align interdepartmental efforts promoting health equity through both member-facing and systemic interventions outlined in the C&L/QIHETP Work plan (see figure below). Lastly, the QIHEC provides recommendations to the Quality/Utilization Advisory Committee (Q/UAC) (see policy MPQP1002). For more details on the QIHEC, refer to MCEP6002 Quality Improvement and Health Equity Committee (QIHEC).

Quality Improvement & Health Equity Committee



Community Engagement

Partnership's Community Advisory Committee (CAC) and Whole Child Model Family Advisory Committee (FAC) serves as a linkage between Partnership and the community (see attachment [MCND9002MPND9002-E CAC Guiding Principles and Policy MCCP2024](#) for more details on these committees). The CAC and FAC consists of culturally and linguistically diverse Partnership members and community advocates. The advisory committee seeks to include individuals representing the racial/ethnic and linguistic groups that constitute at least 5% of the population at a minimum. When possible, Partnership works to include Seniors and Persons with Disabilities (SPD) (including representatives who receive LTSS and/or individuals representing LTSS recipients), persons with chronic conditions, Limited English Proficient (LEP) Members, adolescents and/or parents and/or caregivers of children, including current and/or former foster youth and Members from diverse cultural and ethnic backgrounds or their representatives, to participate in establishing public policy.

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

- Culturally and linguistically appropriate service or program design, including culturally and linguistically appropriate health education;

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

To learn more about the CAC, please refer to [MCND9002MPND9002](#) attachment E CAC Guiding Principles.

Delegate/Vendor Audits

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

(DORS) for additional review and direction, even if the delegate submits appropriate documentation before the DORS meeting.

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

Goals and Work Plan

Partnership has measurable, culturally and linguistically appropriate goals for the improvement of CLAS standards and for the reduction of health care inequities that are presented annually in the C&L/QIHETP Work Plan. This annual work plan describes the planned work for the coming year, along with the strategy and rubrics for monitoring against the measurable goals for the improvement of CLAS and reduction of health care inequities; this annual plan is approved by various committees, including:

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

Partnership communicates its progress in implementing and sustaining CLAS standards by way of the C&L ~~work plan~~ [QIHETP Work Plan](#) to all stakeholders, and constituents as appropriate.

2025 Goals

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

- Goal 1: By June 30, 2025 develop and propose a multi-year health equity strategic and tactical plan.
 - This goal was chosen to strategize and streamline the required initiatives to advance Health Equity.
- Goal 2: By December 31, 2025 Distribute the DEI training to the provider network and MCP staff and submit the final version to DHCS.

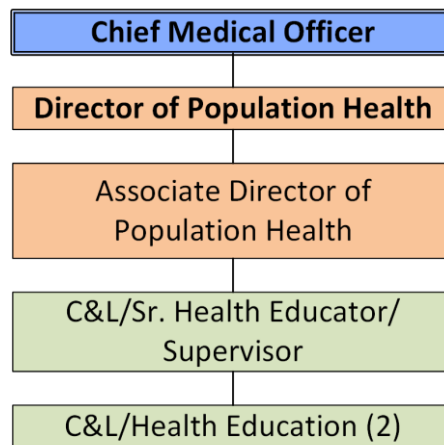
- This goal was chosen due in part to new regulatory requirements around DEI trainings and to ensure all member facing individuals are equipped to provide appropriate care.
- Goal 3: By December 31, 2025, 91% of members who have requested materials in an alternative format will be mailed in their preferred format.
 - This goal was chosen to ensure members receive information in a way that they can understand.
- Goal 4: By December 31, 2025, increase the number of bilingual Member Service Representative (MSR) staff hired by 2% to move closer to organizational goal of 75% of bilingual MSR staff.
 - This goal was chosen to align with an existing organizational goal to have 75% of the Member Services staff possess bilingual skills.
- Goal 5: By December 31, 2025, improve controlled blood pressure rates among American Indian/Alaska Native members by 5% in at least two regions.
 - This goal was chosen due in part to the fact that American Indian/Alaska Native members are a current Population of Focus at Partnership.
- Goal 6: By December 2025, improve the rate of timely translations in the Utilization Management and/or Care Coordination department to achieve the threshold of at least 90%.
 - Goal 6 was chosen due to the recognized need for quality translation services and an overall positive member experience.
- Goal 7: By December 31, 2025, improve timely prenatal visit rates by at least 5% in the American Indian/Alaska Native Member Population within 12 months, in the Eureka region (Del Norte, Humboldt, Lake, and Mendocino), or Redding region (Lassen, Modoc, Shasta, Siskiyou, Tehama, and Trinity), with the global goal of improvement by 22% in the next 5 years.
- Goal 8: By December 31, 2025, improve Well Care Visits rate among Black, White, and/or American Indian/Alaska native members by 5% overall or at least 1.25% in at least one region.
 - Goals 7 and 8 were chosen due to the recognized disparities in each goal's respective clinical measure and population of focus.

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

Population Health Department Structure

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

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



Team Roles and Responsibilities

Chief Medical Officer:

As the principal manager of medical care, the Chief Medical Officer is responsible for the appropriateness and quality of medical care delivered through Partnership HealthPlan of California (Partnership) and for the cost-effectiveness of the utilization of

services. This position provides overall direction to multiple departments, including the Population Health Management Team and has the ultimate responsibility of ensuring that departmental programs and services are consistent and meet all regulatory requirements in every office location. Required education includes an MD/DO degree from an accredited program preferably in a primary care specialty required; minimum two (2) years' experience in a managed care plan preferred with duties comparable to those listed above, and experience administering medical programs. This role also requires board certification in a specialty and a minimum of seven (7) years clinical/medical practice experience.

Director of Population Health

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

Associate Director of Population Health

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

Supervisor

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

Supports and assists Population Health Management leadership and other Supervisors in developing and maintaining a cohesive team with a high level of productivity and accuracy to achieve the department's overall performance metrics. Required education

includes a Bachelor's degree in Business, Communication, Healthcare Administration, a related field, or 3-5 years of managed care experience, or equivalent combination of education and experience.

Senior Health Educator

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

Health Educator(s)

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

Cultural & Linguistic Program Description Approval

	03/19/2025 06/18/2025

Robert Moore, MD, MPH, MBA

Date Approved

Quality/Utilization Advisory Committee Chairperson

	04/09/2025 08/13/25

Angela Brennan, DO

Date Approved

Physician Advisory Committee Chairperson

	06/25/2025 08/27/2025

Kim Tangermann

Date Approved

Board of Commissioners Chairperson

Criteria and Authorization Requirements for Interpreting Services

Telephonic or Video Remote Interpreter Services

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

Sign Language Interpreters

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

Face-to-Face Interpreter Services

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

contact Carelon three (3) business days in advance of their appointment to arrange the service.

Providing Auxiliary Aids and Services for Persons with Disabilities

1. Identification and Assessment of Need:

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

2. Provision of Auxiliary Aids and Services:

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

Threshold and Concentration Languages For All Counties as of March 2024

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

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

Notes:

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

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

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

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



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

May 28, 2025

ULG: Written Translation Quality Processes and Overview

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

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

1. Translator Qualifications and Language Proficiency Assessments

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

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

Additionally, ULG looks to ensure the following:

- **ATA Accreditation:** Many of our translators are certified by the American Translators Association (ATA). However, ATA certification is not available in many of the language pairs of the U.S. LEP populations. Due to our high standards of linguist proficiency requirements, we rely on our multi-step qualification process and translator's background, assessment results, education and references to determine their skill level.
- **Technical capabilities:** We require translators to have appropriate electronic tools, working knowledge of translation memory, automated term lists and other software programs.
- **Onboarding:** Once a translator is qualified and approved through the recruitment and qualification process mentioned above, an on-boarding process is in place that includes contract signing, confidentiality agreements, portal training and customer-specific training as well as process and policy review.
- **Ongoing monitoring:** Work completed by our active translators undergoes our internal quality assessment audits on a regular sample of translation projects. All linguists must maintain high quality scores on these audits to continue working with us.

2. Metrics and KPI's For Consistent Service Delivery

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

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

- **On-time deliveries:** ULG maintains a 99% on-time delivery (OTD) rating. On-time delivery is automatically tracked through our secure portal and Translation Management System. ULG translation services and timelines are aligned to meet customer-specific or product-specific timelines, such as rapid-turn Grievance and Appeals, annual enrollment materials, and more.
- **Translation Quality:** Measuring translation quality is vital to understanding and evaluating final deliverables. Regular quality-level audits help to identify any potential issues with processes/resources and allow us to identify trends that require immediate corrective action.

- Customer Satisfaction: Gathering feedback directly from our clients allows us to identify potential issues which are not visible/identifiable from other reports/KPIs. As well, it indicates where improvements and innovations may be needed.
- TM leveraging analysis: By analyzing TM (translation memory) we identify content trends and savings to maximize TM leveraging.
- Utilization: Comparing translation volumes against utilization numbers is a great way to identify ULG's capacity for scalability planning for account growth and managing volume projects.

3. Language Quality Control and Quality Assessment Process

Language quality control is at the heart of ULG's ability to help ensure accurate, effective and culturally appropriate translations. Our documented quality-driven policies, procedures, evaluation standards, and multi-step translation processes, help ensure consistently high quality for every translation in every language.

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

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

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



Certificate of Registration

This certifies that the Information Security Management System of

United Language Group, Inc.

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

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

ISO 27001:2013

Scope of Certification:

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

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

Sameer Vachani
Senior Director, NSF-ISR

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

Issued by:

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

Authorized Certification and/or Accreditation Marks. This certificate is property of NSF-ISR and must be returned upon request.

*Company is audited for conformance at regular intervals. To verify certification call (888) NSF-9000 or visit our web site at www.nsf-isr.org Page 408 of 579





Certificate of Registration

ANNEX PAGE FOR CERTIFICATE NUMBER: C0748976-IM3

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

CERTIFICATE ISSUE DATE:
24-MAR-2023

CERTIFICATE EXPIRATION DATE:
10-APR-2026

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

Location:

United Language Group, Inc. - 67852
Unit 27
Glenrock Business Park
Ballybane, Galway, H91 AE12,
Ireland

Scope:

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

Location:

United Language Group, Inc.-
C0359514
Office No. 713- 714, Neelkanth
Corporate IT Park
Neelkanth Corporate IT Park
Kirol Road, Vidyavihar (West)
Mumbai, 400086, India

Scope:

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

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~~Consumer~~Community Advisory Committee Guiding Principles

I. Purpose & Overview

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

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

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

- ~~Identify member concerns that may influence Partnership policies and practices~~
- Identifying and advocating for preventative care practices utilized by Partnership
- Participate in the development and updating of cultural and linguistic policy and procedure decisions related to quality improvement, member education, ~~and operational~~, and cultural competency issues that may affect groups who speak a primary language other than English
- Make recommendations regarding the cultural appropriateness of communications, partnerships, and/or services
- Provide input on necessary member/provider targeted services, programs, and trainings
- ~~Make recommendations regarding the cultural appropriateness of communications, partnerships, and/or services~~
- Review Population Needs Assessment findings and discuss improvement opportunities related to Health Equity and Social Drivers of Health
- Contribute feedback and suggestions on Community Health Assessments (CHA)/Community Health Improvement Plans (CHIP) and other health education and community focused initiatives

~~Consumer~~Community Advisory Committee

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~~Identify member concerns that may influence Partnership policies and practices~~

- Ensure that the concerns of members of all cultures are respected and addressed, including members that speak a primary language other than English
- Serve as advocates for members of Partnership, promote self-advocacy, and cultural competency, thereby improving health outcomes
- Review and provide input regarding Member Rights and Responsibilities and other member materials
- Annually review grievance and appeal data
- Review and make recommendations regarding ~~Member Services'~~ Quality Improvement activities, including but not limited to the Member Satisfaction Survey results

~~Provide feedback and input on Partnership's health education and community focused activities~~

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

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

II. Membership

Member Selection

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

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

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

~~Consumer~~ Community Advisory Committee

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- Members of hard-to-reach populations
- Members of diverse racial and ethnic backgrounds, genders, gender identity, sexual orientation, physical disabilities, age backgrounds (including parents/caregivers of adolescents/foster youth), and Indian Health Care Providers (IHCP)S Provider representatives)
- Limited English Proficient (LEP) Members
- Members who receive Long-Term Supports Services (LTSS), and/or individuals representing those members

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

Each county within Partnership's service area is allocated a set amount of CAC seats available to members. To ensure appropriate representation, our internal teams established a membership baseline and corresponding committee capacity. Our CAC membership baseline shall align with the Board of Commissioner seats per county. The ratio selected for each county is defined as one (1) times the number of Partnership Board of Commissioner seats per county, whereas the membership capacity will be two (2) times the baseline.

~~To determine this allocation, Partnership established a ratio based on the number of Partnership Board of Commissioner seats that each county holds. The ratio selected for each county is defined as one (1) times the number of Partnership Board of Commissioner seats per county.~~

The CAC Coordinator, Facilitators, and the CAC selection committee are responsible for selecting new CAC members and/or replacing former CAC members whose position has been vacated. If a CAC member resigns or is asked to resign, the CAC Coordinator, Facilitators, and the CAC selection committee must make their best effort to promptly replace a vacant seat within 60 calendar days. The CAC Team will continue to ensure that Partnership is responsive to the diversity of health care needs of all members and is reflective of Partnership's service area.

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

~~Consumer~~Community Advisory Committee

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Member Responsibilities

- Regularly attend scheduled meetings
 - If a member of Partnership's Board (or committees) has an ADA-qualifying disability that prevents in-person attendance, the member may participate in a public meeting remotely as reasonable accommodation.
- Arrive in a timely manner
- ~~Participate~~ Actively participate in CAC meetings by providing opinions and feedback to improve Partnership services
- ~~Provide opinions and feedback to improve Partnership services~~
- Provide updated contact information to the CAC ~~Facilitator~~ Coordinator and/or ~~Coordinator~~ Facilitators for the purpose of meeting notices
- Notify the CAC ~~Facilitator~~ Coordinator and/or ~~Coordinator~~ Facilitators in advance if you cannot attend a meeting

Membership Term

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

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

CAC members may lose their membership seat and privileges by a quorum of the CAC. CAC members may terminate their position at any time by resigning. The member may resign by calling, emailing, or sending a letter to the CAC ~~Facilitator~~ Coordinator and/or ~~Coordinator~~ Facilitators. The CAC Coordinator, Facilitators, and the CAC selection committee will make a good-faith effort to promptly replace any vacancy due to member resignations (voluntary or involuntary) within 60 calendar days.

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

Compensation

A CAC member may receive a stipend for travel and childcare expenses that allows them to attend CAC meetings during their membership term. No CAC member shall receive any profit from the operations of Partnership. This provision shall not prevent reasonable compensation to a CAC member for services performed for Partnership, if such compensation is not in conflict with

~~Consumer~~Community Advisory Committee

Guiding Principles

Partnership policies or procedures, is permitted by these Guiding Principles, and is approved by the Chief Executive Officer of Partnership.

Member Demographic Report

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

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

Board of Commissioners

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

Department of Healthcare Services (DHCS) Statewide ~~Consumer-Medi-Cal Member~~ Advisory Committee (MMAC)

The CAC shall select and appoint one member of the CAC, or another Partnership member, to serve as the Partnership representative to the DHCS' Statewide ~~Consumer-MMAC~~ Advisory Committee. Partnership shall compensate the representative for time and participation within the Statewide MMAC ~~GAG~~, including transportation expenses to appear in-person.

~~Consumer~~Community Advisory Committee

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Non-Liability of Members

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

III. Committee Meetings

Meeting Schedule

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

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

Address	County
<u>2760 Esplanade Avenue, Suite 130, Chico, CA 95973</u>	<u>Butte</u>
<u>1036 5th St., Suite E, Eureka, CA 95501</u>	<u>Humboldt</u>
<u>281 Nevada Street, Auburn, CA 95603</u>	<u>Placer</u>
<u>2525 Airpark Drive, Redding, CA 96001</u>	<u>Shasta</u>
<u>4665 Business Center Drive, Fairfield, CA 94534</u>	<u>Solano</u>
<u>495 Tesconi Circle, Santa Rosa, CA 95401</u>	<u>Sonoma</u>
Address	County
~~4665 Business Center Drive, Fairfield, CA 94534~~	~~Solano~~
~~495 Tesconi Circle, Santa Rosa, CA 95401~~	~~Sonoma~~
~~3688 Avtech Parkway, Redding, CA 96002~~	~~Shasta~~
~~1036 5th St., Suite E, Eureka, CA 95501~~	~~Humboldt~~

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

~~Consumer~~Community Advisory Committee

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the meeting. Video conferencing equipment is used when members from multiple locations participate.

Facilitation of Meetings

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

Quorum

For the purpose of the CAC, a quorum is defined as the minimum number of members in attendance required to conduct the business of the committee. The CAC quorum shall consist of at least $\frac{1}{2}$ (one half) of the CAC membership seats held. Every act or decision done or made by a quorum is an act of the CAC as a whole.

CAC Records

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

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



Cultural & Linguistic Program Description

MPND9002

August 2025

Original Date: 02/19/2014

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

Revision Dates: MCND9002 09/09/20; 09/08/21; 09/14/22; 11/8/23; 11/13/24;
04/9/2025; MPND9002 08/13/25

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Program Purpose

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

Introduction

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

Partnership works to ensure there is equal access to the provision of high quality interpreter and linguistic services for LEP members and potential members, and for members and potential members with disabilities, in compliance with federal and state law, and APL 25-005.² Partnership makes this commitment to the availability and accessibility of these C&L services, along with a commitment to nondiscriminatory treatment of members regardless of sex, race, color, national origin (including LEP and primary language), religion, ancestry, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or group as defined in Title VI of the Civil Rights Act of 1964³ or Section 1557 of the Affordable Care Act of 2010,⁴ the Americans with Disabilities Act of 1990,⁵ or as specified in APL 25-005. Partnership maintains, continually monitors, improves, and evaluates cultural and linguistic services that support covered services for all members, including members less than 21 years of age.

All covered services, member-facing programs, member facing (including health education) and/or outreach material are provided in a culturally and linguistically appropriate manner that promotes health equity for all members. Member facing

¹ [National Culturally and Linguistically Appropriate Services Standards](#)

² [All Plan Letter 25-005 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services](#) and [Threshold and Concentration Languages](#)

³ [Penal Code 422.56](#)

⁴ [ACA 1557](#)

⁵ [Americans with Disabilities Act of 1990](#)

materials are routinely distributed in all of Partnerships threshold languages, meet the requirements of APL 18-016 Readability and Suitability of Written Health Education Materials,⁶ and are available in accessible formats upon member request. Partnership also ensures that members receive all Member Information in a language or alternative format of their choice.

Objectives

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

- Collecting and updating data on the race/ethnicity, language, sexual orientation and gender identity of Partnership members and sharing this information with providers. This effort is part of Partnership's goal to monitor and evaluate how CLAS may impact health equity and outcomes, which can better inform service delivery. Members will be advised of the intent to share their data and will be given the right to opt out of data sharing in accordance with their privacy rights.
- Ensuring Partnership's staff, providers' and delegates' Cultural and Linguistic services comply with the Department of Health Care Services (DHCS) and Federal regulations without limitations, particularly relating to communication assistance requirements and access for members with disabilities.^{7,8,9,10,11}
- Continually assessing, monitoring, improving, and evaluating Partnership's C&L services that support covered services for members, including members under the age of 21.
- Addressing deficiencies and gaps in Partnership's C&L services.
- Communicating Partnership's C&L Services and Standards to staff, providers, delegates, and community members.

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

⁶ [APL 18-016 Readability and Suitability of Written Health Education Materials](#)

⁷ 22 CCR 53876; 21202.5; 51202.5; 51309.5(a)

⁸ 28 CCR 1300.67.04(c)(2)(A)-(B); 1300.67.04(c)(2)(G)(v)-(c)(4)

⁹ 42 CFR 438.206(c)(2); 438.10; 438.404

¹⁰ W&I Code 14029.91

¹¹ Medi-Cal Managed Care Plans, Exhibit A, Scope of Work 5.2.10

Programs and Services

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

Language Data Collection

At least every three years, DHCS gathers language information for individuals enrolled in Medi-Cal and shares this information with Managed Care Plans (MCPs) to address potential changes to threshold and concentration standard languages (see MPND9002 attachment C for threshold languages) as well as any changes in state and/or federal law. Partnership reviews overall language prevalence per state-published data every three years in order to identify emerging language patterns that may impact Partnership members or potential members. This data is also used to assess languages in a way that aligns with DHCS requirements as outlined in APL 25-005 as well as aligns with NCQA requirements for threshold languages of five (5) percent or 1,000 individuals, as well as languages spoken by one (1) percent or 200 individuals (whichever is less). According to APL 25-005 and its attachments, MCPs must provide translated written member information to specific groups in the MCP's service area as identified by DHCS in the Threshold and Concentration Language dataset.¹² Partnership also routinely collects and maintains records of member language preferences spoken by one (1) percent of the member population or less.

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

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

¹² [APL 25-005](#) and [Threshold and Concentration Languages](#)

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

Partnership distributes a written notice in English and other languages spoken by 1 percent of the members served by the organization or by 200 individuals (whichever is less), informing members that the organization provides language assistance services and how they can obtain it at no cost to the member. Non-speaking or Limited English Proficient (LEP) members can also request language and/or interpretation services, or even refuse interpreter services; this request is then documented in Partnership's member record.¹³ Partnership may use or disclose the member's preferred language with Partnership network practitioners/providers, subcontractors, or other covered entities for the purposes of ensuring communication and care delivery are in a culturally sensitive and linguistically appropriate manner. Members are informed that their language preferences may be shared when language information is directly collected.

Partnership also assesses and collects data on the cultural and linguistic needs of the member population through the written Population Needs Assessment (PNA). Each year, Partnership assesses the overall environment, specific community needs, and the factors that influence the health and well-being of the assigned member population. This information is collected from its member population data and integrated into the PNA, which helps drive the goals of Partnership's Population Health Management Strategy, the Cultural & Linguistics Program, and their associated work plans. Both of these work plans are the driving force by which Partnership responds to the cultural and linguistic diversity and needs of Partnership's member population. The report is written in accordance with the requirements of the National Committee for Quality Assurance (NCQA) Health Plan Accreditation Standards for an annual Population Needs Assessment (PNA).

Finally, in alignment with DHCS's Population Health Management Policy Guide, Partnership collects information on language needs as part of its collaboration with each Local Health Jurisdiction in its service area.¹⁴ This collaborative work is referred to as the Community Health Assessment (CHA) and Community Health Improvement Plan

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

¹⁴ [DHCS Basic Population Health Management Policy Guide](#)

(CHIP) process. Based on this collaborative work, and input from various stakeholders, including Partnership's Community Advisory Committee (CAC) (formerly known as the Consumer Advisory Committee), Partnership annually reviews, and updates as needed, its strategies and work streams related to the DHCS Bold Goals, health equity, health education materials, wellness and prevention programs, and cultural and linguistic and quality improvement strategies to address identified health and social needs in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy.¹⁵ Findings from both the PNA and CHA/CHIP work are shared with our providers and other stakeholders as needed on a regular basis.

Language Assistance Services

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

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

In alignment with APL 25-005¹⁶ and other DHCS requirements, Partnership provides nondiscrimination notices and Language Assistance Notice of Availability. Nondiscrimination notices are provided and inform Members, Potential Members, and the public about nondiscrimination, protected characteristics, accessibility requirements, and information on how to file a grievance. A Language Assistance Notice of Availability is also provided in a visible font size in English and the top 18 non-English languages spoken by Limited English Proficient (LEP) individuals in the state; they inform members, potential members, and the public of all available language assistance services at no cost to them as well as how to access them (including written translation and interpretation). To see these two notices in detail please refer to attachment A & B in MCNP9004 Regulatory Required Notices.

The Language Assistance Notice of Availability and nondiscrimination notices are provided in a font size no smaller than 12-point and are available in all Threshold

¹⁵ [DHCS Comprehensive Quality Strategy](#)

¹⁶ [APL 25-005](#)

Languages/Concentration Standard Languages and in an ADA-compliant, accessible format. Alternative formats available to members includes Braille, large-size print font that is no smaller than 20-point, accessible electronic format, or audio format, and Auxiliary Aids-at no cost to the member, and upon request. Consideration is also given for the special needs of members with disabilities or LEP members. Although quick response codes, otherwise known as QR code may be used alongside the nondiscrimination notice and notice of availability, they are not to be replaced by the use of QR codes.

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

- Partnership Member Handbook/Evidence of Coverage (EOC)
- Partnership Provider Directory
- Form letters and notices critical to obtaining services
- Notices of Action
- Notice of Appeal Resolution Letters
- Notices of Adverse Benefit Determination
- Grievance and Appeals letters
- Welcome Packets
- Marketing Information
- Preventive health reminders
- Member surveys
- Notices advising of the availability of free language assistance services
- Newsletters
- Notices of Organization and Coverage Determinations
- All member information, informational notices, and materials critical to obtaining services targeted to members, potential enrollees, applicants, and members of the public
- Other written communications and/or informational notices for members, Potential Members, and the public as applicable.

In alignment with APL 25-005, Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services and Alternative Formats, the nondiscrimination notice and the Notice of Availability includes Partnership's toll-free and/or Telephone Typewriters (TTY)/Telecommunication Devices for the Deaf (TDD) telephone number for obtaining these services. The nondiscrimination notice also includes information on how to file a discrimination

grievance directly with Partnership, DHCS' OCR, and HHS' OCR. The regulatory notices are posted in the following places in a clear and prominent manner:¹⁷

- a) In the Member Handbook/EOC and other electronic and written communications,
- b) In all physical locations in 20-point font sans serif where Partnership interacts with the public and where members seeking health programs or activities would be able to read or hear the notice;
- c) In a location on Partnership's website that is accessible on the home page, and in a manner that allows Members, Potential Members, and members of the public to easily locate the information; and
- d) In all Member information and other informational notices, in accordance with federal and state law and this APL.

In alignment with DHCS requirements, all member facing material and correspondences (member informing and health education) are created using simple language, are culturally and linguistically appropriate, are provided at a 6th grade reading level, are in a format that is easily understood, in a font size no smaller than 12-point, are translated and sent in the member's preferred language (including Partnership's threshold languages) and format; member informing materials are approved by DHCS before distribution, while health education materials are approved by a Qualified Health educator as defined by APL 18-016.¹⁸ Translation of member facing materials are provided to members at no cost to them.

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

¹⁷ [APL 25-005](#)

¹⁸ [APL 18-016 Readability and Suitability of Written Health Education Materials](#)

Translation Service

Partnership utilizes United Language Group (ULG) as the certified translation service of all member-facing materials (including vital written materials) for LEP Members and Potential Members who speak Partnership's Threshold or Concentration Standard Languages. Partnership translates all member facing materials into its designed threshold and concentration standard languages or other languages as requested. Members can inform Partnership of their preferred language to receive written translations of member materials in the identified Threshold Language, or other languages as necessary, at no cost to the member from a qualified translator. If a member has requested to receive translated written information in either traditional or simplified Chinese characters, Partnership must provide written information in the member's preferred characters. If member does not indicate a preference, Partnership will provide translations in Simplified Chinese characters. Only upon member request, Partnership is required to provide translated written information in Traditional Chinese characters.

Member requests are fulfilled in a timely manner. ULG services are provided at no cost to the member. Partnership aims to have written member information translated within 2-5 business days depending on the complexity and rarity of the language requested; threshold and concentration languages are defined by DHCS APL 25-005. All translations are verified by separate, additional ULG translators to ensure cultural and linguistic accuracy as well as appropriate grammar and context (see MPND9002 attachment D Process for Culturally and Linguistically Appropriate Translations for further translation explanation).

Partnership has adopted the definition of a qualified translator/vendor as delineated in APL 25-005.¹⁹ Per this APL, a translator interpreting for Partnership member must:

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

¹⁹ [APL 25-005](#)

Partnership has requirements for their translator certification process, as set forth by ULG Translations in MPND9002 D Process for Culturally and Linguistically Appropriate Translations.

Interpreter Services

Partnership provides equal and timely access to high quality, oral and non-oral interpretation services to members who are monolingual, non-English-speaking, or LEP from a qualified interpreter on a 24-hour, 7 days a week basis at all key points of contact and at no cost to all members and potential members. Points of contact include the medical care setting, such as telephone, advice, Urgent Care, and other outpatient encounters with providers; and non-medical care settings, such as a member services, orientations, and appointment scheduling. Oral interpreter services are available for any language spoken by the member (see MPND9002 attachment A for criteria and authorization requirements for interpreting services). Interpreter services are available in all of Partnership's threshold languages, and over 140 additional languages are available upon member request through Partnership's contracted language service provider. The member's preferred language (if other than English) is also prominently noted in their medical record, as well as their request or refusal of language/interpretation services (including refusal of interpreter services from members with disabilities) in accordance with APL 25-005.²⁰ As described in the translation services section above, Partnership offers written translation services of member facing materials in its threshold and concentration languages and upon member request; however, sight translation (oral interpretation) of written information can also be provided upon member request.

Partnership will not require Members with LEP or members with a disability to provide their own interpreters or pay for the cost of their own interpreter or rely on staff who are not qualified interpreters or qualified bilingual/multilingual staff. Any Partnership staff member who provides interpreter services to members in a non-English language is tested for proficiency through Human Resources before engaging members in that language. Partnership has also contracted with AMN HealthCare as their language interpretation service provider. Partnership ensures that timely access to care will not be delayed due to lack of interpretation services. Language services through AMN Healthcare are available for any member in need of an interpreter, member facing staff, and providers working with Partnership members. Member-facing delegates are also required to provide interpreter services for members, however, workflows vary per delegate.

²⁰ [APL 25-005](#)

Partnership uses the definition provided by APL 25-005 in vendor selection and to define a qualified interpreter as an interpreter who:

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

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

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

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

When providing Video Remote Interpreter (VRI) services, Partnership provides real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection. The connection is delivered through high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular

pauses in communication; and provide a sharply delineated image that is large enough to display the interpreter's face, arms, hands, and fingers, and the participating individual's face, arms, hands, and fingers, regardless of body position. Partnership provides clear, audible transmission of voices, and adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the VRI.

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

- As a temporary measure when there is an emergency involving an imminent threat to the safety or welfare of the Member or the public and a qualified interpreter is not immediately available; or,
- If the LEP Member or member with a disability specifically requests that an accompanying adult interpret or facilitate communication. This request must be done in private with a qualified interpreter present and without an accompanying adult present. Additionally, the accompanying adult must agree to provide that assistance, the request and agreement is documented, and reliance on that accompanying adult for that assistance is appropriate under the circumstances.

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

Auxiliary Aids and Services

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

opportunity to participate in, or enjoy the benefits of, the MCP's services, programs, and activities. Auxiliary aids and services include

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

Please see MPND9002 attachment B to learn more about how Partnership provides auxiliary aids and services for persons with disabilities.

Alternate Formats

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

In alignment with APL 22-002, when a member contacts Partnership about electronic alternative formats, Partnership also informs the member that, unless they request a password-protected format, the requested member information will be provided in an electronic format that is not password protected. Partnership then communicates to the member that they may request an encrypted electronic format with unencrypted instructions on how the Member can access the encrypted information.²¹

Trainings

In alignment with APL 24-016, Partnership provides Diversity, Equity, and Inclusion (including sensitivity, communication skills, cultural competency/humility training, health equity, and related trainings) for practitioners of our network providers, Partnership staff, and subcontractors and downstream subcontractors. Contracted network providers, contractors, and subcontractors are eligible to submit their own diversity, equity, and inclusion training for review and approval by Partnership's Director of Health Equity in consideration of DHCS regulatory requirements. Separately, Partnership educates contracted network providers, contractors, subcontractors, and staff on Partnership-specific policies, practices, and guidelines for Partnership-specific cultural and language assistance services.

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

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

Also in alignment with APL 24-016, Partnership's Director of Health Equity reviews and oversees the evidence-based DEI trainings and program. The training content will be delivered as digital training modules via an electronic Learning Management System (LMS) to allow asynchronous training delivery throughout Partnership's 24 counties of

²¹ [APL 22-002 Alternative Format Selection for Members with Visual Impairments](#)

service. It will review 3 three major themes to ensure coverage of Partnership member demographics including, but not limited to, members' sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other person or groups defined in Penal Code section 422.56 within specific regions. For details on the 3 three themes described in the training, see the forthcoming policy Diversity, Equity, and Inclusion Training Program Requirements for External Practitioners.

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

Partnership's State Hearing Representative is working towards becoming a certified ADA Coordinator, who advises Partnership on how and when accommodation requests should be honored.

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

- Staff
- Leadership
- Governing bodies
- Committees
- Providers

Assessment and Evaluation

Cultural and Linguistic Program Evaluation

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

Linguistic Capacity Assessments

Partnership identifies and tracks the language capabilities of clinicians and other provider office staff during the credentialing process. When available, Partnership

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

Annually, Partnership performs an audit of its delegated cultural and linguistic services providers to ensure their services meet the needs of our members, including members under 21 years of age as well as their parents, guardians, and authorized representatives. Identified gaps are addressed as needed.

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

Member-facing Departments include:

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

Administrative Oversight & Compliance Monitoring

Internal Oversight

Within Partnership's Population Health department, the Senior Health Educator (a masters-prepared or MCHES-certified professional) monitors and oversees regulatory requirements related to Cultural & Linguistics programs and requirements for compliance purposes and to ensure the delivery of culturally and linguistically appropriate health care services. Partnership also created the Population Needs Assessment Committee to review findings and strategies, as needed, to address C&L needs identified in the collaborative work referred to as the CHA and CHIP (please refer to MCND9001 for more detail). To protect the privacy of members, Partnership treats race/ethnicity, language, sexual orientation and gender identity as protected health information (PHI). Member PHI data cannot be used for denial of services, nor for coverage and benefits.

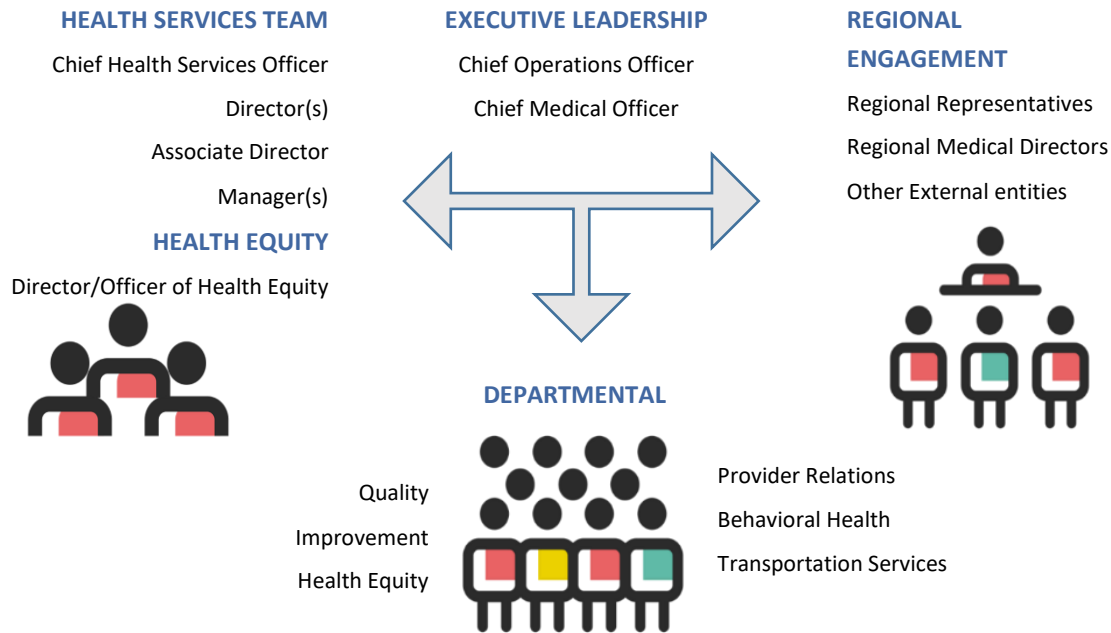
Partnership also houses the Quality Improvement Health Equity Transformation Program (QIHETP). The QIHETP is designed to develop, implement, monitor, and maintain a health equity transformation system. The goal of this system is to address improvements in the quality of care delivered by all of its providers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

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

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

As part of the QIHETP, in accordance with MCND9001 and MCEP6002, the Quality Improvement Health Equity Committee (QIHEC) is responsible for analyzing and evaluating the results of quality improvement and health equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and findings and activities of internal PHC specific committee. This committee is also responsible for developing actions to address performance deficiencies and ensuring appropriate follow-up of identified performance deficiencies. Furthermore, the QIHEC meets bi-monthly to align interdepartmental efforts promoting health equity through both member-facing and systemic interventions outlined in the C&L/QIHETP Work plan (see figure below). Lastly, the QIHEC provides recommendations to the Quality/Utilization Advisory Committee (Q/UAC) (see policy MPQP1002). For more details on the QIHEC, refer to MCEP6002 Quality Improvement and Health Equity Committee (QIHEC).

Quality Improvement & Health Equity Committee



Community Engagement

Partnership's Community Advisory Committee (CAC) and Whole Child Model Family Advisory Committee (FAC) serves as a linkage between Partnership and the community (see attachment MPND9002-E CAC Guiding Principles and Policy MCCP2024 for more details on these committees). The CAC and FAC consists of culturally and linguistically diverse Partnership members and community advocates. The advisory committee seeks to include individuals representing the racial/ethnic and linguistic groups that constitute at least 5% of the population at a minimum. When possible, Partnership works to include Seniors and Persons with Disabilities (SPD) (including representatives who receive LTSS and/or individuals representing LTSS recipients), persons with chronic conditions, Limited English Proficient (LEP) Members, adolescents and/or parents and/or caregivers of children, including current and/or former foster youth and Members from diverse cultural and ethnic backgrounds or their representatives, to participate in establishing public policy.

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

- Culturally and linguistically appropriate service or program design, including culturally and linguistically appropriate health education;

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

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

Delegate/Vendor Audits

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

(DORS) for additional review and direction, even if the delegate submits appropriate documentation before the DORS meeting.

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

Goals and Work Plan

Partnership has measurable, culturally and linguistically appropriate goals for the improvement of CLAS standards and for the reduction of health care inequities that are presented annually in the C&L/QIHETP Work Plan. This annual work plan describes the planned work for the coming year, along with the strategy and rubrics for monitoring against the measurable goals for the improvement of CLAS and reduction of health care inequities; this annual plan is approved by various committees, including:

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

Partnership communicates its progress in implementing and sustaining CLAS standards by way of the C&L/QIHETP Work Plan to all stakeholders, and constituents as appropriate.

2025 Goals

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

- Goal 1: By June 30, 2025 develop and propose a multi-year health equity strategic and tactical plan.
 - This goal was chosen to strategize and streamline the required initiatives to advance Health Equity.
- Goal 2: By December 31, 2025 Distribute the DEI training to the provider network and MCP staff and submit the final version to DHCS.

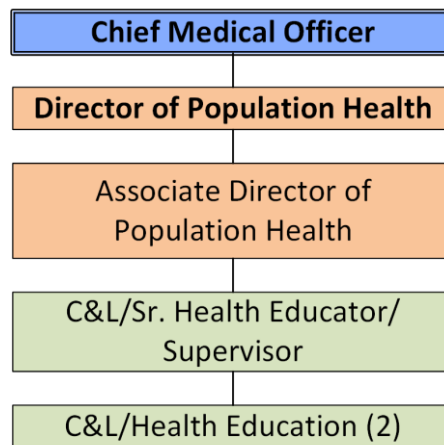
- This goal was chosen due in part to new regulatory requirements around DEI trainings and to ensure all member facing individuals are equipped to provide appropriate care.
- Goal 3: By December 31, 2025, 91% of members who have requested materials in an alternative format will be mailed in their preferred format.
 - This goal was chosen to ensure members receive information in a way that they can understand.
- Goal 4: By December 31, 2025, increase the number of bilingual Member Service Representative (MSR) staff hired by 2% to move closer to organizational goal of 75% of bilingual MSR staff.
 - This goal was chosen to align with an existing organizational goal to have 75% of the Member Services staff possess bilingual skills.
- Goal 5: By December 31, 2025, improve controlled blood pressure rates among American Indian/Alaska Native members by 5% in at least two regions.
 - This goal was chosen due in part to the fact that American Indian/Alaska Native members are a current Population of Focus at Partnership.
- Goal 6: By December 2025, improve the rate of timely translations in the Utilization Management and/or Care Coordination department to achieve the threshold of at least 90%.
 - Goal 6 was chosen due to the recognized need for quality translation services and an overall positive member experience.
- Goal 7: By December 31, 2025, improve timely prenatal visit rates by at least 5% in the American Indian/Alaska Native Member Population within 12 months, in the Eureka region (Del Norte, Humboldt, Lake, and Mendocino), or Redding region (Lassen, Modoc, Shasta, Siskiyou, Tehama, and Trinity), with the global goal of improvement by 22% in the next 5 years.
- Goal 8: By December 31, 2025, improve Well Care Visits rate among Black, White, and/or American Indian/Alaska native members by 5% overall or at least 1.25% in at least one region.
 - Goals 7 and 8 were chosen due to the recognized disparities in each goal's respective clinical measure and population of focus.

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

Population Health Department Structure

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

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



Team Roles and Responsibilities

Chief Medical Officer:

As the principal manager of medical care, the Chief Medical Officer is responsible for the appropriateness and quality of medical care delivered through Partnership HealthPlan of California (Partnership) and for the cost-effectiveness of the utilization of

services. This position provides overall direction to multiple departments, including the Population Health Management Team and has the ultimate responsibility of ensuring that departmental programs and services are consistent and meet all regulatory requirements in every office location. Required education includes an MD/DO degree from an accredited program preferably in a primary care specialty required; minimum two (2) years' experience in a managed care plan preferred with duties comparable to those listed above, and experience administering medical programs. This role also requires board certification in a specialty and a minimum of seven (7) years clinical/medical practice experience.

Director of Population Health

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

Associate Director of Population Health

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

Supervisor

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

Supports and assists Population Health Management leadership and other Supervisors in developing and maintaining a cohesive team with a high level of productivity and accuracy to achieve the department's overall performance metrics. Required education

includes a Bachelor's degree in Business, Communication, Healthcare Administration, a related field, or 3-5 years of managed care experience, or equivalent combination of education and experience.

Senior Health Educator

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

Health Educator(s)

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

Cultural & Linguistic Program Description Approval

	06/18/2025

Robert Moore, MD, MPH, MBA

Date Approved

Quality/Utilization Advisory Committee Chairperson

	08/13/25

Angela Brennan, DO

Date Approved

Physician Advisory Committee Chairperson

	08/27/2025

Kim Tangermann

Date Approved

Board of Commissioners Chairperson

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Population Health Grand Analysis

DeLorean Ruffin, DrPH, MPH

June 2025



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 Utilization Management system, Hospital ADT data, 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

- **Goal 1:** 75% of engaged members would have a Tdap vaccine within 120 days (4 months) of delivery
 - Goal *not* met (rate = 73%)
 - Engaged members were more likely to get a Tdap vaccine.

Note: Engaged members had a statistically significantly higher rate of completing Tdap vaccination before delivery (Rate = 73%) compared to members who were declined, members who were unable to reach and members who were not referred

Prenatal Program Engagement Results

Campaign Outcome	Members (% of Total)	Members who had TDAP vaccination in the 4 months before delivery (% of outcome)
Engaged	464 (38%)	340 (73%)
Declined	229 (19%)	150 (66%)*
Left message	351 (29%)	236 (67%)
Unable to reach	168 (14%)	109 (65%) *
Total	1212	835
Not Referred	7945	5393 (68%) *

* Indicates statistically significant result



Growing Together Postpartum Program



Postpartum Program Goal Outcome

- **Goal 1:** 75% of moms engaged in the program will attend a postpartum visit within 60 days of delivery
 - **Goal met** (Rate = 75%)
 - 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 races and ethnicities and unknown races

Postpartum Program Engagement Results

Campaign Outcome	Members (% of Total)	Members who attended a post- partum visit within 60 days of delivery (% of outcome)
Engaged	385 (32%)	290 (75%)
Declined	193 (16%)	140 (73%)
Left Message	300 (25%)	213 (71%)
Unable to Reach	126 (10%)	88 (70%)
Total	1004	731
Not Referred	7408	5380(73%)

* Indicates statistically significant result



Growing Together Healthy Babies Program



Healthy Babies Goal Outcome

- **Goal 1:** 80% of members engaged in the program will be compliant with 50% or more of their vaccinations during the program period
 - Goal met (Rate = 92%)
 - Engaged members were more likely to get a vaccine.
- **Goal 2:**
 - **Goal 2.1:** 25% of engaged members would attend all the well-child visits
 - Goal met (Rate = 67%).
 - Engaged members were more likely to attend WC visits.

Note: The white population had a statistically significant lower rate of completing vaccination and well-child visit rates compared to the Hispanics population.

Healthy Babies Engagement Results: Vaccines

Campaign Outcome	Members (% of Total)	2024 Members who completed vaccines (% of outcome)
Engaged	1551 (23%)	514 (86%)
Declined	1090 (16%)	405 (77%)*
Left Message	2698 (41%)	699 (75%)*
Unable to Reach	1282 (19%)	357 (69%)*
Total	6621	1975
Not Referred	12,689	3989 (53%)*

* Indicates statistically significant result

Healthy Babies Goal Outcome

- **Continued...**
- **Goal 2:**
 - **Goal 2.2:** 65% of members engaged in the program would be compliant with at least half of the recommended well-child visits was met
 - Goal met (Rate = 89%)
 - Engaged members were more likely of completing 3+ or 2+ WC visits (Rate =89%)

Note: The white population had a statistically significant lower rate of completing 3+ or 2+ WC visits (Rate= 83%) when compared to Hispanics (Rate =92%, Chi-square = 12.79, $p = 0.0003$).

Healthy Babies Engagement Results: WC Visits

Campaign Outcome	Members (% of Total)	Members who completed all recommended visits (% of outcome)
Engaged	1551 (23%)	1033 (67%)
Declined	1090 (16%)	593 (54%)*
Left Message	2698 (41%)	1415 (52%)*
Unable to Reach	1282 (19%)	588 (46%)*
Total	6621	3629
Not Referred	12,689	3141 (25%)*

* Indicates statistically significant result



Growing Together Healthy Kids Program



Healthy Kids Goal Outcome

- **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 = 32%).
 - Engaged members were more likely to attend a WC visit 120 days after call.

Note: There was no statistically significant difference in the rate of completing a well-child visit 120 days after the campaign contact date between the engaged white population and all the other ethnic groups.

Healthy Kids Engagement Results

Campaign Outcome	Members (% of Total)	Members who completed well-child visits between July 2023-June 2024 (% of outcome)
Engaged	1947 (23%)	1536 (79%)
Declined	689 (8%)	392 (57%)*
Left Message	3683 (44%)	2210 (60%)*
Unable to Reach	2092 (25%)	1108 (53%)*
Total	8411	5246
Not referred	44397	31067 (70%)*



Transitions of Care



Transitions of Care Program Criteria

Adult members (age > 20) **and:**

- Discharging home from acute care after hospital length of stay longer than four days, or
- Discharging home from an out-of-county hospital with any length of stay, or
- Having more than one admission in 10 days
- Excludes members in Long Term Care or in a Long Term Care Psychiatric facility

Pediatric members (under age 21) **and:**

- Discharging home from an acute care hospital stay with an admission date > 60 days from his/her date of birth and having any length of stay.

Transitions of Care: Member Experience Results

- **Goal 1:** 75% of members surveyed agree with each statement of the Adult TOC Satisfaction Survey.
 - Goal was met.
 - Average score ranged from 2.62 to 2.98, exceeding the goal average of 2.5
- **Goal 2:** 75% of members surveyed agree with each statement of the Pediatric TOC Satisfaction Survey.
 - Goal was met.
 - Average score ranged from 2.60 to 2.95, exceeding the goal average of 2.5.

TOC Member Experience Results

Survey Question	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my health issues.	2.97	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager).	2.98	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.91	Yes
After working with the case management team, I feel my ability to manage my healthcare needs is better.	2.89	Yes
My health has improved since working with my case management team.	2.66	Yes
I was able to safely transition between Providers with the help of my Care Team.	2.78	Yes
The relationship that I have with the PCP and/or Specialist offices has improved since working with my case management team.	2.62	Yes
I was provided the available equipment, medication and/or services that were needed.	2.85	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.

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 2.8 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.
 - All categories scored 3.00, above the goal average of 2.5

CCM Member Experience Results

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.	3	Yes
I feel my ability to manage my child's healthcare needs is better after working with CM.	2.50	Yes
I have a better understanding of my child's health conditions and/or diagnosis after working with CM.	3	Yes
I have a better understanding of my child's medications after working with CM.	3	Yes
My child's health has improved since working with our case management team.	3	Yes
The relationship that my child and I have with the PCP and/or Specialist offices has improved since working with our case management team.	3	Yes

Summary of Findings

Program Enhancements

Refined offerings based on lessons learned from prior years lessons learned

Multi-modal outreach (mail, calls, incentives) proved most effective for member engagement

Clinical & Utilization Goals Met

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

Member Experience Outcomes

Nearly **all experience goals met** in *Transitions of Care and Complex Case Management*

Ongoing challenge: limited provider availability for timely well-child visit scheduling

Equity & Stratified Outcomes

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

Opportunity to enhance analytics **by stratifying data by geographic location (county and ZIP code)**

Summary & Opportunities

PHM participants showed improved outcomes 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

PARTNERSHIP



HEALTHPLAN
of CALIFORNIA

A Public Agency

Population Health Management 2024 Program Impact Analysis

June 2025

Production Date: June 10, 2025

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I. Objective

The purpose of this report is to evaluate the Population Health Management (PHM) interventions performed during 2024 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 each staff member involved in program execution and qualitative analysis, along with their respective titles and department names:

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 and for adults (including older adults). The PHM Program clinical measures evaluated this year focused on campaigns that promoted influenza and Tdap vaccinations, specifically:

- Growing Together Prenatal Program
- Healthy Babies Growing Together

B. Utilization Measures

In alignment with California's Department of Health Care Services (DHCS) Bold Goals 2025¹, 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 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

¹ [CalAIM Bold Goals: 50x2025](#)

compiles and reviews these responses at least annually to assess whether 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:

- 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. In 2024, flu vaccinations were added as an incentivized component of this program, however, results of this addition will not be reviewed in this impact analysis reports. 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 75% of members who engaged in the program between September 1, 2023, and December 31, 2024, 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

<i>Measure Description:</i>	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.
<i>Denominator:</i>	Partnership members who had at least one prenatal care visit and delivered a baby between January-December 2024
<i>Numerator:</i>	Of denominator, those who had a Tdap September 2023-December 2024
<i>Measurement Period:</i>	September 2023 through December 2024 for numerator. January 2024, through December 2024 for denominator.
<i>Exclusion Criteria:</i>	Individuals who were not Partnership members when they delivered a baby.

Results

<i>Campaign Outcome</i>	<i>Members (% of Total)</i>	<i>Members who had Tdap vaccination in the 4 months before delivery (% of outcome)</i>
Engaged	464(38%)	340 (73%)
Declined	229(19%)	150 (66%)*
Left Message	351(29%)	236(67%)
Unable to Reach	168(14%)	109 (65%) *
Total	1212	835
Not Referred	7945	5393 (68%) *

* Indicates statistically significant result

Analysis

<i>Measure</i>	<i>Test</i>	<i>Statistic</i>	<i>P-value</i>	<i>Significance</i>
Engaged Vs Declined	Chi-Square	4.4735	0.0344	Yes*
Engaged Vs Left Message	Chi-Square	3.5168	0.0607	No
Engaged Vs Unable to Reach	Chi-Square	4.2255	0.0398	Yes*

Engaged Vs Not Referred	Chi-Square	6.2283	0.0126	Yes*

* Indicates statistically significant result

The goal for this intervention was for 75% of members engaged in the program in 2024 to have a higher percentage of Tdap vaccinations within 120 days (four months) prior to delivery. The goal was not met (Rate = 73%). Engaged members had a statistically significantly higher rate of completing Tdap vaccination 4 months before delivery (Rate = 73%) compared to members who

- Declined (Rate = 66%, Chi-square = 4.47, $p = 0.0344$),
- Members who were unable to be reached (Rate = 65%, Chi-square = 4.22, $p = 0.0398$), and
- Members who were not referred (Rate = 68%, Chi-square = 6.15, $p = 0.0131$).

While the data does show statistical significance in the engaged category compared to other campaign categories, we did not meet our goal. Since the control groups are not randomized, the degree to which the conversation with PHM staff changes behavior is uncertain. If propensity for answering the phone and having a conversation with Partnership staff is associated with probability of also seeking out and obtaining vaccination, then the additional effects of the educational intervention cannot be determined.

Analysis by Race and Ethnicity

Ethnicity Group	Members in Campaign	Engaged	Members with Tdap				
			N(%)	Test	Statistic	P-value	Sig
WHITE	365	117(32%)	76(65%)	Reference			
AMERICAN INDIAN	19	5(26%)	3(60%)	Fishers Exact	0.3445	1.0000	No
ASIAN	66	21(32%)	18(86%)	Chi-Square	3.5321	0.0602	No
BLACK	40	21(53%)	13(62%)	Chi-Square	0.0724	0.7878	No
HISPANIC	544	233(43%)	186(80%)	Chi-Square	9.1519	0.0025	Yes*
UNKNOWN/ OTHER	174	64(37%)	41(64%)	Chi-Square	0.0145	0.9042	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	4	3(75%)	3(100%)	Fishers Exact	0.2816	0.5502	No

* Indicates statistically significant result

The engaged white population had a statistically significant lower rate of completing a Tdap vaccination before delivery (Rate = 65%) compared to the Hispanics (Rate = 80%, Chi-

square = 9.15, $p = 0.0025$). The results for other groups are displayed in the table above. This data shows our current campaign is associated with a measurable difference in the Tdap vaccination rate 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

<i>Measure Description:</i>	Members who engaged in the Growing Together Prenatal program will attend a post-partum visit in the 60 days following delivery
<i>Denominator:</i>	Partnership members who had at least one prenatal care visit and delivered baby January-November 2024.
<i>Numerator:</i>	Of denominator, those who attended a post-partum visit within 60 days of delivery.
<i>Measurement Period:</i>	January 2024 through November 2024. (Adjusted measurement period to account for claims lag).
<i>Exclusion Criteria:</i>	Individuals who were not Partnership members when they delivered a baby

Results

<i>Campaign Outcome</i>	<i>Members (% of Total)</i>	<i>Members who attended a post-partum visit within 60 days of delivery (% of outcome)</i>
Engaged	385(32%)	290(75%)
Declined	193(16%)	140(73%)
Left Message	300(25%)	213(71%)
Unable to Reach	126(10%)	88(70%)
Total	1004	731
Not Referred	7408	5380(73%)

* Indicates statistically significant result

Analysis

<i>Measure</i>	<i>Test</i>	<i>Statistic</i>	<i>P-value</i>	<i>Significance</i>
Engaged Vs Declined	Chi-Square	0.5237	0.4692	No
Engaged Vs Left Message	Chi-Square	1.6164	0.2036	No
Engaged Vs Unable to Reach	Chi-Square	1.4826	0.2234	No
Engaged Vs Not Referred	Chi-Square	1.3465	0.2459	No

* Indicates statistically significant result

The Growing Together Prenatal Program did not meet the goal of 80% attendance at postpartum visits (Rate = 75%). While the engaged members had the best outcomes, there was no statistically significant difference in the rate of postpartum visit attendance within 60 days of delivery between the engaged members and all the other campaign outcomes. This data seems to suggest that this program is not making a difference in postpartum visit rates among our eligible population.

Analysis by Race and Ethnicity

<i>Ethnicity Group</i>	<i>Members in Campaign</i>	<i>Engaged</i>	<i>Members with postpartum visits</i>				
			<i>N (%)</i>	<i>Test</i>	<i>Statistic</i>	<i>P-value</i>	<i>Sig</i>
WHITE	365	117(32%)	63(54%)	Reference			
AMERICAN INDIAN	19	5(26%)	3(60%)	Fishers Exact	0.3378	1.0000	No
ASIAN	66	21(32%)	17(81%)	Chi-Square	3.8537	0.0496	Yes*
BLACK	40	21(53%)	9(43%)	Chi-Square	2.6406	0.1042	No
HISPANIC	544	233(43%)	151(65%)	Chi-Square	5.2504	0.0219	Yes*
UNKNOWN/ OTHER	174	64(37%)	44(69%)	Chi-Square	2.8874	0.0893	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	4	3(75%)	3(100%)	Fishers Exact	0.3104	0.5490	No

* Indicates statistically significant result

The engaged white population had a statistically significant lower rate of attending a postpartum visit within 60 days of delivery (Rate = 54%) compared to the Asians (Rate = 81%, Chi-square = 3.85, p = 0.0496) and Hispanics (Rate = 65%, Chi-square = 5.25, p = 0.0219).

Results for other groups are as follows:

- American Indians (Rate = 60%, Fishers Exact = 0.3378, p = 1.0000);
- Asian (Rate = 81%, Chi-Square = 3.8537, p = 0.0496);

- Black (Rate = 43%, Chi-Square = 2.6406, p = 0.1042
- Hispanics (Rate = 65%, Chi-Square = 5.2504, p = 0.0219);
- Unknown/other population (Rate = 69%, Chi-Square = 2.8874, p = 0.0893); and
- Native Hawaiian or Other Pacific Islander (Rate = 100%, Fishers Exact = 0.3104, p = 0.5490).

This data shows our current campaign may not be making any measurable difference in the lives of some of our non-white population Race and ethnicity analysis is limited by 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

<i>Measure Description:</i>	Newborns linked to members who engaged in the Growing Together Prenatal program will attend a well-baby visit in the 60 days following birth
<i>Denominator:</i>	Linked babies that were born between January-November 2024 whose mother had at least one prenatal care visit and delivered a baby between January-November 2024.
<i>Numerator:</i>	Of denominator, linked babies who attended a well-child visit within 60 days of birth.
<i>Measurement Period:</i>	January 2024 through November 2024 for denominator.(Adjusted measurement period to account for claims lag).
<i>Exclusion Criteria:</i>	Individuals who were not Partnership members when they delivered a baby

Results

<i>Campaign Outcome</i>	<i>Members (% of Total)</i>	<i>Members who were linked to a Newborn (% of Outcome)</i>	<i>Newborns who attended a well-child visit within 60 days of birth (% of linked Newborns)</i>
Engaged	385(32%)	340(88%)	236(81%)
Declined	193(16%)	169(88%)	122(87%)
Left Message	300(25%)	264(88%)	185(87%)
Unable to Reach	126(10%)	118(94%)	82(93%)
Total	1004	891	625
Not Referred	7408	6770	4714(88%)

Analysis of Newborns who attended a well-child visit within 60 day of birth

<i>Measure</i>	<i>Test</i>	<i>Statistic</i>	<i>P-value</i>	<i>Significance</i>
Engaged Vs Declined	Chi-Square	0.4174	0.5182	No
Engaged Vs Left Message	Chi-Square	0.0310	0.8602	No
Engaged Vs Unable to Reach	Chi-Square	0.0003	0.9871	No
Engaged Vs Not Referred	Chi-Square	0.0067	0.9349	No

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 = 81%). However, there was no statistically significant difference in the rate of new-born attending a well-child visit within 60 days of birth between the engaged members and all the other campaign outcomes. As such, this data seems to suggest that this program is not making a difference among our eligible member population.

Analysis by Race and Ethnicity

<i>Ethnicity Group</i>	<i>Members in Campaign</i>	<i>Engaged</i>	<i>Newborns with well-child visits</i>				
			<i>N (%)</i>	<i>Test</i>	<i>Statistic</i>	<i>P-value</i>	<i>Sig</i>
WHITE	365	117(32%)	57(49%)	Reference			
AMERICAN INDIAN	19	5(26%)	3(60%)	Fishers Exact	0.4256	1.0000	No
ASIAN	66	21(32%)	14(67%)	Fishers Exact	0.1090	0.2247	No
BLACK	40	21(53%)	11(52%)	Chi-Square	0.7111	0.3991	No
HISPANIC	544	233(43%)	118(51%)	Chi-Square	0.0530	0.8180	No
UNKNOWN/ OTHER	174	64(37%)	31(48%)	Chi-Square	1.2038	0.2726	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	4	3(75%)	2(67%)	Fishers Exact	0.4469	1.0000	No

There was no statistically significant difference in the rate of newborns attending a well-child visit within 60 days of birth between the engaged white population (Rate = 49%) and all the other ethnic groups. Results for other groups are as follows:

- American Indian (Rate = 60%, Fishers Exact = 0.4256, p = 1.0000);
- Asian (Rate = 67%); Fishers Exact = 0.1090, p = 0.2247);
- Black (Rate = 52%, Chi-Square = 0.7111, p = 0.3991);
- Hispanic (Rate = 51%), Chi-Square = 0.0530, p = 0.8180);
- Unknown/Other (Rate = 48%, Chi-Square = 1.2038, p = 0.2726);
- Native Hawaiian or Other Pacific Islander (Rate = 67%, Fishers Exact = 0.4469, p = 1.0000)

This data seems to show our current campaign is not making any measurable difference in the lives of our non-white population. This analysis is limited by the the small sample size for some groups.

Year-Over-Year Analysis of the Prenatal Program

In 2024, 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:

<i>Campaign Outcome</i>	<i>2024 Members (% of Total)</i>	<i>2024 Post-Partum Visits (% of outcome)</i>	<i>2023 Members (% of Total)</i>	<i>2023 Post-Partum Visits (% of outcome)</i>
Engaged	385(32%)	290(75%)	251(32%)	194(77%)
Declined	193(16%)	140(73%)	92(12%)	62(67%)
Left Message	300(25%)	213(71%)	302(39%)	214(71%)
Unable to Reach	126(10%)	88(70%)	129(17%)	94(73%)
Total	1004	731	774	564
Not Referred	7408	5380(73%)	4652	3405(73%)

In 2024, Partnership explored additional strategies to increase engagement among pregnant members in the Growing Together Prenatal Program. As a result, we continued to refine our prenatal member identification algorithm to improve accuracy and outreach effectiveness. Between 2023 and 2024, there was an increase of members identified, from 774 in 2023 to 1,004 in 2024. We anticipate increased identification of pregnant members in 2025.

In addition, we made improvements to the scripts and did further training for motivational interviewing to attempt to improve member-engagement skills in order to increase our overall percentage of members engaged in the program. The overall number of members engaged

who agreed to participate increased between 2023 (251) to 2024 (385), 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 the 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. The goal of increasing the percentage of members attending a postpartum visit within 60 days of delivery was not met. Additionally, 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. Furthermore, the engaged white population had a statistically significant lower rate of completing a Tdap vaccination before delivery and of attending a post-partum visit within 60 days of delivery when compared to certain race/ethnic groups among Partnership's membership. Staff from Partnership's Population Health Department, including the manager and community health needs liaison, conduct member satisfaction surveys over the phone at the end of the program to gather and analyze qualitative feedback. Results of this qualitative feedback from Partnership members highlights significant barriers to achieving these goals and primarily includes long appointment wait times, limited provider access, and not feeling the need to be seen for a postpartum checkup. Vaccine hesitancy also plays a role in not meeting the vaccination goals.

The prenatal program engagement rate for Tdap vaccines has decreased from 188 (75%) in 2023 to 340 (73%) in 2024. The prenatal program engagement rates for postpartum visits within 60 days of delivery has increased from 194 (77%) in 2023 to 290 (75%) in 2024. Current efforts to continue improving program engagement rates for both programs include assisting members with scheduling appointments via warm handoffs by directly contacting providers on their behalf. 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 decline in results may be associated with vaccine hesitancy, access to care challenges, low perceived need, and/or possible gaps in program implementation.

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. In addition, Partnership is exploring alternative opportunities and models to help providers extend clinic hours for well child, prenatal, and postpartum visits. 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 and will continue to make efforts to address 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. It also includes an on-call obstetrics teams programs to improve perinatal access to care. These efforts aim to strengthen access to care for Partnership members.

2. Identifying and referring high-risk pregnant members

Prior to 2024, Partnership saw, and began to act on, an opportunity to assign a high risk level to pregnant members as part of new program efforts referred to as Transitions of Care (TOC) services (soon to be called Transitional Care Services). Since then, 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 community resources such as Community Health Worker or doula benefits to strengthen engagement during their pregnancy and post-partum period. By conducting these activities, the hope is for these interventions to serve as an opportunity to improve the percentage of members who complete a post-partum 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 encourages 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

<i>Measure Description:</i>	Members who engaged in the Growing Together Post-Partum Program will attend a post-partum visit in the 60 days following delivery
<i>Denominator:</i>	Partnership members who delivered a baby January-November 2024.
<i>Numerator:</i>	Of denominator, the percentage of members who attended a post-partum visit within 60 days of delivery
<i>Measurement Period:</i>	January 2024 through November 2024 for denominator. January 2023-January 2024 for numerator. (Adjusted measurement period to account for claims lag).
<i>Exclusion Criteria:</i>	Individuals who were not Partnership members when they delivered a baby.

Results

<i>Campaign Outcome</i>	<i>Members (% of Total)</i>	<i>Members who attended a post-partum visit within 60 days of delivery (% of outcome)</i>
Engaged	1757(24%)	1324(75%)
Declined	1179(16%)	802(68%)*
Left Message	2568(35%)	1604(62%)*
Unable to Reach	1763(24%)	1160(66%)*
Total	7267	4890
Engaged in Prenatal	274(3%)	208(76%)*
Not Referred	2520	1449(58%)*

* Indicates statistically significant result

Analysis

<i>Measure</i>	<i>Test</i>	<i>Statistic</i>	<i>P-value</i>	<i>Significance</i>
Engaged Vs Declined	Chi-Square	18.9861	<.0001	Yes*
Engaged Vs Left Message	Chi-Square	79.3241	<.0001	Yes*
Engaged Vs Unable to Reach	Chi-Square	38.7133	<.0001	Yes*
Engaged Vs Not Engaged in Prenatal	Chi-Square	5.0452	0.0247	Yes*
Engaged Vs Not Referred	Chi-Square	144.7667	<.0001	Yes*

* Indicates statistically significant result

This intervention did meet the goal that 75% of members engaged in the program will attend a post-partum visit within 60 days of delivery (Rate = 75%). Engaged members had a statistically significantly higher rate of attending a postpartum visit within 60 days of delivery (Rate = 75%) when compared to the following outcomes:

- Declined members (Rate =68%, Chi-square = 18.98, p<.0001),
- Members who were left message (Rate =62%, Chi-square = 79.32, p <.0001),
- Members who were unable to reach (Rate =66%, Chi-square = 38.71, p<.0001) and
- Not referred members (Rate =58%, Chi-square = 144.77, p <.0001)

Furthermore, members engaged only in the postpartum program had a statistically significantly lower rate of attending a postpartum visit within 60 days of delivery when compared to members who were engaged in prenatal program (Rate =76%, Chi-square = 5.04, p=0.0247). Higher rate may be due to the effect of the phone conversation and/or the individual member incentive for post-partum visits, but analysis may be affected by underlying differences in the population willing to be engaged with this effort.

Analysis by Race and Ethnicity

Ethnicity Group	Members in Campaign	Engaged	Members with postpartum visits				
			N (%)	Test	Statistic	P-value	Sig
WHITE	2363	418(18%)	265(63%)	Reference			
AMERICAN INDIAN	173	22(13%)	19(86%)	Chi-Square	4.8172	0.0282	Yes*
ASIAN	348	80(23%)	61(76%)	Chi-Square	4.9063	0.0268	Yes*
BLACK	190	55(29%)	37(67%)	Chi-Square	0.3163	0.5739	No
HISPANIC	3346	973(29%)	789(81%)	Chi-Square	49.8556	<.0001	Yes*
UNKNOWN/OTHER	832	204(25%)	149(73%)	Chi-Square	5.7263	0.0167	Yes*
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	15	5(33%)	4(80%)	Fishers Exact	0.2981	0.6571	No

* Indicates statistically significant result

The engaged white population had a statistically significantly lower rate of members with postpartum visits (Rate = 63%) when compared to

- American Indians (Rate = 86%, Chi-Square = 4.82, p =0.0282), Asians (Rate = 76%, Chi-Square = 4.90, p =0.0268),
- Hispanics (Rate = 81%, Chi-Square = 49.85, p <0.0001) and
- other unknown race (Rate = 73%, Chi-Square = 5.72, p =0.0167).

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. Analysis is limited by 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

<i>Measure Description:</i>	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
<i>Denominator:</i>	Linked babies that were born between January-November 2024 whose mother had at least one prenatal care visit and delivered a baby between January-November 2024.
<i>Numerator:</i>	Of denominator, linked babies who attended a well-child visit within 60 days of birth.
<i>Measurement Period:</i>	January 2024 through November 2024 for denominator. January 2023-January 2024 for numerator. (Adjusted measurement period to account for claims lag).
<i>Exclusion Criteria:</i>	Individuals who were not Partnership members when they delivered a baby.

Results

<i>Campaign Outcome</i>	<i>Members (% of Total)</i>	<i>Members who were linked to a New Born (% of Outcome)</i>	<i>Newborns who attended a well-child visit within 60 days of birth (% of linked Newborns)</i>
Engaged	1757(24%)	1623(92%)	1158(71%)
Declined	1179(16%)	1076(91%)	779(72%)
Left Message	2568(35%)	2366(92%)	1650(70%)
Unable to Reach	1763(24%)	1613(91%)	1120(69%)
Total	7267	6678	4707
Engaged in Prenatal	274(3%)	250(91%)	176(70%)
Not Referred	2520	2132	1274(60%)

* Indicates statistically significant result

Analysis of newborns who attended a well-child visit within 60 days of birth

<i>Measure</i>	<i>Test</i>	<i>Statistic</i>	<i>P-value</i>	<i>Significance</i>
Engaged Vs Declined	Chi-Square	0.3510	0.5535	No
Engaged Vs Left Message	Chi-Square	1.1994	0.2734	No

Engaged Vs Unable to Reach	Chi-Square	1.4214	0.2332	No
Engaged Vs Not Engaged in Prenatal	Chi-Square	0.4264	0.5138	No
Engaged Vs Not Referred	Chi-Square	54.2754	<.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 = 71%). Engaged members had a statistically significantly higher rate of newborns attending a well-child visit within 60 days of delivery (Rate = 71%) when compared to not referred members (Rate =60%, Chi-square = 54.28, p <.0001). This data seems to suggest our current campaign is making an impact.

Analysis by Race and Ethnicity

Ethnicity Group	Members in Campaign	Engaged	Newborns with well-child visits				
			N (%)	Test	Statistic	P-value	Sig
WHITE	2363	418(18%)	267(64%)	Reference			
AMERICAN INDIAN	173	22(13%)	15(68%)	Chi-Square	0.0278	0.8676	No
ASIAN	348	80(23%)	62(78%)	Chi-Square	4.3985	0.0360	Yes*
BLACK	190	55(29%)	34(62%)	Chi-Square	0.1376	0.7106	No
HISPANIC	3346	973(29%)	654(67%)	Chi-Square	0.5667	0.4516	No
UNKNOWN/ OTHER	832	204(25%)	121(59%)	Chi-Square	0.3546	0.5515	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	15	5(33%)	5(100%)	Fishers Exact	0.1674	0.3278	No

* Indicates statistically significant result

The engaged white population had a statistically significantly lower rate of members with well-child visits (Rate = 64%) when compared to Asians (Rate = 78%, Chi-Square = 4.4, p =0.036). This data shows our current campaign may not be making a measurable difference in the lives of many of our non-white populations. Analysis is limited by 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 the results compared to non-engaged members. Furthermore, both program goals were met. However, the engaged white population had a statistically significant lower rate of members with well-child visit when compared to certain race/ethnic groups among Partnership's membership.

Staff from Partnership's Population Health Department, including the manager and community health needs liaison, conduct member satisfaction surveys over the phone at the end of the program to collect and analyze qualitative feedback. Significant barriers based on this qualitative feedback from Partnership members include primarily concerns of long appointment wait times, limited provider choices, and transportation. Other barriers identified by Population Health staff include certain eligibility requirements and logistical challenges in which a newborn's enrollment into Medi-Cal can be delayed. The postpartum program engagement rates for postpartum visits within 60 days of delivery increased from 942 (73%) in 2023 to 1,342 (75%) in 2024. The postpartum program engagement rates for newborns linked to care has also increased from 815 (68%) in 2023 to 1,158 (71%) in 2024. Current efforts to continue improving program engagement rates for both programs include assisting with scheduling appointments by directly calling the provider on their behalf or warm handoffs connecting member to provider. 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.

To help address logistical challenges faced by program participants, the Population Health Team has identified an opportunity to enhance outreach efforts to parents of newborns. The goal of this additional outreach is to 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 also 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 organizations. Furthermore, the Population Health department is exploring opportunities to extend provider clinic hours for well child and postpartum visits. Partnership also increased the incentive amount 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 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 12 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. Please note in July 2024, enrollment age was modified to include infants under 24 month of age. This shift will be reflected in next year's report.

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

<i>Measure Description:</i>	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. - Age at enrollment 0 - 6 months – 9+ vaccines - Age at enrollment 7 - 12 months – 4+ vaccines
<i>Denominator:</i>	Members enrolled with Partnership at less than 12 months of age and who were enrolled with Partnership for at least 12 months as of report run date.
<i>Numerator:</i>	Of denominator, those who completed immunizations by age at enrollment: * 0 - 6 months - 9+ vaccinations * 7 - 12 months - 4+ vaccinations
<i>Measurement Period:</i>	July 2023 through June 2024 (Adjusted measurement period to account for a delay in provider billing of services and to include recent Partnership enrolled members).
<i>Exclusion Criteria:</i>	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.

<i>Campaign Outcome</i>	<i>Members (% of Total)</i>	<i>July 2023-June 2024 Members who completed vaccines (% of outcome)</i>	<i>2023 Members who completed vaccines (% of outcome)</i>
Engaged	1551(23%)	1424(92%)	514(86%)
Declined	1090(16%)	886(81%)*	405(77%)*
Left Message	2698(41%)	2216(82%)*	699(75%)*
Unable to Reach	1282(19%)	1052(82%)*	357(69%)*
Total	6621	5578	1975
Not Referred	12,689	4140(33%)*	3989(53%)*

* Indicates statistically significant result

Analysis

<i>Measure</i>	<i>Test</i>	<i>Statistic</i>	<i>P-value</i>	<i>Significance</i>
Engaged Vs Declined	Chi-Square	64.7147	<.0001	Yes*
Engaged Vs Left Message	Chi-Square	75.1082	<.0001	Yes*
Engaged Vs Unable to Reach	Chi-Square	60.6115	<.0001	Yes*
Engaged Vs Not Referred	Chi-Square	2033.6048	<.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 = 92%). Engaged members had a statistically significantly higher rate of completing 9+ or 4+ vaccines (Rate =92%) compared to the following outcomes:

- Members who declined (Rate =81%, Chi-square = 64.71, p =0.0001),
- Members who were left message (Rate =82%, Chi-square = 75.11, p <0.0001),
- Members who were unable to reach (Rate = 82%, Chi-square = 60.61, p <0.0001) and
- Members who were not referred (Rate = 33%, Chi-square = 2033.6, p <0.0001)

In addition, significantly more members completed vaccines in July 2023-June 2024 than in 2023 (1,424 compared to 514, respectively). This may be due in part to Partnership's 10 county expansion in 2024.

Analysis by Race and Ethnicity

Ethnicity Group	Members in Campaign	Engaged	Members completing recommended vaccinations				
			N (%)	Test	Statistic	P-value	Sig
WHITE	962	155(16%)	123(79%)	Reference			
AMERICAN INDIAN	57	7(12%)	6(86%)	Fishers Exact	0.3684	1.0000	No
ASIAN	179	48(27%)	46(96%)	Chi-Square	7.1374	0.0075	Yes*
BLACK	123	26(21%)	25(96%)	Fishers Exact	0.0238	0.0516	No
HISPANIC	2273	677(30%)	655(97%)	Chi-Square	62.8848	<.0001	Yes*
UNKNOWN/ OTHER	3021	638(21%)	569(89%)	Chi-Square	10.8421	0.0010	Yes*
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	6	0(0%)	Insufficient Data				

* Indicates statistically significant result

The engaged white population had a statistically significant lower rate of completing 9+ or 4+ vaccines (Rate =79%) when compared to Asians (Rate =96%, Chi-square = 7.13, p =0.0075), Hispanics (Rate =97%, Chi-square = 62.88, p <0.0001) and unknown/other race (Rate =89%, Chi-square = 10.8, p =0.001). This data shows our current campaign may be making a measurable difference in the lives of some of our non-white populations. Analysis is limited 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 12 months of engagement (5+ visits for members enrolled between ages 0 – 6 months and 4+ visits for members enrolled between 7 – 12 months). The tertiary goal aims for 65% of members engaged in the program to be compliant with at least half of the recommended well-child visits within 12 months of engagement (3+ visits for members enrolled between 0 – 6 months of age and 2+ visits for members enrolled between 7 – 12 months of age).

Methodology

<i>Measure Description:</i>	The percentage of members who were reached in the first twelve 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 half of the recommended child visits for their enrollment time period.
<i>Denominator:</i>	Members enrolled with Partnership at less than 12 months of age and who were enrolled with Partnership for at least 12 months as of report run date.
<i>Numerator:</i>	Of denominator, those who had completed all well-care visits by age at 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)
<i>Measurement Period:</i>	July 2023 through June 2024 (Adjusted measurement period to account for a delay in provider billing of services and to include recent Partnership enrolled members).
<i>Exclusion Criteria:</i>	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.

<i>Campaign Outcome</i>	<i>Members (% of Total)</i>	<i>Members who completed all recommended visits (% of outcome)</i>	<i>Members who completed some of the recommended visits (% of outcome)</i>
Engaged	1551(23%)	1033(67%)	1377(89%)
Declined	1090(16%)	593(54%)*	862(79%)*
Left Message	2698(41%)	1415(52%)*	2100(78%)*
Unable to Reach	1282(19%)	588(46%)*	925(72%)*
Total	6621	3629	5264
Not Referred	12,689	3141(25%)*	4097(32%)*

* Indicates statistically significant result

Analysis

Members who completed all the recommended well-child visits by age at campaign enrollment

<i>Measure</i>	<i>Test</i>	<i>Statistic</i>	<i>P-value</i>	<i>Significance</i>
Engaged Vs Declined	Chi-Square	40.2564	<.0001	Yes*
Engaged Vs Left Message	Chi-Square	80.8151	<.0001	Yes*
Engaged Vs Unable to Reach	Chi-Square	123.2894	<.0001	Yes*
Engaged Vs Not Referred	Chi-Square	1168.1509	<.0001	Yes*

* Indicates statistically significant result

These results indicate that the goal of 25% of engaged members would attend all the well-child visits was met (Rate = 67%). Engaged members had a statistically significantly higher rate of completing 5+ or 4+ WC visits (Rate =67%) compared to the following outcomes:

- Declined members (Rate = 54%, Chi-square = 40.26 p <0.0001),
- Members who were left message (Rate = 52%, Chi-square = 80.82, p<0.0001),
- Members who were unable to reach (Rate = 46%, Chi-square = 123.29, p <0.0001) and
- Members who were not referred (Rate = 25%, Chi-square = 1168.15, p <0.0001)

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

<i>Measure</i>	<i>Test</i>	<i>Statistic</i>	<i>P-value</i>	<i>Significance</i>
Engaged Vs Declined	Chi-Square	46.6625	<.0001	Yes*
Engaged Vs Left Message	Chi-Square	79.3650	<.0001	Yes*
Engaged Vs Unable to Reach	Chi-Square	127.4251	<.0001	Yes*
Engaged Vs Not Referred	Chi-Square	1863.9823	<.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 half of the recommended well-child visits was met (Rate = 89%). Engaged members had a statistically significantly higher rate of completing 3+ or 2+ WC visits (Rate =89%) compared to the following outcomes:

- Declined members (Rate = 79%, Chi-square = 46.66, p <0.0001),
- Members who were left message (Rate =78%, Chi-square = 79.36, p <0.0001),
- Members who were unable to reach (Rate = 72%, Chi-square = 127.42, p <0.0001) and
- Members who were not referred (Rate = 32%, Chi-square = 1863.98, 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 attending all recommended well-child visits

<i>Ethnicity Group</i>	<i>Members in Campaign</i>	<i>Engaged</i>	<i>Members attending all recommended visits</i>				
			<i>N (%)</i>	<i>Test</i>	<i>Statistic</i>	<i>P-value</i>	<i>Sig</i>
WHITE	962	155(16%)	88(57%)	Reference			
AMERICAN INDIAN	57	7(12%)	5(71%)	Fishers Exact	0.2393	0.6997	No
ASIAN	179	48(27%)	31(65%)	Chi-Square	0.9214	0.3371	No
BLACK	123	26(21%)	12(46%)	Chi-Square	1.0157	0.3135	No
HISPANIC	2273	677(30%)	487(72%)	Chi-Square	13.5796	0.0002	Yes*
UNKNOWN/ OTHER	3021	638(21%)	410(64%)	Chi-Square	2.9939	0.0836	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	6	0(0%)	Insufficient Data				

* Indicates statistically significant result

The engaged white population had a statistically significant lower rate of completing 5+ or 4+ WC visits (Rate = 57%) when compared to Hispanics (Rate =72%, Chi-square = 2.99, p =0.0002). This data shows our current campaign is making a measurable difference in the lives of our Hispanic populations.

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	962	155(16%)	128(83%)	Reference			
AMERICAN INDIAN	57	7(12%)	5(71%)	Fishers Exact	0.2561	0.6097	No
ASIAN	179	48(27%)	44(92%)	Chi-Square	2.3384	0.1262	No
BLACK	123	26(21%)	22(85%)	Fishers Exact	0.2203	1.0000	No
HISPANIC	2273	677(30%)	623(92%)	Chi-Square	12.7979	0.0003	Yes*
UNKNOWN/ OTHER	3021	638(21%)	555(87%)	Chi-Square	2.0299	0.1542	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	6	0(0%)	Insufficient Data				

* Indicates statistically significant result

The engaged white population had a statistically significant lower rate of completing 3+ or 2+ WC visits (Rate= 83%) when compared to Hispanics (Rate =92%, Chi-square = 12.79, p =0.0003). This data shows our current campaign is making a measurable difference in the lives of our Hispanic 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 2023-June 2024, of the 19,310 Partnership members ages 0 – 12 months, only 6,621 (~34%) were identified as potential program participants. In 2025, 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, members were more likely to receive vaccinations from June 2023-July 2024 than they were in 2023 (1424 compared to 514, respectively). Furthermore, members were more likely to attend all or some of their well child visits from June 2023-July 2024 than they were in 2023 (1033 compared to 105, respectively and 1377 compared to 396 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. As noted in the 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, both measures under this program saw an increase in rates. Furthermore, both 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 provider, 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 with motivational interviewing skills during outreach call campaigns by reinforcing the importance of timely immunizations. Additionally, there is an opportunity to further promote 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. A multi-disciplinary team comprising representative from Quality, Provider Relations, the Office of the Chief Medical Officer, and Population Health will evaluate the data in order to

develop and implement targeted interventions to adopt in 2025/2026 to mitigate these concerns.

VII. Healthy Kids Growing Together

In January 2023, Partnership transitioned away from the Healthy Kids Pilot programs to create a program designed to reach all children between ages 3 through 6. 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 2023-June 2024.

Methodology

<i>Measure Description:</i>	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.
<i>Denominator:</i>	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 have never had a well-child visit coded while enrolled with Partnership.
<i>Numerator:</i>	Of denominator, those who completed a well-child visit during the: • 120 days after the call • The measurement period (July 2023-June 2024)
<i>Measurement Period:</i>	July 2023 through June 2024. (Adjusted measurement period to include more eligible participants).
<i>Exclusion Criteria:</i>	Members enrolled less than 12 total months and members identified as California Children's Services (CCS)

Results

Members who completed a well-child visits 120 days after the call

<i>Campaign Outcome</i>	<i>Members (% of Total)</i>	<i>Members who completed a well-child visits 120 days after the call (% of outcome)</i>
Engaged	1947(23%)	621(32%)
Declined	689(8%)	167(24%)*
Left Message	3683(44%)	962(26%)*
Unable to Reach	2092(25%)	423(20%)*
Total	8411	2173
Not Referred	44397	NA

* Indicates statistically significant result

Analysis

Members who completed a well-child visits 120 days after the call

<i>Measure</i>	<i>Test</i>	<i>Statistic</i>	<i>P-value</i>	<i>Significance</i>
Engaged Vs Declined	Chi-Square	14.2378	0.0002	Yes*
Engaged Vs Left Message	Chi-Square	21.0183	<.0001	Yes*
Engaged Vs Unable to Reach	Chi-Square	71.7205	<.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 = 32%). Engaged members had a statistically significantly higher rate of completing WC visit 120 days after call (Rate =32%) when compared to the following outcomes:

- Declined members (Rate = 24%, Chi-square = 14.24, p =0.0002)
- Members who were left message (Rate = 26%, Chi-square = 21.02, p <0.0001),
- Members who were unable to reach (Rate = 20%, Chi-square = 71.72, p < 0.0001).

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 2023-June 2024

<i>Campaign Outcome</i>	<i>Members (% of Total)</i>	<i>Members who completed well-child visits between July 2023-June 2024 (% of outcome)</i>
Engaged	1947(23%)	1536(79%)
Declined	689(8%)	392(57%)*
Left Message	3683(44%)	2210(60%)*
Unable to Reach	2092(25%)	1108(53%)*
Total	8411	5246
Not Referred	44397	31067(70%)*

* Indicates statistically significant result

Analysis

Members who completed well-child visits between July 2023-June 2024

<i>Measure</i>	<i>Test</i>	<i>Statistic</i>	<i>P-value</i>	<i>Significance</i>
Engaged Vs Declined	Chi-Square	125.3428	<.0001	Yes*
Engaged Vs Left Message	Chi-Square	204.0183	<.0001	Yes*
Engaged Vs Unable to Reach	Chi-Square	299.8251	<.0001	Yes*
Engaged Vs Not Referred	Chi-Square	71.0714	<.0001	Yes*

* Indicates statistically significant result

The goal that 70% of engaged members will have a well-child visit between July 2023 and June 2024 was met (Rate = 79%). Engaged members had a statistically significantly higher rate of completing WC visit (Rate = 79%) when compared to the following outcomes:

- Declined members (Rate = 57%, Chi-square =125.34 , p <0.0001),
- Members who were left message (Rate = 60%, Chi-square = 204.02, p <0.0001),
- Members who were unable to reach (Rate = 53%, Chi-square = 299.83, p <0.0001), and
- Members who were not referred (Rate = 70%, Chi-square =71.07, p <0.0001) Analysis by Race and Ethnicity

This data seems to suggest that the program is making an impact among the eligible population.

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	2056	316(15%)	94(30%)	Reference			
AMERICAN INDIAN	158	27(17%)	9(33%)	Chi-Square	0.1523	0.6964	No
ASIAN	253	71(28%)	26(37%)	Chi-Square	1.2801	0.2579	No
BLACK	311	66(21%)	22(33%)	Chi-Square	0.3321	0.5644	No
HISPANIC	3057	910(30%)	301(33%)	Chi-Square	1.1911	0.2751	No
UNKNOWN/ OTHER	2561	554(22%)	169(31%)	Chi-Square	0.0549	0.8147	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	15	3(20%)	0(0%)	N/A			

* Indicates statistically significant result

There was no statistically significant difference in the rate of completing a well-child visit 120 days after the campaign contact date between the engaged white population and all the other ethnic groups. This data seems to demonstrate that our current campaign is not making a measurable difference in the lives of eligible members.

Members who completed a well-child visits between July 2023-June 2024

Ethnicity Group	Members in Campaign	Engaged	Members attending a well-child visit between July 2023-June 2024				
			N (%)	Test	Statistic	P-value	Sig
WHITE	2056	316(15%)	237(75%)	Reference			
AMERICAN INDIAN	158	27(17%)	20(74%)	Chi-Square	0.0114	0.9151	No
ASIAN	253	71(28%)	54(76%)	Chi-Square	0.0347	0.8523	No
BLACK	311	66(21%)	48(73%)	Chi-Square	0.1489	0.6996	No
HISPANIC	3057	910(30%)	763(84%)	Chi-Square	12.2073	0.0005	Yes*
UNKNOWN/ OTHER	2561	554(22%)	413(75%)	Chi-Square	0.0217	0.8829	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	15	3(20%)	1(33%)	N/A			

* Indicates statistically significant result

The engaged white population had a statistically significant lower rate of completing a WC visit between June 2023-July 2024 (Rate = 75%) compared to the Hispanics (Rate =84%,

Chi-square = 12.21, $p = 0.0005$). 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. In 2025, the Population Health team will continue 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 2023 and June 2024 was met. 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. The healthy kids program engagement rates for attending all well child visits during the outcome period has increased from 1,319 (68%) in 2023 for the calendar year to 1,536 (79%) for July 2023-June 2024. Partnership’s Population Health staff conduct member satisfaction surveys over the phone at the end of the program to gather and analyze qualitative feedback. Staff from Partnership’s Population Health Department, including the manager and community health needs liaison Based on qualitative feedback from Partnership members obtained through these surveys, barriers to achieving this goal includes 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. Partnership has made and 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. 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 has an opportunity to improve well-child visit rates by continuing to educate and encourage members during outbound call campaigns on the importance of well-child visits. 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. Transitions of Care

Transitions of Care (TOC) services focus on members who are transitioning across settings or benefit structures. Partnership's Care Coordination (CC) team provides TOC 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 criteria for the members identified include the following:

Adult members (age > 20) **and**:

- Discharging home from acute care after hospital length of stay longer than four days, or
- Discharging home from an out-of-county hospital with any length of stay, or
- Having more than one admission in 10 days
- Excludes members in Long Term Care or in a Long-Term Care Psychiatric facility

Pediatric members (under age 21) **and**:

- Discharging home from an acute care hospital 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 TOC services, a Partnership Coordinator contacts the members by phone to complete a member-experience survey. 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 Member Experience

There were 191 adult members who completed TOC services, and 150 completed Adult TOC Satisfaction Surveys between January 1 and December 31, 2024, a survey completion rate of 79%. 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. 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.	2.97	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager).	2.98	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.91	Yes
After working with the case management team, I feel my ability to manage my healthcare needs is better.	2.89	Yes
My health has improved since working with my case management team.	2.66	Yes
I was able to safely transition between Providers with the help of my Care Team	2.78	Yes
The relationship that I have with the PCP and/or Specialist offices has improved since working with my case management team.	2.62	Yes
I was provided the available equipment, medication and/or services that were needed.	2.85	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 Satisfaction Survey. The average score ranged from the lowest at 2.62 to the highest at 2.98, which exceeds the goal average of 2.5. The results of the Adult TOC 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 65 pediatric members who completed TOC interventions, and 41 of them provided responses for the Pediatric TOC Satisfaction Surveys between January 1 and December 31, 2024; a response rate of 63%. 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
I am satisfied with the case management program that has helped me manage my child's health issues.	2.88	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).	2.93	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.83	Yes
After working with the case management team, I feel my ability to manage my child's healthcare needs is better	2.78	Yes
My child's health has improved since working with our case management team	2.60	Yes
I was able to safely transition my child between Providers with the help of my Care Team.	2.73	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.	2.63	Yes
My child and I were provided with the available equipment, medication and/or services that were needed.	2.95	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 Satisfaction Survey. The average score ranged from the lowest at 2.60 to the highest at 2.95 which exceeds the goal average of 2.5. The results of the Pediatric TOC surveys and the many positive comments left reveal a high satisfaction rate among the members surveyed. Families report good outcomes with this program for our Pediatric members and we will continue providing this benefit.

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 Coordinator 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 2024.

There were 2 adult members assigned to the Adult CCM Survey intervention after completion of the program and those 2 members completed an Adult CCM Satisfaction Survey between January 1 and December 31, 2024, 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.	3	Yes
I feel my ability to manage my child's healthcare needs is better after working with CM	2.50	Yes
I have a better understanding of my child's health conditions and/or diagnosis after working with CM	3	Yes
I have a better understanding of my child's medications after working with CM.	3	Yes
My child's health has improved since working with our case management team.	3	Yes
The relationship that my child and I have with the PCP and/or Specialist offices has improved since working with our case management team.	3	Yes

I feel like my providers and I work together better to help my child since working with our case management team.	3	Yes
My child and I have had more success reaching our health goals since working with our case management team.	3	Yes

Analysis

With two 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 2.5 and the rest at 3.00, which is above the goal average of 2.5. The number of members eligible to complete the survey is very low; nevertheless, 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. 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, which translates to an average score of 2.5 or greater for each response.

There was one pediatric member assigned to the Pediatric CCM Survey intervention after completion of the program and that member completed a Pediatric CCM Satisfaction Survey between January 1 and December 31, 2024, 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.	3	Yes
I feel my ability to manage my child's healthcare needs is better after working with CM	3	Yes

I have a better understanding of my child's health conditions and/or diagnosis after working with CM	3	Yes
I have a better understanding of my child's medications after working with CM.	3	Yes
My child's health has improved since working with our case management team.	3	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	No
I feel like my providers and I work together better to help my child since working with our case management team.	3	Yes
My child and I have had more success reaching our health goals since working with our case management team.	3	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 CCM Satisfaction Survey in all but one category. All categories scored 3.00, above the goal average of 2.5. The topic of "improved relationship with their PCP" scored 2.00, which fell below the goal average of 2.5; however, the 2.00 score means a "neutral" response with only one response received. With no further clarification commented, the remaining results of the Pediatric CCM survey reveal a high satisfaction rate with the program. We addressed the neutral response outside of the CCM program; nevertheless, the family reported good outcomes with this program for our Pediatric member and we will continue providing this benefit to this population. The number of members eligible to complete the survey is very low; nevertheless, Partnership will continue providing this benefit.

X. Overall Program Effectiveness

In 2024, Partnership refined its program offerings based on insights and successes from previous years. Lessons learned have shown that the most effective program 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 visit 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 almost all goals under both the Transitions of Care and Complex Case Management programs except one.

A significant finding that has carried on through 2024 is the 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, based on both member and provider-level data, 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. In 2024, Partnership integrated 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 2024, Partnership 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.

A. Summary

Moreover, Partnership's members enrolled in Population Health Management (PHM) most interventions demonstrated improved outcomes 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.

PARTNERSHIP



HEALTHPLAN

of CALIFORNIA

A Public Agency

Population Segmentation

Production Date: June 2025

Eligible Partnership Members as of May 1, 2025: 903,815

Data presented in this report reflects distinct members as of April 1, 2025; Activities are presented for 2025 / 2026 fiscal year. This report is a point in time count for the month of April 2025.

Population Subset	Data Source(s) Used for Identification	Interventions for which Members are Eligible	Number of Qualifying Members	% of Membership
Keeping Members Healthy				
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	3,065	0.339%
Partnership members 3 to 6 years of age and have not been seen for a well-child visit in the last 11 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.	813	0.089%
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.	1,362	0.150%

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 21 st 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.	401,393 (sent in December 2024)	44.41%
All Member Households	Partnership Member Enrollment Data	Routine Member Newsletters which 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.	415,024 households as of March 2025	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	68	0.007%
Partnership members living in areas lacking local imaging service providers	- Partnership Member Enrollment Data - Partnership Integrated Claims & Encounter Data	Mobile Mammography Clinics – 15 mobile mammography clinic days in locations known to have poor access to mammography services	TBD	0.008%

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, poster contest with awards, with some vaccination clinics offered during event.	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 April 2025.	723 (estimate)	0.079%

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	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.	25 (estimate)	0.002%

Population Subset	Data Source(s) Used for Identification	Interventions for which Members are Eligible	Number of Qualifying Members	% of Membership
Managing Members with Emerging Risks				
Partnership members who are pregnant	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.	1,016	0.112%

Population Subset	Data Source(s) Used for Identification	Interventions for which Members are Eligible	Number of Qualifying Members	% of Membership
Managing Members with Emerging Risks				
Partnership members who have delivered babies	- 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.	973	0.107%
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	438	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 – 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.	469	0.048%
Partnership 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-	- Partnership Member Enrollment Data - Partnership Integrated Claims & Encounter Data - Laboratory Results	BPHM Diabetes Management Program – Population Health staff will reach out to members and offer Healthy Living Tools and lifestyle coaching to promote wellness and disease management using the diabetes action plan	235	0.026%

Population Subset	Data Source(s) Used for Identification	Interventions for which Members are Eligible	Number of Qualifying Members	% of Membership
Managing Members with Emerging Risks				
identify as African American and/or Native American/Alaskan Native and/or Pacific Islander				
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	336	0.037%

Population Subset	Data Source(s) Used for Identification	Interventions for which Members are Eligible	Number of Qualifying Members	% of Membership
Outcomes Across Settings				
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.	2,626	0.290%
Multiple Chronic Conditions				
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.	6,992	0.773%

Partnership members who have a high-risk pregnancy diagnosis and self-identify as Native American/Alaska Native	• Partnership Member Enrollment Data • Partnership Integrated Claims and Encounter Data	High Risk 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.	112	0.012%

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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.

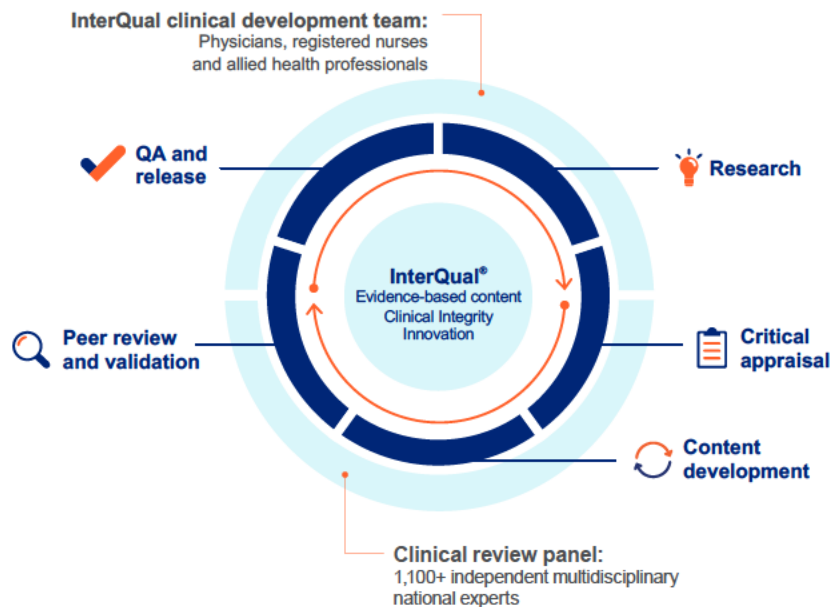
(Please send request by email to UMHelpDeskSR@partnershiphp.org)

InterQual® Clinical Content

Summary of InterQual and the Acute Criteria Review Process	Pages 2 - 3
1. InterQual® Level of Care (LOC) Criteria Acute Adult 2025	Pages 4 - 6
2. InterQual® LOC Criteria Acute Pediatric 2025	Pages 7 - 8
3. InterQual® LOC Criteria Long-Term Acute Care 2025 (NEW)	Page 9
4. InterQual® LOC Criteria Inpatient Rehabilitation 2025 (NEW)	Page 10
5. InterQual® LOC Criteria Subacute/ SNF 2025 (NEW)	Page 11
6. InterQual® Durable Medical Equipment Criteria 2025	Pages 12 - 13
7. InterQual® Medicare: Post Acute & Durable Medical Equipment Criteria 2025 (NEW)	Pages 14 - 16
8. InterQual® Imaging Criteria 2025	Pages 17 - 18
9. InterQual® Procedures Criteria 2025	Pages 19 - 30
10. InterQual® Molecular Diagnostics Criteria 2025	Pages 31 - 34
11. InterQual® Adult and Geriatric Psychiatry Criteria 2025	Page 35
12. InterQual® Child and Adolescent Psychiatry Criteria 2025	Page 36
13. InterQual® Substance Use Disorders Criteria 2025	Page 37
14. InterQual® Behavioral Health Services Criteria 2025	Page 38

InterQual evidence-based criteria development

Unmatched clinical integrity



InterQual® criteria are produced using a rigorous development process based on the principles of evidence-based medicine (EBM) to give complete confidence in the underlying guidance they provide. Our content development and updating approach is a 5-step process:

1. Identify content for development and updating

- Our physician-led teams of registered nurses and allied health professionals monitor the latest evidence, national guidance, industry and regulatory trends, and client needs to identify, assess and case-test potential new offerings and changes to existing content.
- A proprietary, automated literature surveillance system monitors more than 3,000 guidelines, guideline issuers and medical societies for newly published medical literature.
- Criteria updates are provided at least once a year and as frequently as once a month, as new evidence warrants.

2. Clinicians identify and critically appraise clinical evidence

- Development teams formulate key questions and search bibliographic databases (PubMed) and other key sources (specialty societies).
- Our teams evaluate study validity using their extensive training in critical appraisal by the Delfini Group.
- All sources are classified and cited, and landmark studies are acknowledged when applicable.
- Our teams combine findings from multiple primary studies using elements of the GRADE approach so that the overall quality of evidence is apparent for each clinically relevant outcome.

3. Physician-led groups develop new and updated content

- New or updated evidence-based content drafts are created in an iterative process led by our medical directors.
- Recommendations are intended to optimize clinical outcomes while minimizing invasive, costly or potentially harmful interventions.
- Detailed notes and literature references are included to provide the clinical basis for decisions.

4. Independent clinical review panel of more than 1,100 experts provides authoritative peer review

- All clinical review panel members are board-certified physicians or appropriately registered non-physicians in active practice. All are screened for conflicts of interest.
- Multiple reviewers evaluate each proposed criteria point to ensure the correct interpretation of the literature.
- For situations that do not lend themselves to accepted research methods, larger and more geographically dispersed groups of clinical experts help to establish best practices which reflect the current standard of care.

5. Clinical team conducts final quality assurance check and releases content

- A clinical team reviews content for completeness and clinical consistency across products, as well as medical coding.
- InterQual's medical directors provide oversight throughout the development process to help ensure clinical accuracy.

Clinical decision support across the continuum of care

InterQual criteria and industry content				
 Level of Care	 Behavioral Health	 Ambulatory Care Planning	 Industry Content	 Care Coordination
Acute Adult*	Adult and Geriatric Psychiatry	Procedures*		
Acute Pediatric*	Child and Adolescent Psychiatry	Imaging		
Long-Term Acute Care*	Substance Use Disorders	Durable Medical Equipment*		
Inpatient Rehabilitation*	Behavioral Health Services	Molecular Diagnostics		
Subacute and Skilled Nursing*				
			Medicare Post-Acute and Durable Medical Equipment	

* Decision Reasons add-on available.

Objective, specific and comprehensive clinical content

InterQual criteria are objective and specific, helping guide consistent, defensible decisions that ensure appropriate, quality care. The portfolio of 5 content suites offers comprehensive content that spans the continuum of care for medical and behavioral health.

Rigorous, evidence-based development process

Our highly trained clinical development team performs an unbiased, systematic review and critical appraisal of the evidence using elements of the GRADE approach to help ensure InterQual criteria reflect the best available clinical evidence. No other criteria provide a higher level of accuracy and timeliness than InterQual. Developed with rigor and objectivity, InterQual criteria are updated frequently to remain current with the latest evidence.

Extensive peer review

Our clinical review panel of more than 1,100 independent, multidisciplinary experts provides extensive, multilevel peer review. For situations that do not lend themselves to accepted research methods, larger and more geographically dispersed groups of clinical experts are used to establish best practices that reflect the current standard of care.

InterQual is used by:

4,300+
provider organizations

300+
payer organizations

100%
RACs, MACs, CMS and
BFCC-QIOs

The ASAM Criteria is a registered trademark of the American Society of Addiction Medicine.



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InterQual® Acute Adult Criteria 2025

Subset	Product	Version
Acetaminophen Overdose	LOC:Acute Adult	InterQual 2025
Acute Coronary Syndrome (ACS)	LOC:Acute Adult	InterQual 2025
Acute Kidney Injury	LOC:Acute Adult	InterQual 2025
Anemia	LOC:Acute Adult	InterQual 2025
Antepartum	LOC:Acute Adult	InterQual 2025
Arrhythmia, Atrial	LOC:Acute Adult	InterQual 2025
Arrhythmia, Blocks	LOC:Acute Adult	InterQual 2025
Arrhythmia, Ventricular or Abnormal ECG Finding	LOC:Acute Adult	InterQual 2025
Asthma	LOC:Acute Adult	InterQual 2025
Bowel Obstruction	LOC:Acute Adult	InterQual 2025
Carbon Monoxide Poisoning	LOC:Acute Adult	InterQual 2025
COPD	LOC:Acute Adult	InterQual 2025
Cystic Fibrosis	LOC:Acute Adult	InterQual 2025
Deep Vein Thrombosis	LOC:Acute Adult	InterQual 2025
Dehydration or Gastroenteritis	LOC:Acute Adult	InterQual 2025
Diabetes Mellitus	LOC:Acute Adult	InterQual 2025
Diabetic Ketoacidosis	LOC:Acute Adult	InterQual 2025
Electrolyte or Mineral Imbalance	LOC:Acute Adult	InterQual 2025
Epilepsy	LOC:Acute Adult	InterQual 2025
Extended Stay	LOC:Acute Adult	InterQual 2025
Gallbladder Disorders	LOC:Acute Adult	InterQual 2025
Gastrointestinal (GI) Bleeding	LOC:Acute Adult	InterQual 2025
General Medical	LOC:Acute Adult	InterQual 2025
General Surgical	LOC:Acute Adult	InterQual 2025
General Trauma	LOC:Acute Adult	InterQual 2025

Table of Contents**InterQual® Level of Care Criteria 2025 Acute Adult**

Subset	Product	Version
Heart Failure	LOC:Acute Adult	InterQual 2025
Hematology/Oncology: Complications or Diseases...	LOC:Acute Adult	InterQual 2025
Hematology/Oncology: Hemolytic Uremic Syndr...	LOC:Acute Adult	InterQual 2025
Hematology/Oncology: Treatments	LOC:Acute Adult	InterQual 2025
Hospital in the Home	LOC:Acute Adult	InterQual 2025
Hyperglycemic Hyperosmolar State	LOC:Acute Adult	InterQual 2025
Hypertension	LOC:Acute Adult	InterQual 2025
Hypertensive Disorders of Pregnancy	LOC:Acute Adult	InterQual 2025
Hypoglycemia	LOC:Acute Adult	InterQual 2025
Infection: Cellulitis	LOC:Acute Adult	InterQual 2025
Infection: CNS	LOC:Acute Adult	InterQual 2025
Infection: COVID-19	LOC:Acute Adult	InterQual 2025
Infection: Endocarditis	LOC:Acute Adult	InterQual 2025
Infection: General	LOC:Acute Adult	InterQual 2025
Infection: GI/GYN	LOC:Acute Adult	InterQual 2025
Infection: Musculoskeletal	LOC:Acute Adult	InterQual 2025
Infection: Pneumonia	LOC:Acute Adult	InterQual 2025
Infection: Pyelonephritis or Complex UTI	LOC:Acute Adult	InterQual 2025
Infection: Sepsis	LOC:Acute Adult	InterQual 2025
Infection: Skin	LOC:Acute Adult	InterQual 2025
Inflammatory Bowel Disease	LOC:Acute Adult	InterQual 2025
Labor and Delivery	LOC:Acute Adult	InterQual 2025
Non-Traumatic Bleeding	LOC:Acute Adult	InterQual 2025
Pancreatitis	LOC:Acute Adult	InterQual 2025
Postpartum Complication After Discharge	LOC:Acute Adult	InterQual 2025
Pulmonary Embolism	LOC:Acute Adult	InterQual 2025
Rhabdomyolysis or Crush Syndrome	LOC:Acute Adult	InterQual 2025
Sickle Cell Disease	LOC:Acute Adult	InterQual 2025

Table of Contents**InterQual® Level of Care Criteria 2025 Acute Adult**

Subset	Product	Version
Stroke	LOC:Acute Adult	InterQual 2025
Syncope	LOC:Acute Adult	InterQual 2025
TIA	LOC:Acute Adult	InterQual 2025
Transition Plan	LOC:Acute Adult	InterQual 2025
Withdrawal Syndrome	LOC:Acute Adult	InterQual 2025



InterQual® Acute Pediatric Criteria 2025

Subset	Product	Version
Acetaminophen Overdose	LOC:Acute Pediatric	InterQual 2025
Acute Kidney Injury	LOC:Acute Pediatric	InterQual 2025
Anemia	LOC:Acute Pediatric	InterQual 2025
Antepartum	LOC:Acute Pediatric	InterQual 2025
Asthma	LOC:Acute Pediatric	InterQual 2025
Bone Marrow Transplant/Stem Cell Transplant (BMT/SCT)	LOC:Acute Pediatric	InterQual 2025
Bowel Obstruction	LOC:Acute Pediatric	InterQual 2025
Brief Resolved Unexplained Event (BRUE)	LOC:Acute Pediatric	InterQual 2025
Bronchiolitis	LOC:Acute Pediatric	InterQual 2025
Carbon Monoxide Poisoning	LOC:Acute Pediatric	InterQual 2025
Croup	LOC:Acute Pediatric	InterQual 2025
Cystic Fibrosis	LOC:Acute Pediatric	InterQual 2025
Dehydration or Gastroenteritis	LOC:Acute Pediatric	InterQual 2025
Diabetes Mellitus	LOC:Acute Pediatric	InterQual 2025
Diabetic Ketoacidosis	LOC:Acute Pediatric	InterQual 2025
Electrolyte or Mineral Imbalance	LOC:Acute Pediatric	InterQual 2025
Epilepsy	LOC:Acute Pediatric	InterQual 2025
Extended Stay	LOC:Acute Pediatric	InterQual 2025
Failure to Thrive	LOC:Acute Pediatric	InterQual 2025
Gastrointestinal (GI) Bleeding	LOC:Acute Pediatric	InterQual 2025
General Medical	LOC:Acute Pediatric	InterQual 2025
General Surgical	LOC:Acute Pediatric	InterQual 2025
General Trauma	LOC:Acute Pediatric	InterQual 2025
Hematology/Oncology: Acute Leukemia or Lymphoma	LOC:Acute Pediatric	InterQual 2025
Hematology/Oncology: Brain Malignancy or Metastasis	LOC:Acute Pediatric	InterQual 2025
Hematology/Oncology: Chemotherapy	LOC:Acute Pediatric	InterQual 2025

Table of Contents**InterQual® Level of Care Criteria 2025 Acute Pediatric**

Subset	Product	Version
Hematology/Oncology: Hemolytic Uremic Syndrome	LOC:Acute Pediatric	InterQual 2025
Hematology/Oncology: Malignant Disease	LOC:Acute Pediatric	InterQual 2025
Hematology/Oncology: Tumor Lysis Syndrome	LOC:Acute Pediatric	InterQual 2025
Hyperbilirubinemia	LOC:Acute Pediatric	InterQual 2025
Hypertension	LOC:Acute Pediatric	InterQual 2025
Hypertensive Disorders of Pregnancy	LOC:Acute Pediatric	InterQual 2025
Hypoglycemia	LOC:Acute Pediatric	InterQual 2025
Infection: Cellulitis	LOC:Acute Pediatric	InterQual 2025
Infection: CNS	LOC:Acute Pediatric	InterQual 2025
Infection: COVID-19	LOC:Acute Pediatric	InterQual 2025
Infection: Endocarditis	LOC:Acute Pediatric	InterQual 2025
Infection: General	LOC:Acute Pediatric	InterQual 2025
Infection: GI/GYN	LOC:Acute Pediatric	InterQual 2025
Infection: Meningitis	LOC:Acute Pediatric	InterQual 2025
Infection: Musculoskeletal	LOC:Acute Pediatric	InterQual 2025
Infection: Pneumonia	LOC:Acute Pediatric	InterQual 2025
Infection: Pyelonephritis or Complex UTI	LOC:Acute Pediatric	InterQual 2025
Infection: Sepsis	LOC:Acute Pediatric	InterQual 2025
Infection: Skin	LOC:Acute Pediatric	InterQual 2025
Labor and Delivery	LOC:Acute Pediatric	InterQual 2025
Non-Traumatic Bleeding	LOC:Acute Pediatric	InterQual 2025
Nursery	LOC:Acute Pediatric	InterQual 2025
Pancreatitis	LOC:Acute Pediatric	InterQual 2025
Postpartum Complication After Discharge	LOC:Acute Pediatric	InterQual 2025
Rhabdomyolysis or Crush Syndrome	LOC:Acute Pediatric	InterQual 2025
Sickle Cell Disease	LOC:Acute Pediatric	InterQual 2025
Transition Plan	LOC:Acute Pediatric	InterQual 2025
Withdrawal Syndrome	LOC:Acute Pediatric	InterQual 2025



InterQual® Long-Term Acute Care (LTAC) Criteria 2025

Subset	Product	Version
Medically Complex	LOC:Long-Term Acute Care	InterQual 2025
Respiratory Complex	LOC:Long-Term Acute Care	InterQual 2025
Transition Plan	LOC:Long-Term Acute Care	InterQual 2025
Ventilator Weaning	LOC:Long-Term Acute Care	InterQual 2025
Wound / Skin	LOC:Long-Term Acute Care	InterQual 2025



InterQual® Inpatient Rehabilitation Criteria 2025

Subset	Product	Version
Burns	LOC:Inpatient Rehabilitation	InterQual 2025
CNS / TBI	LOC:Inpatient Rehabilitation	InterQual 2025
Medically Intensive Rehabilitation	LOC:Inpatient Rehabilitation	InterQual 2025
Orthopedic / Amputation	LOC:Inpatient Rehabilitation	InterQual 2025
Pediatric Rehabilitation	LOC:Inpatient Rehabilitation	InterQual 2025
Spinal Cord Injury	LOC:Inpatient Rehabilitation	InterQual 2025
Subacute Rehabilitation	LOC:Inpatient Rehabilitation	InterQual 2025
Transition Plan	LOC:Inpatient Rehabilitation	InterQual 2025



InterQual® Subacute / SNF Criteria 2025

Subset	Product	Version
Acute Infections (SAC-SNF)	LOC:Subacute / SNF	InterQual 2025
Acute Neurologic (SNF)	LOC:Subacute / SNF	InterQual 2025
Cancer (SAC-SNF)	LOC:Subacute / SNF	InterQual 2025
Cardiovascular and Coagulation Disorders (SAC-SNF)	LOC:Subacute / SNF	InterQual 2025
General Surgery (excludes Orthopedic Surgery, Major Joint Replacement and Spinal Surgery) (SAC-SNF)	LOC:Subacute / SNF	InterQual 2025
Major Joint Replacement or Spinal Surgery (SNF)	LOC:Subacute / SNF	InterQual 2025
Medical Management (SAC-SNF)	LOC:Subacute / SNF	InterQual 2025
Orthopedic Surgery (excludes Major Joint Replacement or Spinal Surgery) (SNF)	LOC:Subacute / SNF	InterQual 2025
Orthopedic/Musculoskeletal (SNF)	LOC:Subacute / SNF	InterQual 2025
Pediatric (SAC)	LOC:Subacute / SNF	InterQual 2025
Pulmonary (SAC-SNF)	LOC:Subacute / SNF	InterQual 2025
Transition Plan	LOC:Subacute / SNF	InterQual 2025



InterQual® Durable Medical Equipment Criteria 2025

Subset	Product	Version
Aerosol Delivery Devices	CP:Durable Medical Equipment	InterQual 2025
Airway or Secretion Clearance Devices	CP:Durable Medical Equipment	InterQual 2025
Bone Growth Stimulators, Noninvasive	CP:Durable Medical Equipment	InterQual 2025
Cardioverter Defibrillator, Wearable (WCD)	CP:Durable Medical Equipment	InterQual 2025
Continuous Glucose Monitors, Insulin Pumps, and Automated Insulin Delivery Technology	CP:Durable Medical Equipment	InterQual 2025
Continuous Passive Motion Device (CPM), Knee	CP:Durable Medical Equipment	InterQual 2025
Continuous Passive Motion Device (CPM), Upper Extremity	CP:Durable Medical Equipment	InterQual 2025
Enteral and Parenteral Nutrition Therapy	CP:Durable Medical Equipment	InterQual 2025
Hearing Aids	CP:Durable Medical Equipment	InterQual 2025
Home International Normalized Ratio (INR) Monitoring Device	CP:Durable Medical Equipment	InterQual 2025
Home Mechanical Ventilation Devices: Invasive, Noninvasive, and Multifunction	CP:Durable Medical Equipment	InterQual 2025
Home Oxygen Therapy	CP:Durable Medical Equipment	InterQual 2025
Home Phototherapy for Neonatal Hyperbilirubinemia	CP:Durable Medical Equipment	InterQual 2025
Hospital Beds, Cribs, and Accessories	CP:Durable Medical Equipment	InterQual 2025
Negative Pressure Wound Therapy (NPWT) Devices	CP:Durable Medical Equipment	InterQual 2025
Noninvasive Airway Assistive Devices	CP:Durable Medical Equipment	InterQual 2025
Orthoses, Cranial Remodeling	CP:Durable Medical Equipment	InterQual 2025
Orthoses, Lower Extremity, Knee	CP:Durable Medical Equipment	InterQual 2025
Orthoses, Lower Extremity, Knee-Ankle-Foot (KAFO) and Ankle-Foot (AFO)	CP:Durable Medical Equipment	InterQual 2025
Orthoses, Thoracic, Lumbar, and Sacral Spine	CP:Durable Medical Equipment	InterQual 2025
Orthoses, Upper Extremity	CP:Durable Medical Equipment	InterQual 2025
Patient Lift System	CP:Durable Medical Equipment	InterQual 2025
Pediatric Gait Trainers	CP:Durable Medical Equipment	InterQual 2025
Pneumatic and other Powered Compression Devices	CP:Durable Medical Equipment	InterQual 2025
Power Operated Vehicles (POV)	CP:Durable Medical Equipment	InterQual 2025
Prosthetics, Lower Extremity	CP:Durable Medical Equipment	InterQual 2025
Prosthetics, Myoelectric, Upper Extremity	CP:Durable Medical Equipment	InterQual 2025
Seat Lift Mechanism	CP:Durable Medical Equipment	InterQual 2025

Table of Contents**InterQual® Durable Medical Equipment Criteria 2025**

Subset	Product	Version
Speech Generating Devices (SGD)	CP:Durable Medical Equipment	InterQual 2025
Standing Frames	CP:Durable Medical Equipment	InterQual 2025
Stretching Devices, Upper Extremity	CP:Durable Medical Equipment	InterQual 2025
Support Surfaces	CP:Durable Medical Equipment	InterQual 2025
Therapeutic Shoes and Inserts for Persons with Diabetes	CP:Durable Medical Equipment	InterQual 2025
Transcutaneous Electrical Nerve Stimulation (TENS)	CP:Durable Medical Equipment	InterQual 2025
Trigeminal and Vagus Nerve Stimulator Devices, Noninvasive	CP:Durable Medical Equipment	InterQual 2025
Tumor Treatment Field Therapy (TTFT) Devices	CP:Durable Medical Equipment	InterQual 2025
Wheelchair Cushions or Seating System	CP:Durable Medical Equipment	InterQual 2025
Wheelchair Options and Accessories	CP:Durable Medical Equipment	InterQual 2025
Wheelchairs or Strollers, Pediatric	CP:Durable Medical Equipment	InterQual 2025
Wheelchairs, Manual	CP:Durable Medical Equipment	InterQual 2025
Wheelchairs, Power	CP:Durable Medical Equipment	InterQual 2025
Wheels or Wheelchairs, Power-Assist	CP:Durable Medical Equipment	InterQual 2025



InterQual® Medicare: Post Acute & Durable Medical Equipment Criteria 2025

	Product	Version
Ankle-Foot/Knee-Ankle-Foot Orthosis	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Automatic External Defibrillators	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Billing and Coding: Medical Necessity of Therapy Services Noridian	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Bowel Management Devices	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Canes and Crutches	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Cardiac Rehabilitation Programs for Chronic Heart Failure NCD	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Cervical Traction Devices	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Chiropractic Services CGS	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Chiropractic Services First Coast	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Chiropractic Services NGS	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Chiropractic Services Novitas	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Chiropractic Services Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Chiropractic Services WPS	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Chiropractor Services Noridian	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Cold Therapy	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Commodes	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Continuous Passive Motion Device NCD	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Enteral Nutrition	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
External Breast Prostheses	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
External Infusion Pumps	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
External Upper Limb Tremor Stimulator Therapy	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Eye Prostheses	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Facial Prostheses	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Fluidized Therapy Dry Heat for Certain Musculoskeletal Disorders NCD	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Frequency and Duration for Cardiac Rehabilitation Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Glucose Monitors	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Heating Pads and Heat Lamps	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
High Frequency Chest Wall Oscillation Devices	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Home Health Occupational Therapy Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Home Health Physical Therapy CGS	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Home Health Physical Therapy Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Home Health Psychiatric Care Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Home Health Skilled Nursing Care-Teaching and Training: Alzheimer's Disease and Behavioral Disturbances Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Home Health Skilled Nursing Care: Teaching and Training for Dementia Patients with Behavioral Disturbances NGS	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Home Health Speech-Language Pathology Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Home Health Surface Electrical Stimulation in the Treatment of Dysphagia Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Home Oxygen and Oxygen Equipment	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Hospice Alzheimer's Disease & Related Disorders Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025

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InterQual® Medicare: Post Acute & Durable Medical Equipment Criteria 2025

Subset	Product	Version
Hospice Cardiopulmonary Conditions Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Hospice Determining Terminal Status CGS	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Hospice Determining Terminal Status NGS	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Hospice Liver Disease Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Hospice Neurological Conditions Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Hospice Renal Care Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Hospice The Adult Failure To Thrive Syndrome Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Hospital Beds and Accessories	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Immunosuppressive Drugs	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Infrared Heating Devices	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Intensive Cardiac Rehabilitation (ICR) Programs NCD	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Intrapulmonary Percussive Ventilation System	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Intravenous Immune Globulin	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Knee Orthoses	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Lower Limb Prostheses	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Manual Wheelchair Bases	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Mechanical In-exsufflation Devices	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Nebulizers	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Negative Pressure Wound Therapy Pumps	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Neuromuscular Electrical Stimulation (NMES) NCD	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Non-Implantable Pelvic Floor Electrical Stimulator NCD	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Noninvasive Ear or Pulse Oximetry For Oxygen Saturation First Coast	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Oral Anticancer Drugs	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Oral Appliances for Obstructive Sleep Apnea	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Orthopedic Footwear	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Osteogenesis Stimulators	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Ostomy Supplies	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Outpatient Occupational Therapy Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Outpatient Physical and Occupational Therapy Services CGS	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Outpatient Physical and Occupational Therapy Services NGS	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Outpatient Physical Therapy Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Outpatient Speech Language Pathology Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Oximetry Services Novitas	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Parenteral Nutrition	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Patient Lifts	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Percussors NCD	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Pneumatic Compression Devices NCD	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025

Table of Contents**InterQual® Medicare: Post Acute & Durable Medical Equipment Criteria 2025**

Subset	Product	Version
Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Power Mobility Devices	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Pressure Reducing Support Surfaces (Group 1)	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Pressure Reducing Support Surfaces (Group 2)	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Pressure Reducing Support Surfaces (Group 3)	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Pulmonary Rehabilitation Services Noridian	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Refractive Lenses	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Respiratory Assist Devices	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Respiratory Care (Respiratory Therapy) Noridian	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Respiratory Therapy (Respiratory Care) Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Respiratory Therapy and Oximetry Services Palmetto	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Seat Elevation Equipment (Power Operated) on Power Wheelchairs NCD	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Seat Lift Mechanisms	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Speech Generating Devices (SGD)	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Speech-Language Pathology (SLP) Services: Communication Disorders Novitas	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Speech-Language Pathology CGS	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Speech-Language Pathology NGS	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Spinal Orthoses: TLSO and LSO	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Suction Pumps	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) NCD	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Supervised Exercise Therapy for the Treatment of Peripheral Arterial Disease with Symptomatic Lower Extremity Inter...	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Surgical Dressings	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Therapeutic Shoes for Persons with Diabetes	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Tracheostomy Care Supplies	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Transcutaneous Electrical Joint Stimulation Devices (TEJSD)	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Transcutaneous Electrical Nerve Stimulators (TENS)	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Tumor Treatment Field Therapy (TTFT)	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Urological Supplies	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Vacuum Erection Devices (VED)	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Ventilators NCD	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Walkers	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Wheelchair Options/Accessories	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025
Wheelchair Seating	Medicare:Post Acute & Durable Medical Equipment	InterQual 2025



InterQual® Imaging Criteria 2025

Subset	Product	Version
Angiogram, Coronary +/- Left Heart Catheterization	CP:Imaging	InterQual 2025
Angiography, Spinal Cord	CP:Imaging	InterQual 2025
Cardiac Catheterization, Right Heart with Coronary Angiogram (Imaging)	CP:Imaging	InterQual 2025
Cardiac Imaging, Computed Tomography (CT) or Magnetic Resonance Imaging (MRI)	CP:Imaging	InterQual 2025
Echocardiogram, Transthoracic (TTE) or Transesophageal (TEE)	CP:Imaging	InterQual 2025
Hysterosalpingogram (HSG)	CP:Imaging	InterQual 2025
Imaging, Abdomen and Pelvis	CP:Imaging	InterQual 2025
Imaging, Ankle	CP:Imaging	InterQual 2025
Imaging, Bone Marrow	CP:Imaging	InterQual 2025
Imaging, Bone Mineral Density (BMD)	CP:Imaging	InterQual 2025
Imaging, Brain	CP:Imaging	InterQual 2025
Imaging, Breast	CP:Imaging	InterQual 2025
Imaging, Cardiac, Stress	CP:Imaging	InterQual 2025
Imaging, Carotid	CP:Imaging	InterQual 2025
Imaging, Chest, Noncardiac	CP:Imaging	InterQual 2025
Imaging, Elbow	CP:Imaging	InterQual 2025
Imaging, Extremity	CP:Imaging	InterQual 2025
Imaging, Face or Ear or Orbit or Sinonasal	CP:Imaging	InterQual 2025
Imaging, Foot	CP:Imaging	InterQual 2025
Imaging, Hip	CP:Imaging	InterQual 2025
Imaging, Knee	CP:Imaging	InterQual 2025
Imaging, Musculoskeletal Pelvis	CP:Imaging	InterQual 2025
Imaging, Neck	CP:Imaging	InterQual 2025
Imaging, Obstetrical	CP:Imaging	InterQual 2025
Imaging, Peripheral Vascular	CP:Imaging	InterQual 2025
Imaging, Pituitary	CP:Imaging	InterQual 2025

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InterQual® Imaging Criteria 2025

Subset	Product	Version
Imaging, Shoulder	CP:Imaging	InterQual 2025
Imaging, Spine, Cervical	CP:Imaging	InterQual 2025
Imaging, Spine, Lumbar	CP:Imaging	InterQual 2025
Imaging, Spine, Thoracic	CP:Imaging	InterQual 2025
Imaging, Temporomandibular Joint (TMJ)	CP:Imaging	InterQual 2025
Imaging, Wrist	CP:Imaging	InterQual 2025
Lymphoscintigraphy	CP:Imaging	InterQual 2025
Multi Gated Acquisition (MUGA) Scan, Resting	CP:Imaging	InterQual 2025
Musculoskeletal Nuclear Medicine Scan	CP:Imaging	InterQual 2025
Positron Emission Tomography (PET), Cardiac	CP:Imaging	InterQual 2025
Positron Emission Tomography (PET), Whole Body	CP:Imaging	InterQual 2025
Thyroid Scan, Whole Body	CP:Imaging	InterQual 2025



InterQual® Procedures Criteria 2025

Subset	Product	Version
Ablation or Excision, Endometriosis, Laparoscopic	CP:Procedures	InterQual 2025
Ablative or Transarterial Therapy, Liver	CP:Procedures	InterQual 2025
Achilles Tendon Repair	CP:Procedures	InterQual 2025
Adenoidectomy	CP:Procedures	InterQual 2025
Adenoidectomy (Pediatric)	CP:Procedures	InterQual 2025
Amputation of Digit or Extremity	CP:Procedures	InterQual 2025
Angiogram, Coronary +/- Left Heart Catheterization	CP:Procedures	InterQual 2025
Angioplasty and Stent, Carotid or Vertebral	CP:Procedures	InterQual 2025
Angioplasty, Renovascular	CP:Procedures	InterQual 2025
Antireflux Surgery or Hiatal Hernia Repair	CP:Procedures	InterQual 2025
Aortic Valve Replacement (AVR)	CP:Procedures	InterQual 2025
Aortic Valvuloplasty, Percutaneous Balloon	CP:Procedures	InterQual 2025
Appendectomy	CP:Procedures	InterQual 2025
Appendectomy (Pediatric)	CP:Procedures	InterQual 2025
Arthrodesis or Arthroplasty, Interphalangeal Joint, Second-Fifth Toes	CP:Procedures	InterQual 2025
Arthrodesis, Ankle (Talotibial Joint)	CP:Procedures	InterQual 2025
Arthrodesis, First Metatarsophalangeal (MTP) Joint	CP:Procedures	InterQual 2025
Arthrodesis, Hip	CP:Procedures	InterQual 2025
Arthrodesis, Knee	CP:Procedures	InterQual 2025
Arthrodesis, Triple	CP:Procedures	InterQual 2025
Arthroplasty, Carpometacarpal (CMC) Joint, Thumb	CP:Procedures	InterQual 2025
Arthroplasty, Metacarpophalangeal (MCP) Joint, Digits	CP:Procedures	InterQual 2025
Arthroplasty, Proximal Interphalangeal (PIP) Joint, Fingers	CP:Procedures	InterQual 2025
Arthroplasty, Temporomandibular Joint (TMJ)	CP:Procedures	InterQual 2025
Arthroscopy or Arthroscopically Assisted Surgery, Knee	CP:Procedures	InterQual 2025

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InterQual® Procedures Criteria 2025

Subset	Product	Version
Arthroscopy or Arthroscopically Assisted Surgery, Knee (Pediatric)	CP:Procedures	InterQual 2025
Arthroscopy or Arthroscopically Assisted Surgery, Shoulder	CP:Procedures	InterQual 2025
Arthroscopy or Arthroscopically Assisted Surgery, Shoulder (Adolescent)	CP:Procedures	InterQual 2025
Arthroscopy or Arthroscopically Assisted Surgery, Wrist	CP:Procedures	InterQual 2025
Arthroscopy, Diagnostic, +/- Synovial Biopsy, Ankle	CP:Procedures	InterQual 2025
Arthroscopy, Diagnostic, +/- Synovial Biopsy, Elbow	CP:Procedures	InterQual 2025
Arthroscopy, Diagnostic, +/- Synovial Biopsy, Hip	CP:Procedures	InterQual 2025
Arthroscopy, Diagnostic, +/- Synovial Biopsy, Knee	CP:Procedures	InterQual 2025
Arthroscopy, Diagnostic, +/- Synovial Biopsy, Shoulder	CP:Procedures	InterQual 2025
Arthroscopy, Diagnostic, +/- Synovial Biopsy, Wrist	CP:Procedures	InterQual 2025
Arthroscopy, Surgical, Ankle	CP:Procedures	InterQual 2025
Arthroscopy, Surgical, Elbow	CP:Procedures	InterQual 2025
Arthroscopy, Surgical, Hip	CP:Procedures	InterQual 2025
Arthroscopy, Surgical, Hip (Pediatric)	CP:Procedures	InterQual 2025
Arthroscopy, Temporomandibular Joint (TMJ)	CP:Procedures	InterQual 2025
Arthrotomy, Ankle	CP:Procedures	InterQual 2025
Arthrotomy, Elbow	CP:Procedures	InterQual 2025
Arthrotomy, Hip	CP:Procedures	InterQual 2025
Arthrotomy, Knee	CP:Procedures	InterQual 2025
Arthrotomy, Knee (Pediatric)	CP:Procedures	InterQual 2025
Arthrotomy, Shoulder	CP:Procedures	InterQual 2025
Arthrotomy, Wrist	CP:Procedures	InterQual 2025
Artificial Disc Replacement, Cervical	CP:Procedures	InterQual 2025
Artificial Disc Replacement, Lumbar	CP:Procedures	InterQual 2025
Atrial Septal Defect (ASD) Repair	CP:Procedures	InterQual 2025
Balloon Ostial Dilation	CP:Procedures	InterQual 2025
Bariatric or Metabolic Surgery	CP:Procedures	InterQual 2025
Bariatric or Metabolic Surgery (Adolescent)	CP:Procedures	InterQual 2025

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InterQual® Procedures Criteria 2025

Subset	Product	Version
Biopsy, Adrenal Mass, Needle	CP:Procedures	InterQual 2025
Biopsy, Breast, Needle Core	CP:Procedures	InterQual 2025
Biopsy, Prostate, Needle	CP:Procedures	InterQual 2025
Biopsy, Sentinel Lymph Node	CP:Procedures	InterQual 2025
Bladder Neck Suspension/Sling, Female	CP:Procedures	InterQual 2025
Blepharoplasty	CP:Procedures	InterQual 2025
Bone Augmentation, Mandible	CP:Procedures	InterQual 2025
Bone Augmentation, Maxilla	CP:Procedures	InterQual 2025
Bone Graft and Implantable Stimulator, Fracture Nonunion	CP:Procedures	InterQual 2025
Brachytherapy, Prostate	CP:Procedures	InterQual 2025
Breast Implant Removal	CP:Procedures	InterQual 2025
Breast Reconstruction	CP:Procedures	InterQual 2025
Bronchoscopy	CP:Procedures	InterQual 2025
Bypass, Distal, Peripheral Artery	CP:Procedures	InterQual 2025
Bypass, Proximal, Peripheral Artery	CP:Procedures	InterQual 2025
Capsule Endoscopy	CP:Procedures	InterQual 2025
Capsule Endoscopy (Pediatric)	CP:Procedures	InterQual 2025
Capsulotomy	CP:Procedures	InterQual 2025
Cardiac Catheterization, Right Heart with Coronary Angiogram (Procedure)	CP:Procedures	InterQual 2025
Cataract Removal	CP:Procedures	InterQual 2025
Cesarean Section, During Labor	CP:Procedures	InterQual 2025
Cesarean Section, Prior to Onset of Labor	CP:Procedures	InterQual 2025
Cheilectomy, First Metatarsophalangeal (MTP) Joint	CP:Procedures	InterQual 2025
Cholangiogram, Intraoperative	CP:Procedures	InterQual 2025
Cholangiogram, Intraoperative (Pediatric)	CP:Procedures	InterQual 2025
Cholecystectomy, Laparoscopic	CP:Procedures	InterQual 2025
Cholecystectomy, Laparoscopic (Pediatric)	CP:Procedures	InterQual 2025

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InterQual® Procedures Criteria 2025

Subset	Product	Version
Cholecystectomy, Open	CP:Procedures	InterQual 2025
Circumcision	CP:Procedures	InterQual 2025
Circumcision (Pediatric)	CP:Procedures	InterQual 2025
Cleft Lip or Palate Repair (Pediatric)	CP:Procedures	InterQual 2025
Cochlear Implantation	CP:Procedures	InterQual 2025
Cochlear Implantation (Pediatric)	CP:Procedures	InterQual 2025
Colectomy, Left	CP:Procedures	InterQual 2025
Colectomy, Right	CP:Procedures	InterQual 2025
Colonoscopy	CP:Procedures	InterQual 2025
Colonoscopy (Pediatric)	CP:Procedures	InterQual 2025
Coronary Artery Bypass Grafting (CABG)	CP:Procedures	InterQual 2025
Craniotomy	CP:Procedures	InterQual 2025
Cryoablation, Prostate	CP:Procedures	InterQual 2025
Cutaneous Lipoma Excision	CP:Procedures	InterQual 2025
Cystolithotomy	CP:Procedures	InterQual 2025
Cystolithotomy (Pediatric)	CP:Procedures	InterQual 2025
Decompression +/- Fusion, Cervical	CP:Procedures	InterQual 2025
Decompression +/- Fusion, Lumbar	CP:Procedures	InterQual 2025
Decompression +/- Fusion, Thoracic	CP:Procedures	InterQual 2025
Dental Implant, Osseointegrated	CP:Procedures	InterQual 2025
Dilatation and Curettage (D & C)	CP:Procedures	InterQual 2025
Discectomy, Temporomandibular Joint (TMJ)	CP:Procedures	InterQual 2025
Discography, Spine, Lumbar	CP:Procedures	InterQual 2025
Ectropion Repair	CP:Procedures	InterQual 2025
Electrocardiography, Ambulatory (AECG)	CP:Procedures	InterQual 2025
Electromyography (EMG) and Nerve Conduction Studies (NCS)	CP:Procedures	InterQual 2025
Electrophysiology (EP) Testing +/- Radiofrequency (RFA) or Cryothermal Ablation, Cardiac	CP:Procedures	InterQual 2025
Endarterectomy, Carotid or Vertebral	CP:Procedures	InterQual 2025
Endoscopy, Upper Gastrointestinal (GI)	CP:Procedures	InterQual 2025

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InterQual® Procedures Criteria 2025

Subset	Product	Version
Endoscopy, Upper Gastrointestinal (GI) (Pediatric)	CP:Procedures	InterQual 2025
Endovascular Intervention, Intracranial	CP:Procedures	InterQual 2025
Endovascular Intervention, Peripheral Artery	CP:Procedures	InterQual 2025
Endovascular Repair, Abdominal Aortic Aneurysm (AAA)	CP:Procedures	InterQual 2025
Endovascular Repair, Thoracic Aortic Aneurysm	CP:Procedures	InterQual 2025
Endovenous Ablation, Lower Extremity Superficial Truncal or Perforator Vein	CP:Procedures	InterQual 2025
Entropion Repair	CP:Procedures	InterQual 2025
Epicondyloplasty, Lateral, Elbow	CP:Procedures	InterQual 2025
Epicondyloplasty, Medial, Elbow	CP:Procedures	InterQual 2025
Epidural or Intrathecal Catheter Placement	CP:Procedures	InterQual 2025
Epidural Steroid Injection	CP:Procedures	InterQual 2025
Ethmoidectomy	CP:Procedures	InterQual 2025
Exercise Treadmill Testing (ETT)	CP:Procedures	InterQual 2025
Exostectomy, Fifth Metatarsal (MT) Head	CP:Procedures	InterQual 2025
Exostectomy, First Metatarsophalangeal (MTP) Joint (Bunionectomy)	CP:Procedures	InterQual 2025
Extraction, Third Molar	CP:Procedures	InterQual 2025
Eyelid Lesion Excision, +/- Reconstruction	CP:Procedures	InterQual 2025
Eyelid Reconstruction	CP:Procedures	InterQual 2025
Facet Joint Injection	CP:Procedures	InterQual 2025
Facial Nerve Repair	CP:Procedures	InterQual 2025
Fusion, Cervical Spine	CP:Procedures	InterQual 2025
Fusion, Lumbar Spine	CP:Procedures	InterQual 2025
Fusion, Thoracic Spine	CP:Procedures	InterQual 2025
Ganglion Cyst Excision	CP:Procedures	InterQual 2025
Gastric Stimulation	CP:Procedures	InterQual 2025
Gender Affirmation Surgery	CP:Procedures	InterQual 2025
Glossectomy, Partial or Hemiglossectomy	CP:Procedures	InterQual 2025
Hearing Device, Bone Anchored or Bone Conduction	CP:Procedures	InterQual 2025

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InterQual® Procedures Criteria 2025

Subset	Product	Version
Hearing Device, Bone Anchored or Bone Conduction (Pediatric)	CP:Procedures	InterQual 2025
Hearing Device, Middle Ear	CP:Procedures	InterQual 2025
Hemiarthroplasty, Hip	CP:Procedures	InterQual 2025
Hemorrhoid Procedures, Minimally Invasive	CP:Procedures	InterQual 2025
Hemorrhoidectomy	CP:Procedures	InterQual 2025
Herniorrhaphy, Inguinal (Pediatric)	CP:Procedures	InterQual 2025
Herniorrhaphy, Inguinal or Femoral	CP:Procedures	InterQual 2025
Herniorrhaphy, Umbilical	CP:Procedures	InterQual 2025
Herniorrhaphy, Umbilical (Pediatric)	CP:Procedures	InterQual 2025
Herniorrhaphy, Ventral or Incisional or Epigastric	CP:Procedures	InterQual 2025
Herniorrhaphy, Ventral or Incisional or Epigastric (Pediatric)	CP:Procedures	InterQual 2025
High-Intensity Focused Ultrasound (HIFU)	CP:Procedures	InterQual 2025
Hydrocelectomy	CP:Procedures	InterQual 2025
Hydrocelectomy (Pediatric)	CP:Procedures	InterQual 2025
Hyperbaric Oxygen Therapy	CP:Procedures	InterQual 2025
Hyperbaric Oxygen Therapy (Pediatric)	CP:Procedures	InterQual 2025
Hypoglossal Nerve Stimulation (HNS)	CP:Procedures	InterQual 2025
Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy	CP:Procedures	InterQual 2025
Hysterectomy, Radical	CP:Procedures	InterQual 2025
Hysteroscopy, + Dilatation and Curettage (D & C), Diagnostic	CP:Procedures	InterQual 2025
Hysteroscopy, Operative	CP:Procedures	InterQual 2025
Implantable Cardioverter Defibrillator (ICD) Insertion	CP:Procedures	InterQual 2025
Interspinous Process Device with or without Open Decompression	CP:Procedures	InterQual 2025
Joint Replacement, Elbow	CP:Procedures	InterQual 2025
Joint Replacement, Shoulder	CP:Procedures	InterQual 2025
Joint Replacement, Wrist	CP:Procedures	InterQual 2025
Keloid Excision	CP:Procedures	InterQual 2025
Keratoplasty	CP:Procedures	InterQual 2025
Laparoscopy, Diagnostic (Abdomen)	CP:Procedures	InterQual 2025

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InterQual® Procedures Criteria 2025

Subset	Product	Version
Laparoscopy, Diagnostic (Abdomen) (Pediatric)	CP:Procedures	InterQual 2025
Laparoscopy, Diagnostic (Pelvic)	CP:Procedures	InterQual 2025
Laparotomy or Exploratory Laparotomy	CP:Procedures	InterQual 2025
Laparotomy or Exploratory Laparotomy (Pediatric)	CP:Procedures	InterQual 2025
Left Atrial Appendage Closure	CP:Procedures	InterQual 2025
Left Ventricular Assist Device (LVAD) Insertion	CP:Procedures	InterQual 2025
Ligation and Division +/- Stripping or Excision, Lower Extremity Superficial Vein	CP:Procedures	InterQual 2025
Lithotripsy, Extracorporeal Shock Wave (ESWL)	CP:Procedures	InterQual 2025
Lithotripsy, Extracorporeal Shock Wave (ESWL) (Pediatric)	CP:Procedures	InterQual 2025
Lobectomy	CP:Procedures	InterQual 2025
Lung Volume Reduction Surgery (LVRS)	CP:Procedures	InterQual 2025
Manipulation Under Anesthesia, Shoulder	CP:Procedures	InterQual 2025
Mastectomy, Modified Radical (MRM)	CP:Procedures	InterQual 2025
Mastectomy, Partial, +/- Axillary Dissection	CP:Procedures	InterQual 2025
Mastectomy, Prophylactic, Total or Simple	CP:Procedures	InterQual 2025
Mastectomy, Total or Simple	CP:Procedures	InterQual 2025
Median Nerve Decompression, +/- Neurolysis, Wrist	CP:Procedures	InterQual 2025
Mitral Valve Replacement (MVR) or Repair	CP:Procedures	InterQual 2025
Mitral Valvuloplasty, Percutaneous Balloon	CP:Procedures	InterQual 2025
Morton's or Interdigital Neuroma Excision	CP:Procedures	InterQual 2025
Myomectomy	CP:Procedures	InterQual 2025
Myringotomy, +/- Tympanostomy Tube	CP:Procedures	InterQual 2025
Nephrectomy, Partial	CP:Procedures	InterQual 2025
Nephrectomy, Radical	CP:Procedures	InterQual 2025
Nephrectomy, Simple	CP:Procedures	InterQual 2025
Nephrolithotomy, Percutaneous	CP:Procedures	InterQual 2025
Nerve Graft, Hand or Digit	CP:Procedures	InterQual 2025
Nerve Repair, Wrist or Hand or Digit	CP:Procedures	InterQual 2025

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InterQual® Procedures Criteria 2025

Subset	Product	Version
Neuroablation, Percutaneous	CP:Procedures	InterQual 2025
Orbitotomy	CP:Procedures	InterQual 2025
Orchiopexy (Pediatric)	CP:Procedures	InterQual 2025
Orthognathic Surgery	CP:Procedures	InterQual 2025
Orthognathic Surgery (Pediatric)	CP:Procedures	InterQual 2025
Osteotomy, Calcaneal	CP:Procedures	InterQual 2025
Osteotomy, Distal Transpositional, First Metatarsal (MT) (Bunionectomy)	CP:Procedures	InterQual 2025
Osteotomy, High Tibial	CP:Procedures	InterQual 2025
Osteotomy, Pelvic or Proximal Femur	CP:Procedures	InterQual 2025
Osteotomy, Proximal Phalanx, First Toe +/- Bunionectomy	CP:Procedures	InterQual 2025
Osteotomy, Proximal, First Metatarsal (MT) (Bunionectomy)	CP:Procedures	InterQual 2025
Osteotomy, Supracondylar Femur	CP:Procedures	InterQual 2025
Osteotomy, Transpositional, Distal or Proximal, Fifth Metatarsal (MT)	CP:Procedures	InterQual 2025
Pacemaker Insertion	CP:Procedures	InterQual 2025
Pacemaker Insertion, Biventricular	CP:Procedures	InterQual 2025
Pacemaker Insertion, Biventricular + Implantable Cardioverter Defibrillator (ICD) Insertion	CP:Procedures	InterQual 2025
Palmar Fasciectomy	CP:Procedures	InterQual 2025
Panniculectomy, Abdominal	CP:Procedures	InterQual 2025
Pectus Deformity Repair (Pediatric)	CP:Procedures	InterQual 2025
Penile Implant Insertion	CP:Procedures	InterQual 2025
Percutaneous Coronary Intervention (PCI)	CP:Procedures	InterQual 2025
Phlebectomy, Lower Extremity Superficial Tributary Varicose Vein	CP:Procedures	InterQual 2025
Photocoagulation, Focal Laser	CP:Procedures	InterQual 2025
Photocoagulation, Grid Laser	CP:Procedures	InterQual 2025
Plantar Fascial Release	CP:Procedures	InterQual 2025
Plantar Fasciitis, Extracorporeal Shock Wave Therapy (ESWT)	CP:Procedures	InterQual 2025
Pneumectomy	CP:Procedures	InterQual 2025
Polypectomy, Nasal	CP:Procedures	InterQual 2025

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InterQual® Procedures Criteria 2025

Subset	Product	Version
Prostatectomy, Open	CP:Procedures	InterQual 2025
Prostatectomy, Radical	CP:Procedures	InterQual 2025
Prostatectomy, Transurethral Ablation	CP:Procedures	InterQual 2025
Prostatectomy, Transurethral Resection	CP:Procedures	InterQual 2025
Proton Beam Radiotherapy (PBRT)	CP:Procedures	InterQual 2025
Proton Beam Radiotherapy (PBRT) (Pediatric)	CP:Procedures	InterQual 2025
Ptosis Repair	CP:Procedures	InterQual 2025
Pyloromyotomy (Pediatric)	CP:Procedures	InterQual 2025
Radiofrequency Ablation (RFA) or Cryoablation, Renal	CP:Procedures	InterQual 2025
Reconstruction, Temporomandibular Joint (TMJ)	CP:Procedures	InterQual 2025
Reduction and Fixation, Distal Radius +/- Ulna	CP:Procedures	InterQual 2025
Reduction and Fixation, Radius +/- Ulna Shaft	CP:Procedures	InterQual 2025
Reduction Mammoplasty, Female	CP:Procedures	InterQual 2025
Reduction Mammoplasty, Female (Adolescent)	CP:Procedures	InterQual 2025
Reduction Mammoplasty, Male	CP:Procedures	InterQual 2025
Reduction Mammoplasty, Male (Adolescent)	CP:Procedures	InterQual 2025
Reimplantation, Ureter (Pediatric)	CP:Procedures	InterQual 2025
Removal and Replacement or Revision, Joint Replacement, Shoulder	CP:Procedures	InterQual 2025
Removal and Replacement, Total Joint Replacement (TJR), Hip	CP:Procedures	InterQual 2025
Removal and Replacement, Total Joint Replacement (TJR), Knee	CP:Procedures	InterQual 2025
Removal or Revision, Arthroplasty, Elbow	CP:Procedures	InterQual 2025
Removal or Revision, Arthroplasty, Wrist	CP:Procedures	InterQual 2025
Resection and Graft, Abdominal Aortic Aneurysm (AAA)	CP:Procedures	InterQual 2025
Resection and Graft, Thoracic or Thoracoabdominal Aortic Aneurysm	CP:Procedures	InterQual 2025
Rhinoplasty	CP:Procedures	InterQual 2025
Sacrocolpopexy	CP:Procedures	InterQual 2025
Sacroiliac (SI) Joint Fusion	CP:Procedures	InterQual 2025
Sacroiliac (SI) Joint Injection	CP:Procedures	InterQual 2025

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InterQual® Procedures Criteria 2025

Subset	Product	Version
Salpingectomy	CP:Procedures	InterQual 2025
Salpingo-Oophorectomy, Bilateral or Oophorectomy, Bilateral	CP:Procedures	InterQual 2025
Salpingo-Oophorectomy, Unilateral or Oophorectomy, Unilateral	CP:Procedures	InterQual 2025
Salpingostomy	CP:Procedures	InterQual 2025
Scar Contracture Release	CP:Procedures	InterQual 2025
Scar Revision	CP:Procedures	InterQual 2025
Sclerotherapy, Lower Extremity Superficial Tributary Varicose Vein	CP:Procedures	InterQual 2025
Scoliosis or Kyphosis Surgery	CP:Procedures	InterQual 2025
Scoliosis or Kyphosis Surgery (Pediatric)	CP:Procedures	InterQual 2025
Septoplasty	CP:Procedures	InterQual 2025
Septoplasty (Adolescent)	CP:Procedures	InterQual 2025
Sigmoidoscopy	CP:Procedures	InterQual 2025
Sinusotomy, Frontal	CP:Procedures	InterQual 2025
Sinusotomy, Maxillary	CP:Procedures	InterQual 2025
Skin Graft	CP:Procedures	InterQual 2025
Skin Substitute Graft	CP:Procedures	InterQual 2025
Sleep Studies	CP:Procedures	InterQual 2025
Sleep Studies (Pediatric)	CP:Procedures	InterQual 2025
Small Bowel Resection	CP:Procedures	InterQual 2025
Spinal Cord Stimulator (SCS) Insertion	CP:Procedures	InterQual 2025
Stereotactic Introduction, Subcortical or Cortical Electrodes	CP:Procedures	InterQual 2025
Stereotactic Radiosurgery, Brain or Skull Base	CP:Procedures	InterQual 2025
Strabismus Repair (Pediatric)	CP:Procedures	InterQual 2025
Subfascial Endoscopic Perforator Surgery (SEPS)	CP:Procedures	InterQual 2025
Sympathectomy	CP:Procedures	InterQual 2025
Sympathetic Blockade	CP:Procedures	InterQual 2025
Tendon Sheath Incision or Excision, Hand, Flexor	CP:Procedures	InterQual 2025
Tendon Transfer, Hand or Forearm	CP:Procedures	InterQual 2025

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InterQual® Procedures Criteria 2025

Subset	Product	Version
Thoracoscopy, Video Assisted (VAT)	CP:Procedures	InterQual 2025
Thrombolysis, Deep Vein Thrombosis (DVT)	CP:Procedures	InterQual 2025
Thyroidectomy, Partial or Total	CP:Procedures	InterQual 2025
Thyroidectomy, Partial or Total (Pediatric)	CP:Procedures	InterQual 2025
Tibial Nerve Decompression	CP:Procedures	InterQual 2025
Tissue Transfer (Flap)	CP:Procedures	InterQual 2025
Tonsillectomy	CP:Procedures	InterQual 2025
Tonsillectomy (Pediatric)	CP:Procedures	InterQual 2025
Total Joint Replacement (TJR), Ankle	CP:Procedures	InterQual 2025
Total Joint Replacement (TJR), Hip	CP:Procedures	InterQual 2025
Total Joint Replacement (TJR), Knee	CP:Procedures	InterQual 2025
Trabeculoplasty or Trabeculectomy	CP:Procedures	InterQual 2025
Transcatheter Aortic Valve Replacement (TAVR)	CP:Procedures	InterQual 2025
Transcatheter Mitral Valve Edge-to-Edge Repair (TEER)	CP:Procedures	InterQual 2025
Transplantation, Allogeneic Stem Cell	CP:Procedures	InterQual 2025
Transplantation, Allogeneic Stem Cell (Pediatric)	CP:Procedures	InterQual 2025
Transplantation, Autologous Stem Cell	CP:Procedures	InterQual 2025
Transplantation, Autologous Stem Cell (Pediatric)	CP:Procedures	InterQual 2025
Transplantation, Cardiac	CP:Procedures	InterQual 2025
Transplantation, Liver	CP:Procedures	InterQual 2025
Transplantation, Lung	CP:Procedures	InterQual 2025
Transplantation, Renal	CP:Procedures	InterQual 2025
Transurethral Resection, Bladder Tumor (TURBT)	CP:Procedures	InterQual 2025
Tricuspid Valve Replacement (TVR) or Repair or Resection	CP:Procedures	InterQual 2025
Turbinectomy, Inferior, Partial	CP:Procedures	InterQual 2025
Tympanoplasty (Pediatric)	CP:Procedures	InterQual 2025
Tympanostomy Tube (Pediatric)	CP:Procedures	InterQual 2025

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InterQual® Procedures Criteria 2025

Subset	Product	Version
Ulnar Nerve Decompression or Transposition, Elbow	CP:Procedures	InterQual 2025
Ulnar Nerve Decompression, Wrist	CP:Procedures	InterQual 2025
Ultrasound, Endobronchial (EBUS) or Endoscopic (EUS)	CP:Procedures	InterQual 2025
Unicondylar or Patellofemoral Knee Replacement	CP:Procedures	InterQual 2025
Ureteroscopy	CP:Procedures	InterQual 2025
Ureteroscopy (Pediatric)	CP:Procedures	InterQual 2025
Urethral Sling, Male	CP:Procedures	InterQual 2025
Urethroplasty	CP:Procedures	InterQual 2025
Uterine Artery Embolization (UAE)	CP:Procedures	InterQual 2025
Uvulopalatopharyngoplasty (UPPP)	CP:Procedures	InterQual 2025
Vaginal Delivery, Early Elective	CP:Procedures	InterQual 2025
Vagus Nerve Stimulation (VNS)	CP:Procedures	InterQual 2025
Vagus Nerve Stimulation (VNS) (Pediatric)	CP:Procedures	InterQual 2025
Vertebroplasty or Kyphoplasty	CP:Procedures	InterQual 2025
Video Electroencephalographic (EEG) Monitoring	CP:Procedures	InterQual 2025
Video Electroencephalographic (EEG) Monitoring (Pediatric)	CP:Procedures	InterQual 2025
Vitrectomy, Pars Plana	CP:Procedures	InterQual 2025
Wedge Resection or Segmentectomy, Lung	CP:Procedures	InterQual 2025



InterQual® Molecular Diagnostics Criteria 2025

Subset	Product	Version
21-Hydroxylase-Deficient Congenital Adrenal Hyperplasia (CYP21A2)	CP:Molecular ...	InterQual 2025
Achondroplasia	CP:Molecular ...	InterQual 2025
Acute Myeloid Leukemia (AML)	CP:Molecular ...	InterQual 2025
Adenomatous Polyposis Coli (APC)-associated Polyposis Conditions	CP:Molecular ...	InterQual 2025
AlloMap®	CP:Molecular ...	InterQual 2025
Alpha Thalassemia	CP:Molecular ...	InterQual 2025
Alpha-1 Antitrypsin Deficiency (AATD)	CP:Molecular ...	InterQual 2025
Alzheimer's Disease	CP:Molecular ...	InterQual 2025
Angelman Syndrome (AS)	CP:Molecular ...	InterQual 2025
ARX-Related X-linked Disorders	CP:Molecular ...	InterQual 2025
Ataxia-Telangiectasia (A-T)	CP:Molecular ...	InterQual 2025
BCR::ABL1 Testing in Acute Lymphoblastic Leukemia (ALL)	CP:Molecular ...	InterQual 2025
BCR::ABL1 Testing in Chronic Myeloid Leukemia (CML)	CP:Molecular ...	InterQual 2025
Beckwith-Wiedemann Syndrome (BWS)	CP:Molecular ...	InterQual 2025
Beta globin (HBB) testing for Beta-thalassemia and Sickle Cell Disease	CP:Molecular ...	InterQual 2025
Bloom's Syndrome	CP:Molecular ...	InterQual 2025
BRAF Testing for Drug Response in Melanoma	CP:Molecular ...	InterQual 2025
BRCA1 and BRCA2 in Hereditary Cancer	CP:Molecular ...	InterQual 2025
Canavan Disease	CP:Molecular ...	InterQual 2025
Cancer Antigen 72-4 (CA 72-4)	CP:Molecular ...	InterQual 2025
Carrier Screening (Genetic) for General Population	CP:Molecular ...	InterQual 2025
Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts and Leukoencephalopathy (CADASIL)	CP:Molecular ...	InterQual 2025
Charcot-Marie-Tooth (CMT) Hereditary Neuropathy	CP:Molecular ...	InterQual 2025
Chimerism Analysis after Allogeneic Stem Cell Transplantation (SCT)	CP:Molecular ...	InterQual 2025
Chronic Lymphocytic Leukemia (CLL) Prognostic or Predictive Testing	CP:Molecular ...	InterQual 2025
clonoSEQ® and other Clonality Testing	CP:Molecular ...	InterQual 2025
Cologuard®	CP:Molecular ...	InterQual 2025
Comprehensive Genomic Profiling for Solid Tumor, Liquid Biopsy	CP:Molecular ...	InterQual 2025
Comprehensive Genomic Profiling, Tumor Tissue	CP:Molecular ...	InterQual 2025
ConfirmMDx® for Prostate Cancer	CP:Molecular ...	InterQual 2025
Congenital Factor XIII Deficiency	CP:Molecular ...	InterQual 2025
Congenital Von Willebrand Disease (VWD) testing	CP:Molecular ...	InterQual 2025
COVID-19 Testing	CP:Molecular ...	InterQual 2025
Craniofrontonasal Syndrome (EFNB1)	CP:Molecular ...	InterQual 2025
CYP450 Genotyping	CP:Molecular ...	InterQual 2025
Cystic Fibrosis and Cystic Fibrosis Transmembrane Regulator (CFTR) Disorders	CP:Molecular ...	InterQual 2025
Decipher® for Prostate Cancer	CP:Molecular ...	InterQual 2025

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InterQual® Molecular Diagnostics Criteria 2025

Subset	Product	Version
DPYD Testing for Fluoropyrimidines Toxicity	CP:Molecular ...	InterQual 2025
Duchenne Becker Muscular Dystrophy (DBMD)	CP:Molecular ...	InterQual 2025
EFEMP2-Related Cutis Laxa	CP:Molecular ...	InterQual 2025
Familial Cholestatic Liver Disease	CP:Molecular ...	InterQual 2025
Familial Dysautonomia (FD)	CP:Molecular ...	InterQual 2025
Familial Hypercholesterolemia (FH)	CP:Molecular ...	InterQual 2025
Familial Melanoma (CDKN2A)	CP:Molecular ...	InterQual 2025
Fanconi Anemia (FA)	CP:Molecular ...	InterQual 2025
FIP1L1-PDGFRα Testing for Imatinib Response in Hypereosinophilia (HE)	CP:Molecular ...	InterQual 2025
FMR1 Related Disorders (Fragile X Syndrome)	CP:Molecular ...	InterQual 2025
Gaucher Disease	CP:Molecular ...	InterQual 2025
Glucose-6-phosphate dehydrogenase (G6PD) Deficiency	CP:Molecular ...	InterQual 2025
Glycogen Storage Disease Type I (GSDI)	CP:Molecular ...	InterQual 2025
Hemophilia A	CP:Molecular ...	InterQual 2025
Hemophilia B	CP:Molecular ...	InterQual 2025
Hereditary Cardiomyopathy	CP:Molecular ...	InterQual 2025
Hereditary Hearing Loss	CP:Molecular ...	InterQual 2025
Hereditary Pheochromocytoma and Paraganglioma (PPGL)	CP:Molecular ...	InterQual 2025
Hereditary Prostate Cancer	CP:Molecular ...	InterQual 2025
Hereditary Thrombophilia	CP:Molecular ...	InterQual 2025
HFE (Type I) Hereditary Hemochromatosis	CP:Molecular ...	InterQual 2025
Hirschsprung Disease (HSCR)	CP:Molecular ...	InterQual 2025
HLA Genotyping for Celiac Disease	CP:Molecular ...	InterQual 2025
HLA-B*1502 Genotyping for Drug Response	CP:Molecular ...	InterQual 2025
HLA-B*5701 Genotyping for Abacavir Response	CP:Molecular ...	InterQual 2025
HLA-B*5801 Genotyping for Allopurinol Response	CP:Molecular ...	InterQual 2025
HLA-B27 Genotyping for Ankylosing Spondylitis	CP:Molecular ...	InterQual 2025
Human Epidermal Growth Factor Receptor 2 (HER2) Testing for Drug Response	CP:Molecular ...	InterQual 2025
Huntington Disease (HD)	CP:Molecular ...	InterQual 2025
JAK2, CALR, or MPL related Myeloproliferative Neoplasms (MPN)	CP:Molecular ...	InterQual 2025
Ki-67 Testing in Breast Cancer	CP:Molecular ...	InterQual 2025
Li-Fraumeni Syndrome (LFS)	CP:Molecular ...	InterQual 2025
Long QT Syndrome (LQTS)	CP:Molecular ...	InterQual 2025
Lynch Syndrome (LS)	CP:Molecular ...	InterQual 2025
MammaPrint®	CP:Molecular ...	InterQual 2025
Maple Syrup Urine Disease (MSUD)	CP:Molecular ...	InterQual 2025
Marfan Syndrome	CP:Molecular ...	InterQual 2025
MGMT Methylation Analysis in Glioma	CP:Molecular ...	InterQual 2025

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InterQual® Molecular Diagnostics Criteria 2025

Subset	Product	Version
Mucopolidosis IV (MLIV)	CP:Molecular ...	InterQual 2025
Multi-Gene Panels for Autism Spectrum Disorder (ASD)	CP:Molecular ...	InterQual 2025
Multi-Gene Panels for Hereditary Breast Cancer Syndromes	CP:Molecular ...	InterQual 2025
Multi-Gene Panels for Hereditary Colorectal Cancer Syndromes	CP:Molecular ...	InterQual 2025
Multi-Gene Panels for Hereditary Ovarian Cancer Syndromes	CP:Molecular ...	InterQual 2025
Multiple Endocrine Neoplasia Type 2 (MEN2)	CP:Molecular ...	InterQual 2025
MUTYH-Associated Polyposis (MAP)	CP:Molecular ...	InterQual 2025
Myelodysplastic Syndromes (MDS)	CP:Molecular ...	InterQual 2025
Myotonic Dystrophy Type 1 and 2	CP:Molecular ...	InterQual 2025
Neuroblastoma	CP:Molecular ...	InterQual 2025
Neurofibromatosis 1 (NF1)	CP:Molecular ...	InterQual 2025
Neurofibromatosis 2 (NF2)	CP:Molecular ...	InterQual 2025
Niemann-Pick Disease Type A and B	CP:Molecular ...	InterQual 2025
Niemann-Pick Disease Type C	CP:Molecular ...	InterQual 2025
Noninvasive Prenatal Screening (NIPS)	CP:Molecular ...	InterQual 2025
Oncotype DX® Breast Cancer Assay	CP:Molecular ...	InterQual 2025
Oncotype DX® Colon Recurrence Score Test	CP:Molecular ...	InterQual 2025
Oncotype DX® Genomic Prostate Score (GPS) Assay	CP:Molecular ...	InterQual 2025
p53 Immunohistochemical Analysis in Breast Cancer	CP:Molecular ...	InterQual 2025
Peutz-Jeghers Syndrome (PJS)	CP:Molecular ...	InterQual 2025
Pharmacogenomic Testing for Psychotropic Medication Drug Response	CP:Molecular ...	InterQual 2025
Pharmacogenomic Testing in Breast Cancer	CP:Molecular ...	InterQual 2025
Pharmacogenomic Testing in NSCLC	CP:Molecular ...	InterQual 2025
PML-RARA Testing in Acute Promyelocytic Leukemia (APL)	CP:Molecular ...	InterQual 2025
Pompe Disease (Glycogen Storage Disease Type II)	CP:Molecular ...	InterQual 2025
Prader-Willi Syndrome (PWS)	CP:Molecular ...	InterQual 2025
PROGENSA® PCA3 Assay for Prostate Cancer	CP:Molecular ...	InterQual 2025
Prognostic and Predictive Testing in Colorectal Cancer	CP:Molecular ...	InterQual 2025
Prolaris® for Prostate Cancer	CP:Molecular ...	InterQual 2025
PTEN Hamartoma Tumor Syndrome (PHTS)	CP:Molecular ...	InterQual 2025
Retinoblastoma	CP:Molecular ...	InterQual 2025
Rett Syndrome (RTT)	CP:Molecular ...	InterQual 2025
Short stature Homeobox-containing gene (SHOX) Haploinsufficiency Disorders	CP:Molecular ...	InterQual 2025
Spinal Muscular Atrophy (SMA)	CP:Molecular ...	InterQual 2025
Tay-Sachs Disease	CP:Molecular ...	InterQual 2025
Testing for Imatinib Response in Gastrointestinal Stromal Tumors (GISTs)	CP:Molecular ...	InterQual 2025
Testing for Imatinib Response in Melanoma or Systemic Mastocytosis (SM)	CP:Molecular ...	InterQual 2025
Thiopurine Drug Response Testing	CP:Molecular ...	InterQual 2025

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InterQual® Molecular Diagnostics Criteria 2025

Subset	Product	Version
Thyroid Nodule Genetic Testing	CP:Molecular ...	InterQual 2025
Transthyretin (ATTR) Amyloidosis	CP:Molecular ...	InterQual 2025
Trisomy 13 (Patau syndrome)	CP:Molecular ...	InterQual 2025
Trisomy 18 (Edwards syndrome)	CP:Molecular ...	InterQual 2025
Trisomy 21 (Down syndrome)	CP:Molecular ...	InterQual 2025
UGT1A1 Genotyping for Crigler-Najjar Syndrome	CP:Molecular ...	InterQual 2025
UGT1A1 Genotyping for Drug Response	CP:Molecular ...	InterQual 2025
UGT1A1 Genotyping for Gilbert Syndrome	CP:Molecular ...	InterQual 2025
Urea Cycle Disorder	CP:Molecular ...	InterQual 2025
UroVysion® for Bladder Cancer	CP:Molecular ...	InterQual 2025
Von Hippel-Lindau Syndrome (VHL)	CP:Molecular ...	InterQual 2025
Whole Genome Sequencing (WGS), Whole Exome Sequencing (WES), and Chromosomal Microarray (CMA) for Congenital or Hereditary Disorders	CP:Molecular ...	InterQual 2025
Wilson Disease	CP:Molecular ...	InterQual 2025



InterQual® Adult and Geriatric Psychiatry Criteria 2025

Subset	Product	Version
Adult and Geriatric Psychiatry	BH:Adult and Geriatric Psychiatry	InterQual 2025
Transition Plan	BH:Adult and Geriatric Psychiatry	InterQual 2025



InterQual® Child and Adolescent Psychiatry Criteria 2025

Subset	Product	Version
Child and Adolescent Psychiatry	BH:Child and Adolescent Psychiatry	InterQual 2025
Transition Plan	BH:Child and Adolescent Psychiatry	InterQual 2025



InterQual® Substance Use Disorders Criteria 2025

Subset	Product	Version
Substance Use Disorders	BH:Substance Use Disorders	InterQual 2025
Transition Plan	BH:Substance Use Disorders	InterQual 2025



InterQual® Behavioral Health Services Criteria 2025

Subset	Product	Version
Applied Behavior Analysis (ABA) Program	BH:Behavioral Health Services	InterQual 2025
Electroconvulsive Therapy (ECT)	BH:Behavioral Health Services	InterQual 2025
Esketamine (Spravato)	BH:Behavioral Health Services	InterQual 2025
Lecanemab-irmb (Leqembi)	BH:Behavioral Health Services	InterQual 2025
Multi-Gene Panels for Autism Spectrum Disorder (ASD)	BH:Behavioral Health Services	InterQual 2025
Neuropsychological and Developmental Testing	BH:Behavioral Health Services	InterQual 2025
Outdoor Behavioral Healthcare (OBH) Residential Wilderness Program	BH:Behavioral Health Services	InterQual 2025
Paliperidone palmitate (Invega Hafyera)	BH:Behavioral Health Services	InterQual 2025
Paliperidone palmitate (Invega Sustenna)	BH:Behavioral Health Services	InterQual 2025
Paliperidone palmitate (Invega Trinza)	BH:Behavioral Health Services	InterQual 2025
Pharmacogenomic Testing for Psychotropic Medication Drug Response	BH:Behavioral Health Services	InterQual 2025
Psychological Testing	BH:Behavioral Health Services	InterQual 2025
Psychosocial Rehabilitation (PSR), Adult	BH:Behavioral Health Services	InterQual 2025
Stereotactic Introduction, Subcortical or Cortical Electrodes	BH:Behavioral Health Services	InterQual 2025
Transcranial Magnetic Stimulation (TMS)	BH:Behavioral Health Services	InterQual 2025
Urine Drug Testing (UDT)	BH:Behavioral Health Services	InterQual 2025
Vagus Nerve Stimulation (VNS)	BH:Behavioral Health Services	InterQual 2025

Grievance & Appeals Department Annual Report CY 2024

June 2025

Kory Watkins, MBA-HM
Director, Grievance & Appeals

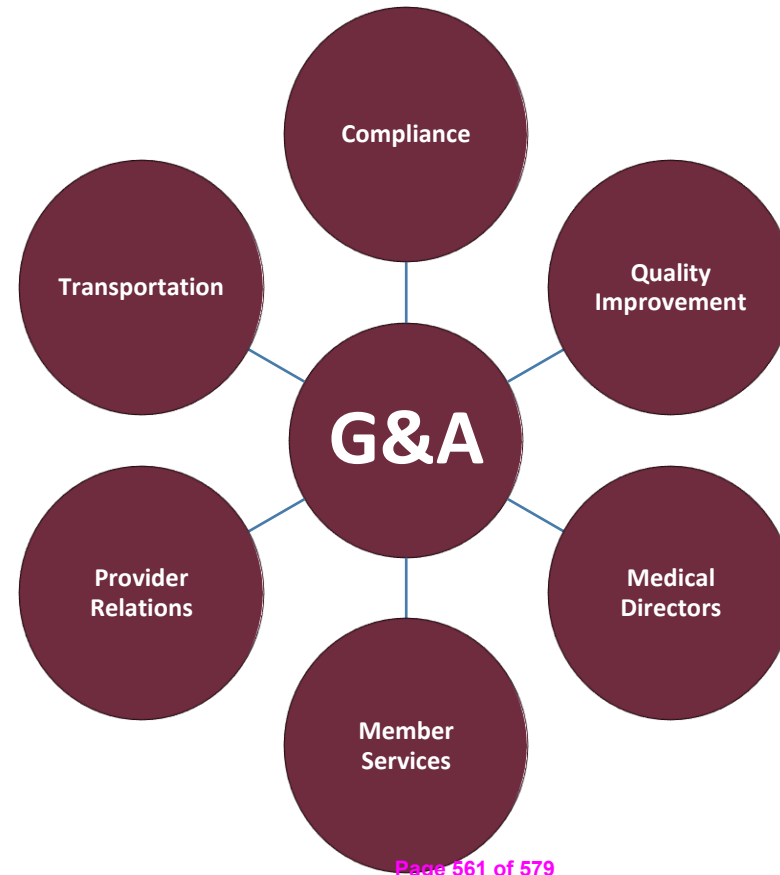


Agenda

- Department Overview
- Case Volume and Trends
- Case Intake and Classification
- Member Demographics
- Grievance Trends and Categories
- Civil Rights Allegations
- Appeals and Outcomes
- Performance Metrics
- Challenges and 2025 Goals

Department Overview

The Grievance & Appeals (G&A) department ensures that members concerns are heard, addressed, and resolved in alignment with regulatory standards and health plan policies. We manage member grievances and appeals with a focus on timeliness, fairness, and improving the overall member experience.



Interdepartmental Collaboration

- **Collaboration with the Quality Improvement Department** – G&A works closely with the Medical Director for Quality, who reviews all clinical grievances flagged by nurses for potential quality issues (PQI). The Medical Director determines whether each case should be referred to the PQI process. Additionally, quarterly interrater reliability reviews (IRR) are conducted to assess the appropriateness of cases not referred. In 2024, 207 grievances were referred to the quality department for PQI review.
- **Collaboration with the Transportation Department** – In 2024, we partnered with the transportation department to enhance our grievance process by capturing the names of individual drivers involved in transportation-related concerns. Previously, only the transportation company was identified. This change allows for more precise data analysis and better identification of driver specific trends.

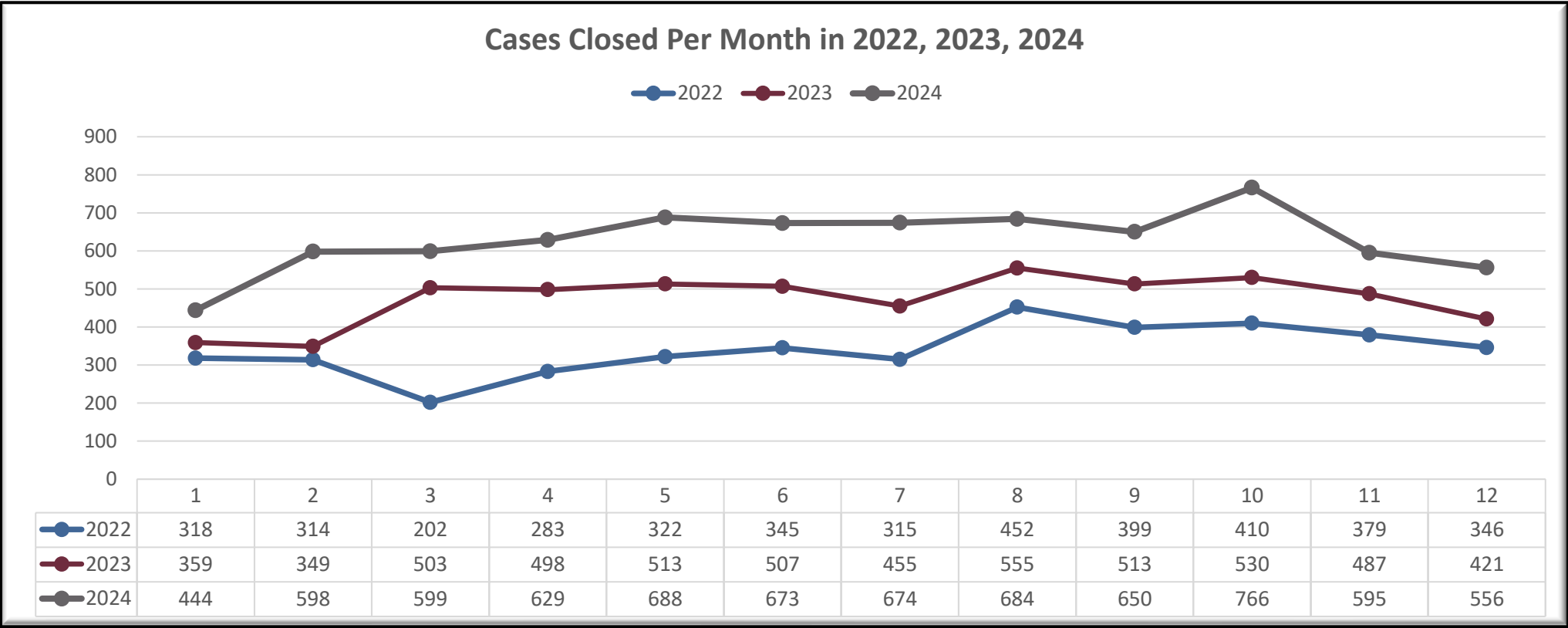
Overview of Process



Case Types We Process:

- **Standard Grievances** - Member complaints about dissatisfaction with services, care, or experiences
- **Exempt Grievances** - Member concerns that are resolved quickly without the formal grievance process
- **Appeals** - Member disagreement with a denied service or treatment
- **State Fair Hearings** - Formal requests for a hearing before an administrative law judge regarding a denied service

Annual Case Volume – 3 Year Comparison



Annual Cases Closed/Cases per 1,000 Members:

2024 – 7,556/8.34

2023 – 5,690/8.39

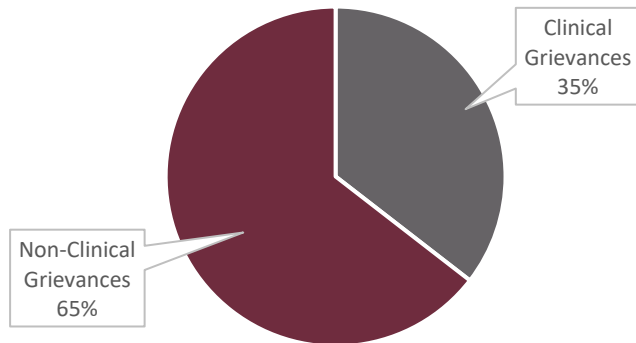
2022 – 4,085/6.40

Case Intake and Classification

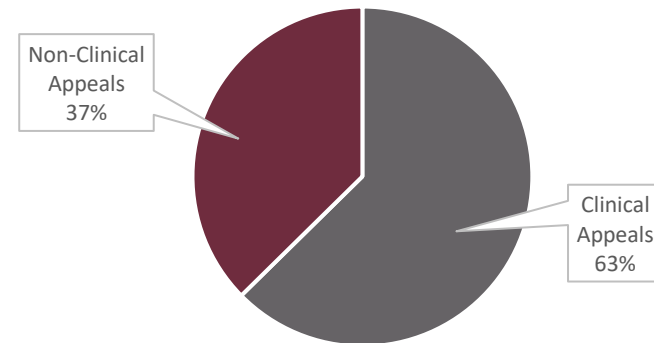
How Cases Were Received		
Phone	6843	91%
Online/Email	509	7%
Mail	129	2%
Fax	65	1%
In-Person	7	0.1%

In 2024, 213 cases were requested to be expedited, but only 28 met the criteria

Clinical vs Non-Clinical Grievances

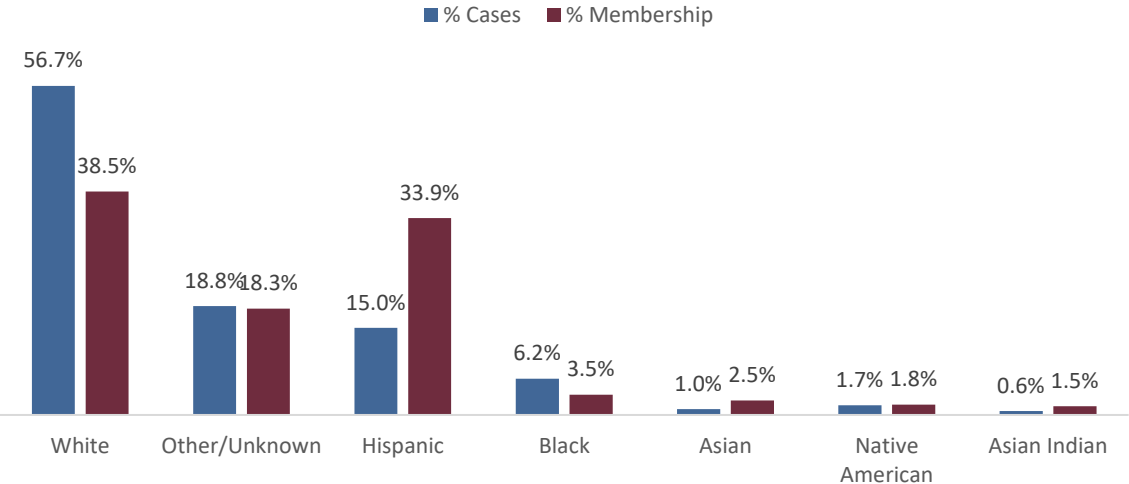


Clinical vs Non-Clinical Appeals

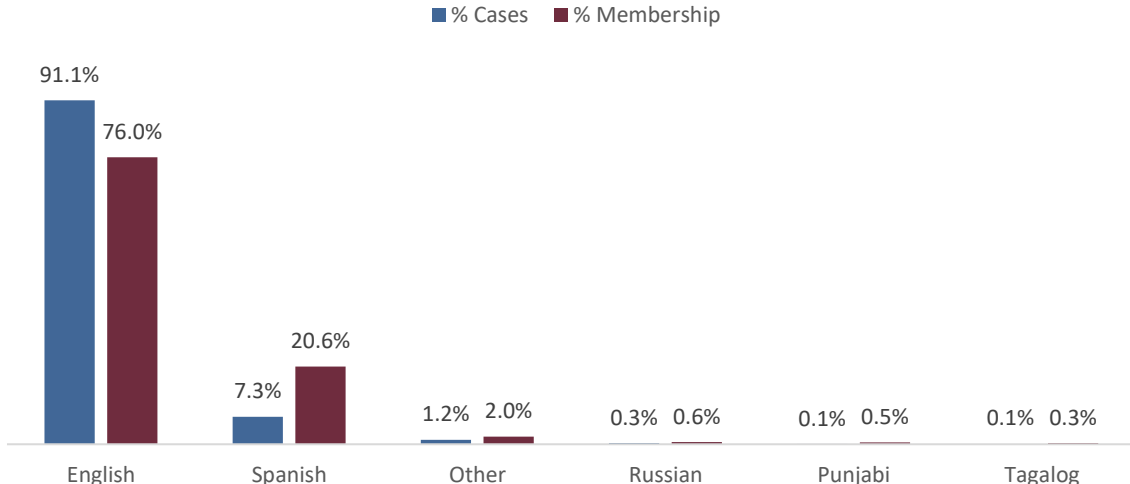


Member Demographics

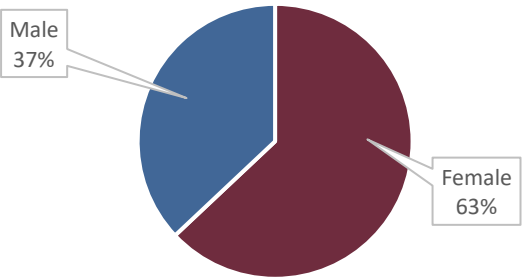
Member Demographics vs Membership by Ethnicity



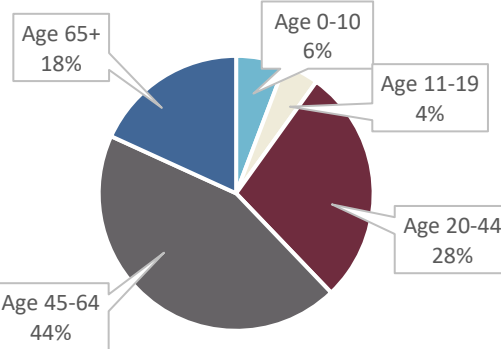
Member Demographics vs Membership by Language



Member Demographics by Gender



Member Demographics by Age

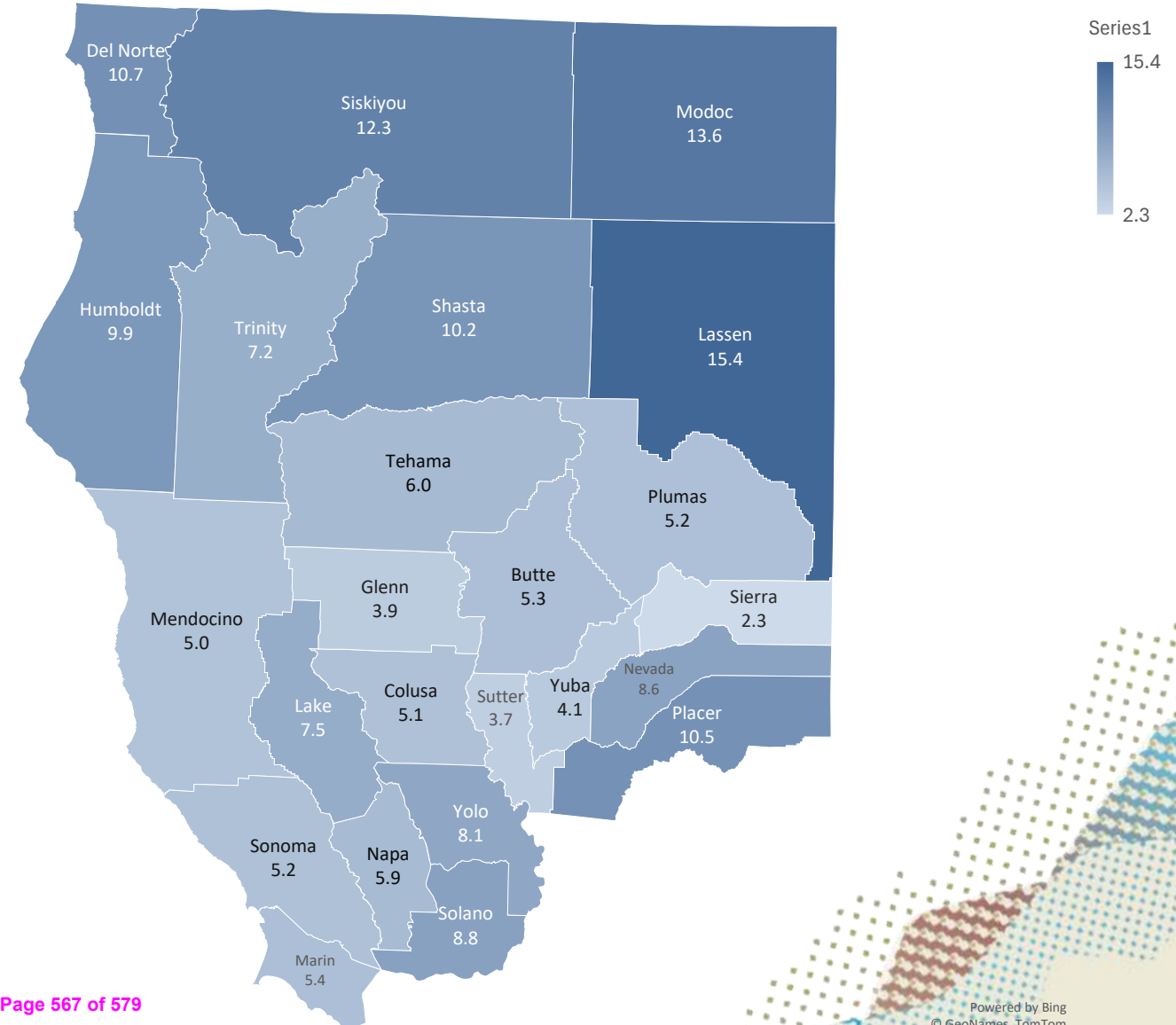


Where Members File Grievances

Grievances per 1,000 Members by County - 2024

Top 3 Counties by Grievances Per 1,000 members:

- Lassen – 15.4
- Modoc – 13.6
- Siskiyou – 12.3



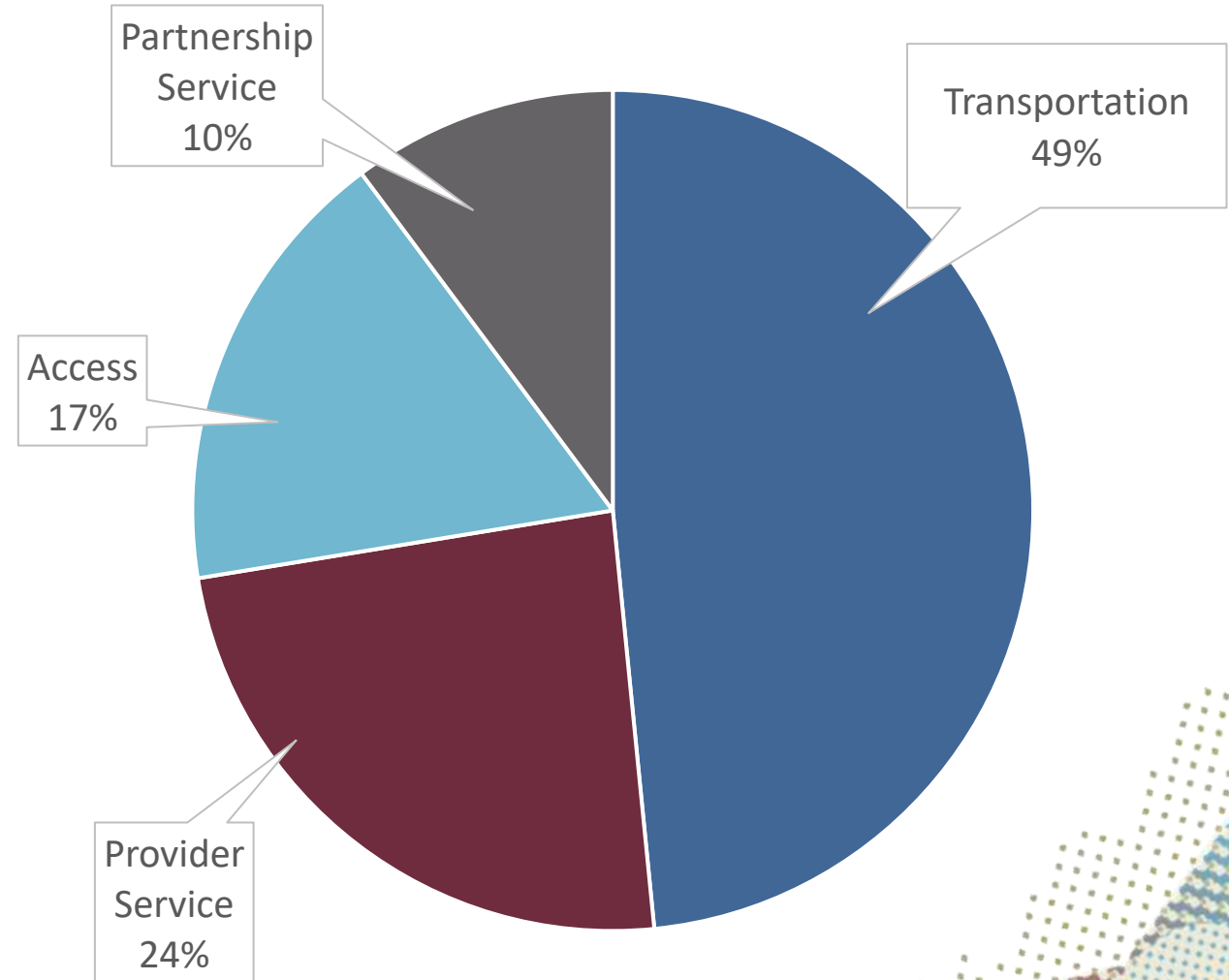
Top Grievance Concerns by Category

Transportation* – includes missed rides, driver arriving late, driver behavior, scheduling issues, and vehicle conditions

Provider Service – includes treatment plan disputes, communication issues, poor attitude, office conditions, and allegations of misconduct

Access – includes long wait times to be seen, delayed referrals/authorizations, and lack of provider availability

Partnership Service – includes staff complaints, advise nurse line, escalation process, website, phone system, and member mailings

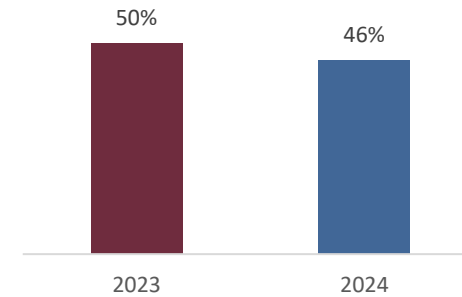


* Partnership provided 1,166,701 rides in 2024 and received 4,472 transportation related concerns – representing less than 0.4% of total rides (down from 0.6% in 2023)

Breakdown of Service-Related Grievances (Excluding Transportation)

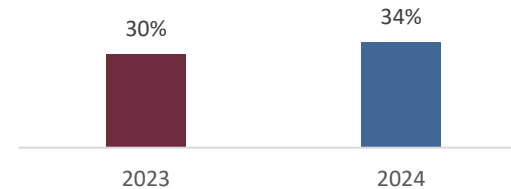
Provider Services (46%)

- Treatment Plan Disputes (39%)
- Communication (29%)
- Poor Attitude (29%)



Access Issues (34%)

- Long Wait Time for Appointments (37%)
- Provider Refusal of Care (13%)
- Provider Network Adequacy (13%)

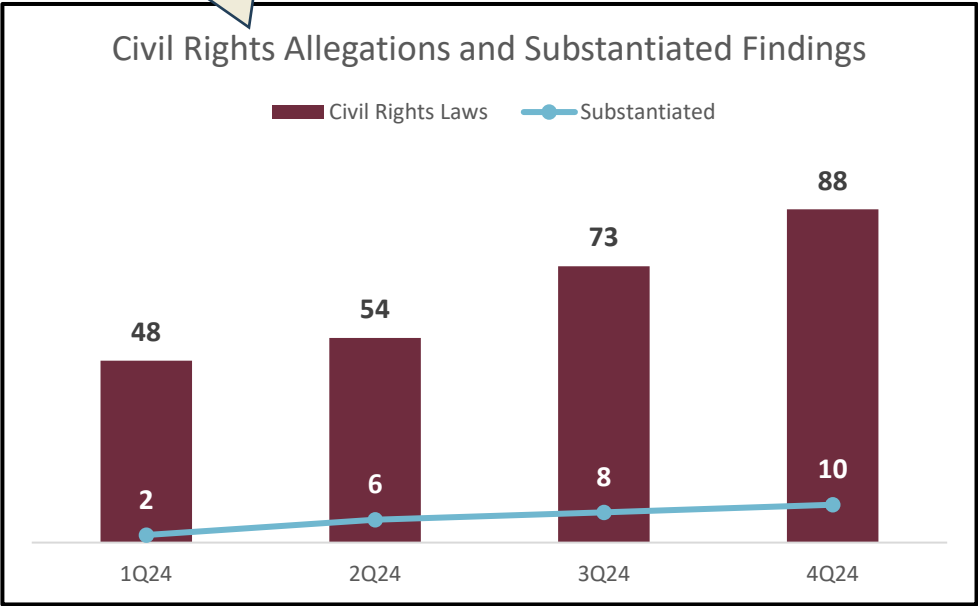


Partnership Services (20%)



Discrimination Allegations - Civil Rights Focus

Only 10% of civil rights allegations were substantiated in 2024, down from 22% in 2023



Type of Civil Rights Concern	Total Concerns Reported
Disability	89
Race or Ethnicity	72
Language Assistance Services	26
Limited English Skills	22
Gender	16
Age	15
Sexual Orientation	7
Auxiliary Aids and Services	5
Religion	5
Nationality	2
Basis of Sex	1
Character Associations	1
Gender Identity	1
Sex Stereotypes	1
Total	263

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

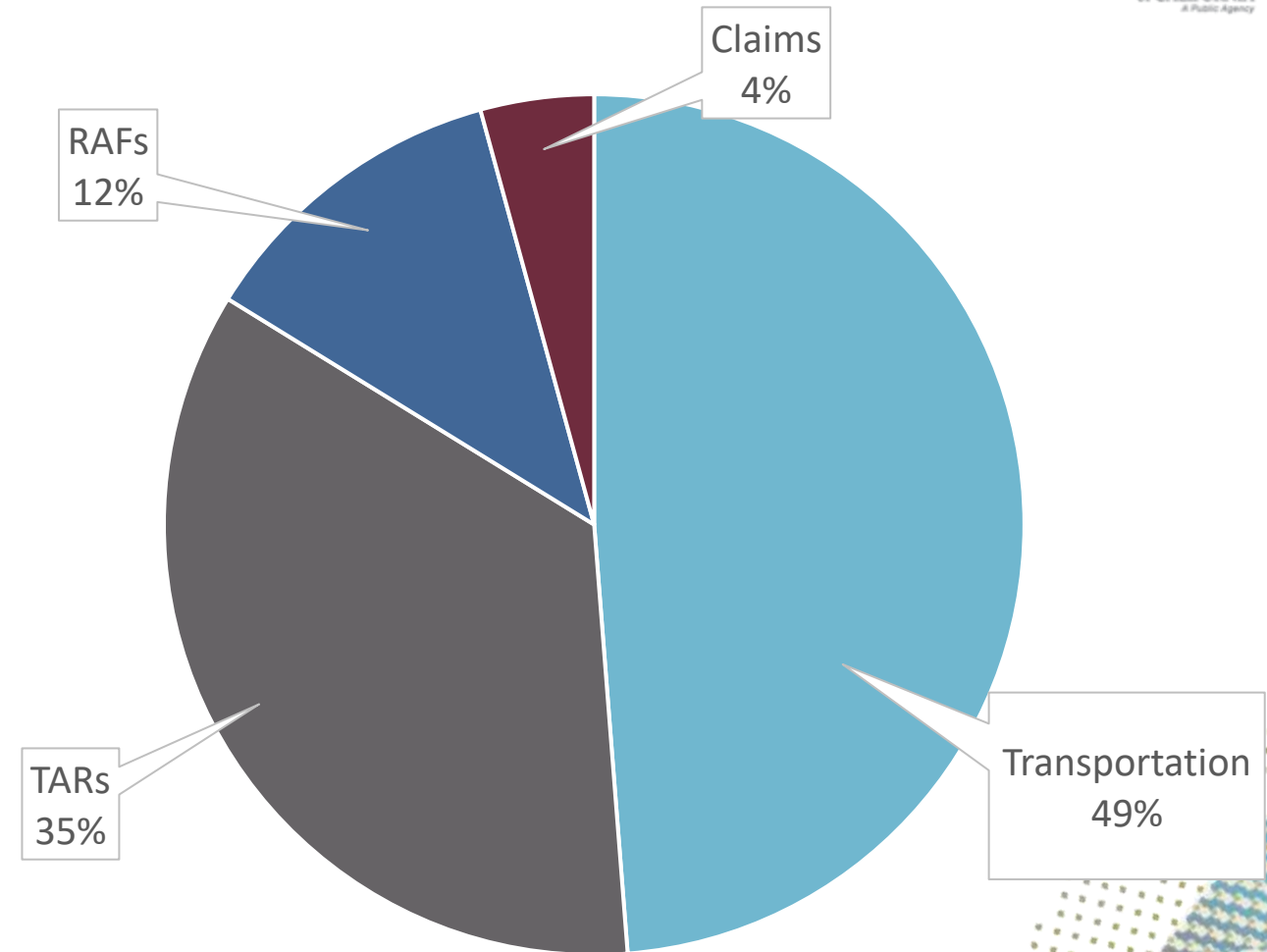
Top Appeals by Category

Transportation – includes meals, lodging, rides, and gas mileage reimbursement

Treatment Authorization Request (TARs) – includes DME, surgery, diagnostic testing, and ancillary services

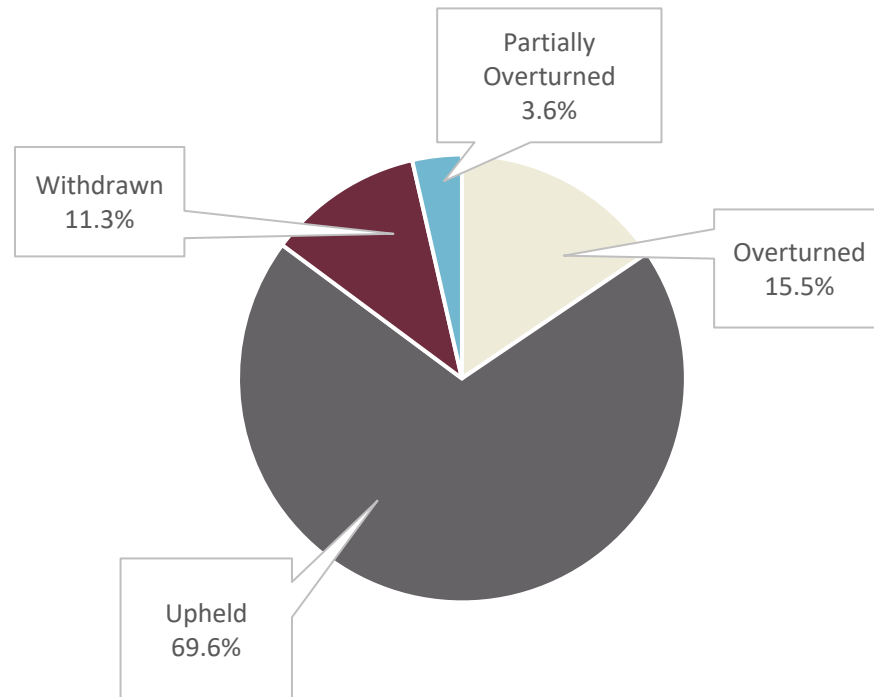
Referral Authorization Forms (RAFs) – includes out-of-network requests

Claims – includes requests for reimbursement of services paid out of pocket

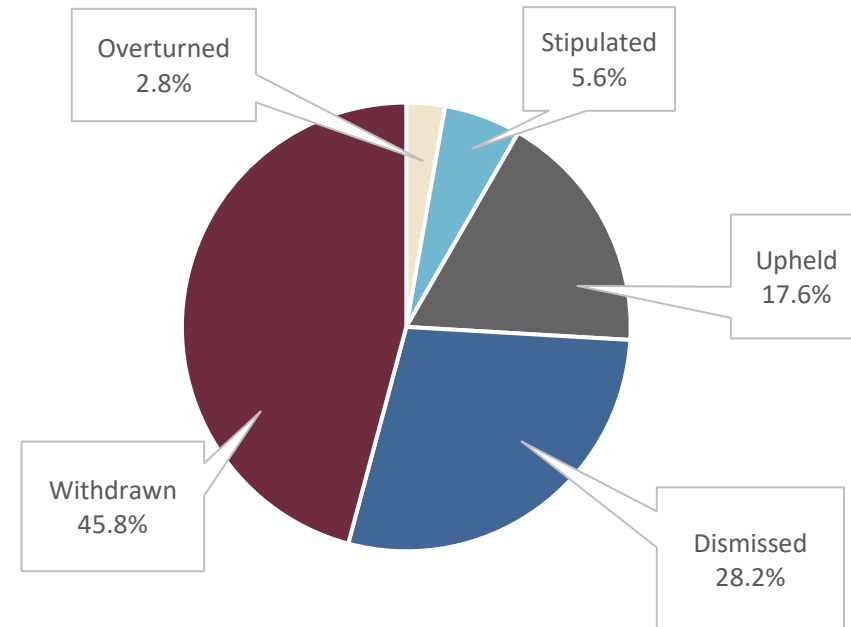


Outcomes and Dispositions

2024 Appeal Outcomes



2024 State Hearing Outcomes



2024 Department Performance

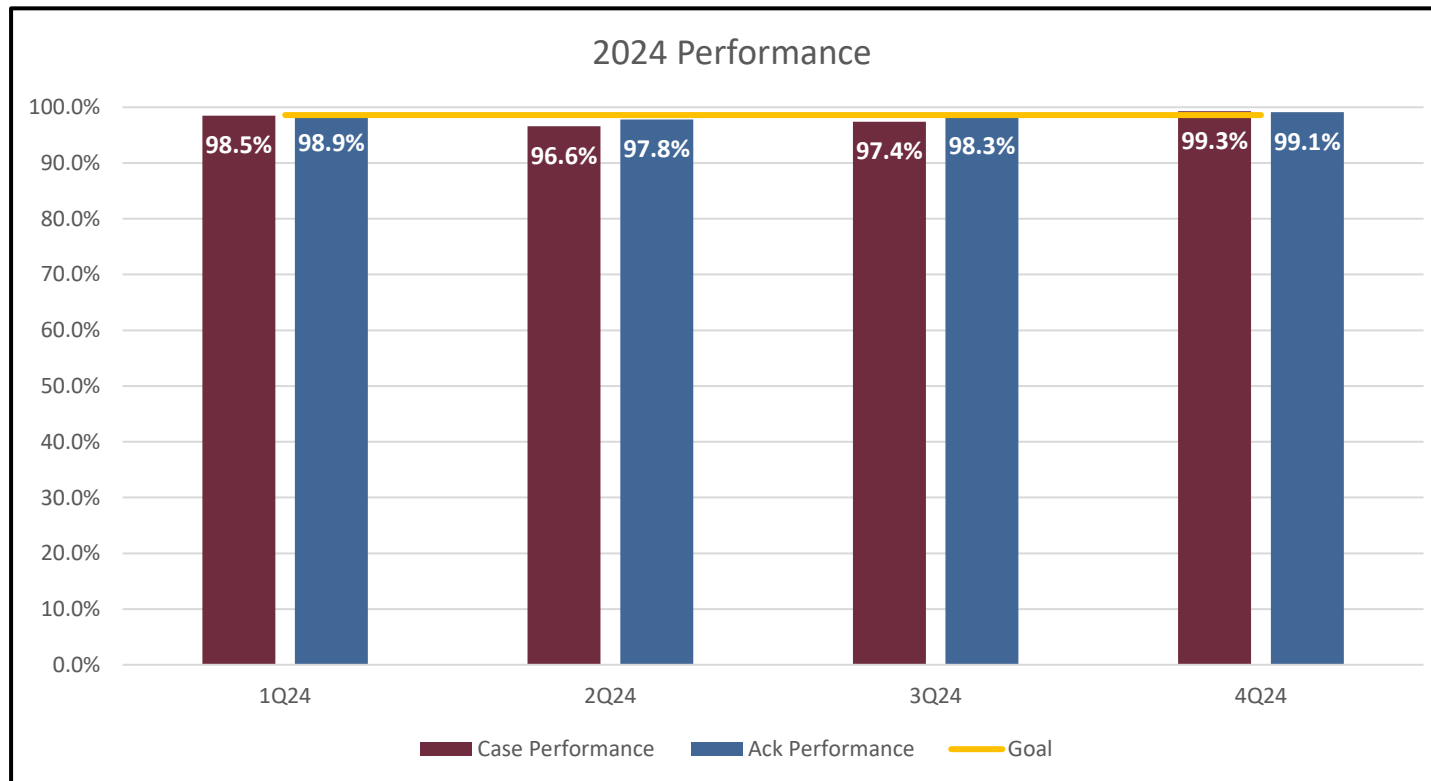
Performance Goals

Case Closure

- Expedited Cases – Investigate 98.6% of cases within 72 hours
- Standard Cases – Investigate 98.6% of cases within 30 days

Acknowledgment Letters

- Letters sent on or before the fifth calendar day after case received



Challenges and Lessons Learned

Challenge	Lesson Learned
Timeliness Goals Were Not Met Across the Year Due to increased caseloads and limited staffing capacity, the department struggled to consistently meet the 30-day resolution timeline.	- Lack of accountability metrics made it difficult to manage timeliness performance. Action Taken: Implemented new metrics to monitor staff performance and flag cases approaching noncompliance.
Delays Caused by Awaiting External Documentation Cases frequently exceeded the timeframe due to outstanding medical records or provider responses.	- Needed a stronger review process to validate whether delays were clinically justified. - Action Taken: Developed a multi-step nurse review protocol: - When one nurse determines documentation is essential, a second nurse confirms or disagrees. - If disagreement, the case is escalated to a Medical Director for final decision - This process ensures only necessary cases are pended and improves oversight on delayed resolutions.

Voice of the Member

“Deija has worked with me on a few discrimination cases. She is always very kind, helpful and knowledgeable whenever I have any questions.”

“We had a hearing this morning with Robert. He was so collaborative and supportive and went over and beyond to give me information and help me navigate some systems an alternatives. It is nice to run across people within the system who are so compassionate and supportive.”

“I had an appeal with you [Amanda], that you fought hard on my behalf and the denial was successfully overturned. I had the surgery, and it changed my life. Thank you so much because you were a key person to make this all happen. I really appreciate you and want to offer you a very sincere thank you.”

Goals and Focus Areas for 2025

- **Jiva Implementation** – Launching a new case management platform in to enhance case tracking, oversight, and reporting.
- **Behavioral Health Transition** – Transitioning mental health and substance use disorder related grievances in-house in Q3 as we end delegation with Carelon.
- **Operational Growth** – Continuing to grow operational staffing while expanding focus on quality assurance and data reporting.
- **Partnership Advantage Prep** – Preparing for launch of the new D-SNP line of business with new processes, policies, and CMS reporting requirements.

Definitions:
 * Engaged = Agreed to Participation
 * Declined = Declined Participaton
 * Not Engaged = Unable to Reach
 * Not Referred = in campaign demographic but not referred to the campaign

Note: programs are measured for effectiveness as appropriate

2025/2026 Population Health Management Work Plan										
NCOA/DHCS Risk Tier	Project/ Program	Target Population / Inclusion / Exclusion	Service Description	Member Notification	Interactive (Y/N)	How to Opt Out	Measure Goals	Denominator	Numerator	Measurement Period
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)	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	Telephone, informational mailer, mailed incentives	Y	When member is called, they will be given the opportunity to Opt Out of further calls	* 25% 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	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	Campaigns: July 2024 - June 2025 Claims: July 2024-Run Date
							* 65% 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		Of denominator, those who completed well child visits by age at enrollment: * 0 - 6 months - 3+ visits * 7 - 12 months - 2+ visits	Campaigns: July 2024 - June 2025 Claims: July 2024-Run Date
							* 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 - 6 months - 9+ vaccinations * 7 - 12 months - 4+ vaccinations		Of denominator, those who completed immunizations by age at enrollment: * 0 - 6 months - 9+ vaccinations * 7 - 12 months - 4+ vaccinations	Campaigns: July 2024 - June 2025 Claims: July 2024-Run Date
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)	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	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 120 days of call outcome "Agreed to Participation"	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: 120 days after call	Campaigns: July 2024 - June 2025 Claims: July 2024-Run Date
							* 70% of members engaged will have a well-child visit by the end of the calendar year		Of denominator, those who completed a well-child visit during the calendar year	Campaigns: July 2024 - June 2025 Claims: July 2024-Run Date
Keeping Members Healthy / Low Risk	Health Care Transitions	* PHC members ages 11 & 12 years old	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	N/A				January 2025 - December 2025
Keeping Members Healthy / Low Risk	Medi-Cal for Kids and Teens (EPSDT) Awareness campaign	* PHC members under the age of 21 and their families	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 annually.	Mailed information packet / Member Newsletter / Partnership Website	N	N/A				Reporting available annually in June
Keeping Members Healthy / Low Risk	Routine Member Newsletters	* Any PHC member * Known mailing address	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	N/A	Newsletters are sent out 2 times per year .			January 2025 - December 2025
Keeping Members Healthy / Low Risk	Community Resource Connections	* PHC members seeking local resources available to Medi-Cal recipients	Provide members with resources, track resources provided, and perform follow up (closed loop referrals) to ensure resource(s) met member needs.	N/A	N	N/A				January 2025 - December 2025
Keeping Members Healthy / Low Risk / Equity	Mobile Mammography Clinics	* Community members living in areas lacking local imaging service providers for mammography screening	40+ clinic days in locations with poor access to mammography services	Clinic-based outreach	N	N/A				July 2025 - June 2026
Keeping Members Healthy / Low Risk	School-Based Vaccination Education & Clinics	* Middle-school event(s) in at least two middle-schools with a high percentage of PHC members enrolled	In-classroom education about the importance of adolescent vaccinations, poster contest with awards, with some vaccination clinics offered during event.	N/A	N	N/A	Conduct 1 school based health education sessions on vaccines.	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 2025 - December 2025 (once on an annual basis)
Keeping Members Healthy / Low Risk	Community Outreach / Engagement Events	* Onsite presence at community events where PHC members are likely to gather.	Offer benefit education, resource referrals, and member surveys to gain insight into barriers and member priorities. Attendance at least 1-2 events per county per year weather permitting (approximately 150+ total events per year).	N/A	N	N/A	N/A	N/A	N/A	January 2025 - December 2025

2025/2026 Population Health Management Work Plan										
NCQA/DHCS Risk Tier	Project/ Program	Target Population / Inclusion / Exclusion	Service Description	Member Notification	Interactive (Y/N)	How to Opt Out	Measure Goals	Denominator	Numerator	Measurement Period
Keeping Members Healthy / Low Risk	Health Disparity Community Events	Pregnant members who self-identify as African American, Native American/Alaska Native, or Native Hawaiian/Pacific Islander	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.	Phone outreach to invite specific members	Y	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?	# of invited members (maximum capacity: 25 per event) # of attendees total # of attendees who expressed a need or interest in services # Surveys measuring maternal care experience administered # surveys measuring event satisfaction administered	# of attendees (pregnant Medi-Cal members) # of attendees who received doula benefits 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 2025 - December 2025 (approximately 3 events per year)
Medium / Emerging Risk	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	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 provider to reschedule	Telephone, informational mailers, mailed incentives	Y	When member is called, they will be given the opportunity to Opt Out of further calls	* 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. * 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	PHC members who had at least one prenatal care visit and delivered baby Jan-Dec 2025 PHC members who had at least one prenatal care visit and delivered baby Jan-Dec 2025 PHC members who had at least one prenatal care visit and delivered baby Jan-Nov 2025 PHC members who had at least one prenatal care visit and delivered baby Jan-Nov 2025 and baby is linked to birth mom	Of denominator, those who had a Tdap Sept 2024-Dec 2025 Of denominator, those who had a Flu shot Aug 2024-Dec 2025 Of denominator, the percentage of moms who attended a post-partum visit within 60 days of delivery Of denominator, the percentage of linked babies who attended a well-child visit within 60 days of birth	Deliveries: Jan 2025 - Dec 2025 Tdap: Sept 2024-Dec 2025 Deliveries: Jan 2025 - Dec 2025 Flu Vacc: Aug 2024 - Dec 2025 Deliveries: Jan 2025 - Nov 2025 Deliveries Jan 2025 - Nov 2025
Medium / Emerging Risk	Perinatal Growing Together - Post-Partum	INCLUDE: *PHC members who delivered a baby in the 2024 Calendar year EXCLUDE: * Individuals who were not PHC members when they delivered a baby	Welcome call when member has delivered 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	Y	When member is called, they will be given the opportunity to Opt Out of further calls	* 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	PHC members who delivered a baby during the 2025 calendar year PHC members who delivered a baby during the 2025 calendar year PHC members who delivered a baby during the 2025 calendar year and baby is linked to birth mom	Of denominator, those were were engaged in the program Of denominator, the percentage of moms who attended a post-partum visit within 60 days of delivery Of denominator, the percentage of linked babies who attended a well-child visit within 60 days of birth	Deliveries: Jan 2025 - Nov 2025 Deliveries Jan 2025 - Nov 2025 Deliveries Jan 2025 - Nov 2025
Medium / Emerging Risk	Disaster Preparedness	INCLUDE: * Any Partnership member	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.	Posted to website	N					January 2025 - December 2025
Medium / 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	If a member calls in after receiving the proram flyer, then a pharmacist 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 informational flyer packet	N	N/A	75% of members who complete a consultation with a Pharmacist and scored a 3 on a Likert scale on the chronic conditions survey in response to the following statement "After working with a PHC staff member, I have a better understanding of how to manage my condition" (1 = Disagree; 2 = Neutral; 3 = Agree) (average score of 2.75).	Members engaged in the Asthma Control program and responded to survey	Members who respond to post-intervention survey questions and responded with agreed or strongly agreed	January 2025 - December 2025
Medium / Emerging Risk	BPHM - Hypertension Lifestyle Control Program Mangement	* 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	PHM 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	Telephone, mailed letter, mailed information packet upon request	Y	When member is called, they will be given the opportunity to Opt Out of further calls	50% of members engaged in the program <i>and who stay engaged for at least 60 days and</i> complete a chronic disease survey will give a score of 3 on a Likert scale in response to the following statement "After working with a PHC staff member, I have a better understanding of how to manage my condition" (1 = Disagree; 2 = Neutral; 3 = Agree) (average score of 2.75).	Members engaged in the Hypertension Control program and responded to survey	Members who respond to post-intervention survey questions and responded with agreed or strongly agreed	January 2025 - December 2025
Medium / 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	PHM staff will reach out to members and offer Healthy Living Tools and lifestyle coaching to promote wellness and disease management using the diabetes action plan	Telephone, mailed letter, mailed information packet upon request	Y	When member is called, they will be given the opportunity to Opt Out of further calls	50% of members engaged in the program <i>and who stay engaged for at least 90 days and</i> 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) (average score of 2.75).	Members engaged in the Diabetes Management Program and responded to survey	Members who respond to post-intervention survey questions and responded with agreed or strongly agreed	January 2025 - December 2025
Medium / Emerging Risk	BPHM Depression Management Program	* PHC 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	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 packet upon request	Y	When member is called, they will be given the opportunity to Opt Out of further calls	50% of members engaged in the program <i>and who stay engaged for at least 60 days and</i> 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) (average score of 2.75).	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 2025 - December 2025

2025/2026 Population Health Management Work Plan										
NCQA/DHCS Risk Tier	Project/ Program	Target Population / Inclusion / Exclusion	Service Description	Member Notification	Interactive (Y/N)	How to Opt Out	Measure Goals	Denominator	Numerator	Measurement Period
Outcomes Across Settings / Transitions of Care	Transitional Care Services	- 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) - Other members assessed as high-risk by 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.	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	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.			January 2025 - December 2025
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.	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 & USPS Letter	Y	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.		January 2025 - December 2025	
			Telephone or USPS Letter		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.			January 2025 - December 2025		
Multiple Chronic Conditions / High Risk	High Risk Pregnancies	INCLUDE: *PHC members who have a high-risk pregnancy diagnosis and self-identify as Native American/Alaska Native	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	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	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 2025 - December 2025