Board of Commissioners Meeting Agenda

June 24, 2026: 10:00 a.m. – 2:00 p.m.

In-person Locations:

Partnership Offices

4605 Business Center Drive, Fairfield, CA (Conference Center)

2525 Airpark Dr., Redding, CA

1036 Fifth Street, Eureka, CA

495 Tesconi Circle, Santa Rosa, CA

281 Nevada St, Auburn, CA

1000 Fortress St, Chico, CA

Public comment is welcome during designated "Public Comments" time frames or by emailing comments to the Board Clerk at ascott@partnershiphp.org by 5:00p.m. on June 23, 2026. Comments received will be read during the meeting.

10:00AM – Opening			
1.1 **Call to Order**			*Chair*
1.2 **Roll Call**			*Clerk*
1.3	***ACTION:*** Approval of Agenda and Board Meeting Minutes for April 22, 2026	1-8	*Chair*
1.4	***ACTION:*** Resolution Accepting the Resignation of Commissioner Dr. Phuong Luu as the Yuba County Representative and Express Appreciation for Service	9-10	*Sonja Bjork*
1.5	***ACTION:*** Resolution to Accept the Board Commissioner Appointment of Jamie Bartolome as a Yuba County Representative	11-12	*Sonja Bjork*
1.6	***ACTION:*** Resolution to Accept Commissioner Darcie Antle's Resignation from the Board as a Mendocino County Representative and Express Appreciation for Service	13-14	*Sonja Bjork*
1.7	***ACTION:*** Resolution to Accept the Board Commissioner Appointment of DeDe Parker as a Mendocino County Representative	15-16	*Sonja Bjork*

1.8 **Commissioner Comment**			*Chair*
1.9	***INFORMATION:*** Comments from Commissioner Jim Yoder		*Commissioner Jim Yoder*
1.10 **Public Comment**			*Chair*
1.11	***INFORMATION:*** CEO Report	17-18	*Sonja Bjork*
11:00AM – Consent Calendar			
2 & 3	***ACTION:*** Consent Calendar ▪ **2.1** Resolution to Ratify the Preliminary Health Care Expense Budget County Representative ▪ **2.2** Resolution to Ratify Commissioner Jayme Bottke's Resignation from the Finance Committee and Board of Commissioners ▪ **3.1** Resolution to Accept all Partnership Committee Minutes, Partnership Policies and Program Descriptions Approved by the Physician Advisory Committee ▪ **3.2** Resolution to Approve Membership Changes to the Physician Advisory Committee and Quality/Utilization Advisory Committee ▪ **3.3** Resolution to Approve Utilization Management Program Description, MPUD3001 ▪ **3.4** Resolution to Approve the Hospital QIP (HQIP) 2026 Six-Month Bridge Measurement Set ▪ **3.5** Resolution to Approve the Palliative Care Quality Incentive Proposed Measures for 2027 ▪ **3.6** Resolution to Approve the Proposed 2027 Perinatal Quality Improvement Program (PQIP) Measurement Set ▪ **3.7** Resolution to Approve Partnership's 2026 Population Needs Assessment	19-32 33-34 35-39 40-41 42-128 129-134 135-137 138-143 144-249	*Chair*
Community Advisory Committee – June 2026 Finance Committee – May 2026 Finance Committee – June 2026 Physician Advisory Committee – May 2026 Physician Advisory Committee – June 2026 Quality and Utilization Advisory Committee (Q/UAC) – May 2026 Quality and Utilization Advisory Committee (Q/UAC) – June 2026 Governance/Compliance Committee – June 2026			
11:05AM – Regular Agenda Items			

4.1	***ACTION:*** Resolution to Approve Final Budget for Fiscal Year 2026-2027	250-271	*Jennifer Lopez*
4.2	***ACTION:*** Resolution to Approve Q12026 Compliance Dashboard	272-275	*Danielle Ogren*
4.3	***ACTION:*** Resolution to Approve Commendations and Appreciation for Brion Burkett's Service to Partnership	276-277	*Sonja Bjork*
4.4	***ACTION:*** Resolution to Approve Commendations and Appreciation for Belle Knight's Service to Partnership	278-279	*Sonja Bjork*
4.5	***ACTION:*** Resolution to Approve Commendations and Appreciation for Marcelo "Nunie" Matta's Service to Partnership	280-281	*Sonja Bjork*
11:45AM-12:05PM– Lunch			
12:05PM – Reports			
5.1	***INFORMATION:*** Metrics and Financial Update	282-295	*Written Report*
5.2	***INFORMATION:*** Operations Update	296-297	*Wendi Davis*
5.3	***INFORMATION:*** Legislative & Media Update	298-304	*Dustin Lyda*
5.4	***INFORMATION:*** CMO Report on Quality	305-307	*Dr. Kermit Jones*
5.5	***INFORMATION:*** Health Services Update	308-313	*Katherine Barresi*
12:45PM – Education Sessions			
6.1	***INFORMATION:*** Employee Survey		*Naomi Gordon*
6.2	***NFORMATION:*** Grievance & Appeals Update		*Kory Watkins*
1:30PM – Closed Session			
7.1	Action Pursuant to Government Code §54957(b)(1) ***PUBLIC EMPLOYEE PERFORMANCE EVALUATION*** Title: Chief Executive Officer		*Full Board, Sonja Bjork, CEO, Naomi Gordon, Sr. Director of Human Resources, and Ashlyn Scott, Board Clerk*
2:00PM – Adjournment			

Upcoming Meetings:

8/26/2026 – August Board Meeting
10/28/2026 – October Board Meeting
12/2/2026 – December Board Meeting

Government Code §54957.5 requires that public records related to items on the open session agenda for a regular commission meeting be made available for public inspection. Records distributed less than 72 hours prior to the meeting are available for public inspection at the same time they are distributed to all members, or a majority of the members of the Commission. The Commission has designated the Board Clerk as the contact for Partnership HealthPlan of California located at 4665 Business Center Drive, Fairfield, CA 94534, for the purpose of making those public records available for inspection. The Board Meeting Agenda and supporting documentation is available for review from 8:00 AM to 5:00 PM, Monday through Friday at all PHC regional offices (see locations above). It can also be found online at www.partnershiphp.org. PHC meeting rooms are accessible to people with disabilities. Individuals who need special assistance or a disability-related modification or accommodation (including auxiliary aids or services) to participate in this meeting, or who have a disability and wish to request an alternative format for the agenda, meeting notice, agenda packet or other writings that may be distributed at the meeting, should contact the Board Clerk at least ten (10) days prior to the scheduled meeting at (707) 863-4516 or by email at ascott@partnershiphp.org. Notification in advance of the meeting will enable the Board Clerk to make reasonable arrangements to ensure accessibility to this meeting and to materials related to it.

MINUTES OF THE MEETING OF
PARTNERSHIP HEALTHPLAN OF CALIFORNIA BOARD OF COMMISSIONERS
In-Person Location:
Hotel Katerina, Ribbon Ballroom, 1930 Baney Ln, Chico, CA 95928
On
April 22, 2026
From 8:00-8:30A.M.

Members Present: Gaby Bernal Leroi, Jayme Bottke, Ranell Brown, Christopher Champlin, Christy Coleman, Cathryn Couch, Lisa Davies, Dean Germano (Chair), Ryan Gruver, Alicia Hardy, Dave Jones, Seth Kaufman, M.D., Scott Kennelly, Belle Knight, Liz Lara-O'Rourke, Phuong Luu, M.D., Jennifer Malone, Nunie Matta, Andrew Miller, M.D., Monica Morales, Robert Oldham, M.D., Tiffany Rowe, Stacy Sphar, Nancy Starck, Nolan Sullivan, Kim Tangermann, Pedro Toledo, Dr. Lisa Warhuus, Jennifer Yasumoto, Jim Yoder

Members Excused: Darcie Antle, Gena Bravo, Brion Burkett, Emery Cowan, Shelly Davis, Liz Hamilton, JoDee Johnson, Elizabeth Kelly, Jonathan Porteus, PhD

Staff: Leigha Andrews, Katherine Barresi, Jill Blake, Mark Bontrager, Isaac Brown, Tina Buop, Greg Cafiero, Naomi Gordon, Vicky Klakken, James Legere, John Lemoine, Jennifer Lopez, Robert Moore, M.D., Kathryn Power, Tim Sharp, Rebecca Stark, Amy Turnipseed, Colleen Valenti, Sonja Bjork, CEO, and Ashlyn Scott, Board Clerk

AGENDA ITEM	DISCUSSION	MOTION / ACTION
1.0 Opening	Commissioner Dean Germano, Board Chair, called the bi-monthly meeting to order and welcomed everyone to the meeting in person at the Hotel Katerina in Chico, CA. Board members were reminded to abstain from voting on any agenda item where they might have a conflict of interest, and to state their name before asking questions or making motions. As a reminder, Commissioner Germano read the Partnership Mission Statement: "to help our members, and the communities we serve, be healthy." He also stated that members of the public would have an opportunity to speak at designated times throughout the agenda.	None
1.2 Roll Call	Ashlyn Scott, Clerk of the Commission, called the roll indicating there was a quorum.	None

1.3 Approval of Agenda and the Board Meeting Minutes for February 25, 2026	Chairman Germano asked if anyone had changes for the agenda or corrections to the February 25, 2026, minutes. Hearing no requests for modification, he asked for a motion to approve the agenda and minutes.	*Commissioner Couch moved to approve the agenda and minutes as presented, seconded by Commissioner Sullivan.* ***ACTION SUMMARY:*** *Yes: 30* *No: 0* *Abstention: 0* *Excused: 9 (Antle, Bravo, Burkett, Cowan, Davis, Hamilton, Johnson, Kelly, Porteus)* **MOTION CARRIED**
1.4 Commissioner Comment	Chairman Germano asked if there were any Commissioner comments. There were none.	None
1.5 & 1.6 Public Comment / Correspondence	Chairman Germano asked for any public comments. There were none. A written correspondence submitted by a member of Partnership was included in the Board packet.	None
2 & 3 Consent Calendar	Chairman Germano stated that all items on the consent calendar would be approved with one motion unless someone requests to pull an item for further discussion. Hearing no requests, he asked for a motion to approve the Consent Calendar and resolutions 2.1, 3.1, 3.2, 3.3, 3.4 and 3.5: ▪ **2.1** Resolution to Approve Edits to Partnership's Annual Investment Policy (FIN-501) ▪ **3.1** Resolution to Accept all Committee Minutes and Policy & Program Updates Approved by PAC. ▪ **3.2** Resolution to Approve the Cultural & Linguistic Program Description, as Approved by PAC ▪ **3.3** Resolution to Approve the Proposed 2026 6-Month Perinatal Quality Improvement Program (PQIP) Measurement Set as Approved by PAC. ▪ **3.4** Resolution to Approve the Appointment of Brenda Shipp to the Strategic Planning Committee. ▪ **3.5** Resolution to Approve the Care Coordination Program Description, MPCD2013, as Approved by PAC	*Commissioner Toledo moved to approve Resolutions 2.1, 3.1, 3.2, 3.3, 3.4 and 3.5 as presented, seconded by Commissioner Starck.* ***ACTION SUMMARY:*** *Yes: 30* *No: 0* *Abstention: 0* *Excused: 9 (Antle, Bravo, Burkett, Cowan, Davis, Hamilton, Johnson, Kelly, Porteus)* **MOTION CARRIED**

4.1 Resolution to Approve Budget Revisions for FY 2025-2026	Jennifer Lopez, Chief Financial Officer, presented a Resolution to Approve Budget Revisions for Fiscal Year 2025–2026, noting that this is a minor revision to the current fiscal year budget. She explained that the initial budget anticipated a $39 million deficit; however, the organization now expects some one-time favorable adjustments related to prior-year revenue. Ms. Lopez further noted that, despite this favorable variance, the organization continues to anticipate decreasing membership and corresponding declines in revenue. The proposed resolution seeks approval to transfer funds across expense and revenue categories in order to remain within the overall approved budget. She clarified that these adjustments reflect a fungibility approach, allowing for the reallocation of funds between categories without changing the total budget.	*Commissioner Jones moved to approve Resolution 4.1 as presented, seconded by Commissioner Sullivan.* ***ACTION SUMMARY:*** *Yes: 30* *No: 0* *Abstention: 0* *Excused: 9 (Antle, Bravo, Burkett, Cowan, Davis, Hamilton, Johnson, Kelly, Porteus)* **MOTION CARRIED**
4.2 Resolution to Approve Budget Assumptions for FY 2026-2027	Ms. Lopez presented Partnership's Budget Assumptions for Fiscal Year 2026–2027, noting that the organization is developing the budget with limited available information. She acknowledged that Partnership is accustomed to operating in uncertain and volatile environments, including prior challenges such as COVID-19, declining membership, and Medicaid work requirements. Given the current uncertainties, a conservative fiscal approach is being applied and a rebudget is likely as conditions evolve. Ms. Lopez outlined the three-month budget development process, which includes establishing budget assumptions in April, developing draft healthcare assumptions in May, and finalizing the budget in June after reviewing updated state budget information and incorporating administrative and capital expenses for presentation to the Finance Committee and Board. The State of California is currently facing a projected $2.9 billion deficit and described the proposed state budget as a "keep the lights on" budget. She noted that the Legislative Analyst's Office has highlighted higher revenues but cautioned that the state faces ongoing structural budget challenges. Ms. Lopez highlighted the high level of uncertainty due to broader economic and global factors, including market volatility and geopolitical issues. Additional reductions to Medi-Cal, education, and correctional system funding are anticipated, along with potential changes to Medi-Cal eligibility and the Managed Care Organization (MCO) tax. The initial Medi-Cal budget totals $222 billion, including $50 billion from the state. Despite recent benefit and membership reductions, overall costs have continued to increase year over year. Declining insurance coverage is expected to place additional strain on Federally Qualified Health Centers (FQHCs) and emergency departments. There is uncertainty surrounding the future coverage for approximately 96,000 undocumented members currently served by Partnership. For undocumented Medi-Cal beneficiaries, the state is likely to follow one of two potential approaches: carving these members out into state fee-for-service or, establishing a non-risk arrangement. She stated that, for budgeting purposes, Partnership is assuming these members will be carved out to	*Commissioner Sullivan moved to approve Resolution 4.2 as presented, seconded by Commissioner Hardy.* ***ACTION SUMMARY:*** *Yes: 30* *No: 0* *Abstention: 0* *Excused: 9 (Antle, Bravo, Burkett, Cowan, Davis, Hamilton, Johnson, Kelly, Porteus)* **MOTION CARRIED**

	Medi-Cal fee-for-service as of January 1, 2027, as this is the most administratively straightforward approach to comply with the federal changes. Ms. Bjork added that carving out undocumented members would present significant challenges for providers, as reimbursement rates under fee-for-service are lower and programs such as enhanced case management and QIP would not be available. She also noted that this approach would create confusion for both members and providers regarding billing and coverage. While a non-risk model may better support care delivery, it would be operationally complex to implement. Ms. Lopez stated that budget assumptions will change as more information becomes available and emphasized the need for flexibility. The Governor is likely to look to the Department of Health Care Services (DHCS) to identify significant cost reductions. The state is expected to implement additional clinical efficiency adjustments, including potential revenue reductions tied to performance measures such as hospital readmissions, short hospital stays, and cesarean section rates. Partnership is prepared to challenge these proposed reductions using clinical data. Ms. Lopez also reported that the state is examining spending related to durable medical equipment and is likely to introduce further cost controls. Additional rate reductions are anticipated and will likely affect provider reimbursement. The state actuaries have noted that Partnership's inpatient provider payments are, on average, significantly higher than those of other plans, excluding directed payments. This will likely contribute to continued pressure to reduce rates and requires careful management of provider contracted costs.	
4.3 Resolution to Approve Six Applicants to the Community Advisory	Ms. Bjork, presented four applicants to the Consumer Advisory Committee (CAC) for the Board's review and approval. She noted that each applicant is a current health plan member who has expressed interest in serving on the CAC. Ms. Davis highlighted that the CAC is composed of individuals from diverse backgrounds who bring a broad range of lived experiences and perspectives to their roles. In addition to their interest in serving on the CAC, the applicants are active participants in their local communities through employment, volunteer work, and involvement with local and state boards, community-based organizations, and faith-based groups. **The following applicants were presented:** Amy Christensen, Placer County Isabell VanMerlin, Butte County Ursula Williams, Butte County Harkirandish Kaur, Sutter County Paula Kahrau, Solano County Shaneata Bomkamp, Shasta County	*Commissioner Knight moved to approve Resolution 4.3 as presented, seconded by Commissioner Matta.* ***ACTION SUMMARY:*** *Yes: 29* *No: 0* *Abstention: 1 (Rowe)* *Excused: 9 (Antle, Bravo, Burkett, Cowan, Davis, Hamilton, Johnson, Kelly, Porteus)* **MOTION CARRIED**

Adjournment	Chairman Germano adjourned the meeting at 8:31AM	None

Respectfully submitted by:
Ashlyn Scott, Board Clerk

Board Approval Date: 6/24/2026

Signed: ______________________________
Ashlyn Scott, Clerk

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:	**Agenda Item Number:**
June 24, 2026	1.4

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
Partnership Staff

Topic Description:
Partnership Board Commissioner, Dr. Phuong Luu, has resigned from the Partnership Board.

Commissioner Luu has made numerous outstanding contributions to Partnership HealthPlan of California and the Commission (known as the Board) since April 2024. She has provided excellent leadership and has been a dedicated volunteer. Her knowledge has been of great value to Partnership, and she has kept the needs of our members, providers and the community as a guiding principle.

Reason for Resolution:
To provide Commissioner Luu with the highest level of commendation and appreciation for her excellent service.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of Partnership staff, the Board is asked to approve the commendations and appreciation for the support Commissioner Luu has provided to Partnership and the Board.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:	**Agenda Item Number:**
June 24, 2026	1.4
	Resolution Number:
	26-

IN THE MATTER OF: COMMENDATIONS AND APPRECIATION FOR DR. PHUONG LUU'S SERVICE TO PARTNERSHIP AND THE BOARD

Recital: Whereas,

A. Dr. Luu has provided valuable guidance, insight, and support to Partnership HealthPlan of California and to the Board of Commissioners.

B. Dr. Luu was a faithful and active member of the Board.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the highest level of commendations and appreciation for Commissioner Luu's outstanding service to Partnership and the Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 24th day of June 2026 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

____
Dean Germano, Chair

____
Date

ATTEST:

BY: ____________________________
Ashlyn Scott, Clerk

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 24, 2026

Agenda Item Number:
1.5

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
Yuba County Board of Supervisors

Topic Description:
On May 12, 2026, Jamie Bartolome, Yuba County Health & Human Deputy Director, was appointed by the Yuba County Board of Supervisors to the Partnership HealthPlan of California Commission (known as the Board) as a County Representative.

Jamie Bartolome has been appointed on an interim basis while the County conducts a search for a new Board representative. The appointment will begin on June 24, 2026, and continue at the discretion of the Yuba County Board of Supervisors.

Reason for Resolution:
To obtain Board approval to appoint Jamie Bartolome to the Partnership Board as a Yuba County Representative.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of the Yuba County Board of Supervisors, the Board is asked to approve the new appointment of Jamie Bartolome to the Partnership Board.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 24, 2026

Agenda Item Number:
1.5

Resolution Number:
26-

IN THE MATTER OF: APPROVING THE NEW YUBA COUNTY APPOINTMENT OF JAMIE BARTOLOME TO THE PARTNERSHIP BOARD

Recital: Whereas,

A. Each county board of supervisors is responsible for appointing representatives to the Partnership Board of Commissioners.

B. Yuba County has a vacancy on the Partnership Board.

C. The Board has authority to approve appointed Board members.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the new Yuba County appointment of Jamie Bartolome to the Partnership Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 24th day of June, 2026 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

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Dean Germano, Chair

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Date

ATTEST:

BY: ____________________________
Ashlyn Scott, Board Clerk

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 24, 2026

Agenda Item Number:
1.6

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
Partnership Staff

Topic Description:
Partnership Board Commissioner, Darcie Antle, has resigned from the Partnership Board and Finance Committee.

Commissioner Antle has made numerous outstanding contributions to Partnership HealthPlan of California and the Commission (known as the Board) since August 2020. She has provided excellent leadership and has been a dedicated volunteer. Her knowledge has been of great value to Partnership, and she has kept the needs of our members, providers and the community as a guiding principle.

Reason for Resolution:
To provide Commissioner Antle with the highest level of commendation and appreciation for her excellent service.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of Partnership staff, the Board is asked to approve the commendations and appreciation for the support Commissioner Darcie Antle has provided to Partnership and the Board.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:	**Agenda Item Number:**
June 24, 2026	1.6
	Resolution Number:
	26-

IN THE MATTER OF: COMMENDATIONS AND APPRECIATION FOR DARCIE ANTLE'S SERVICE TO PARTNERSHIP AND THE BOARD

Recital: Whereas,

A. Darcie Antle has provided valuable guidance, insight, and support to Partnership HealthPlan of California and to the Board of Commissioners.

B. Darcie Antle was a faithful and active member of the Board.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the highest level of commendations and appreciation for Commissioner Antle's outstanding service to Partnership and the Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 24th day of June 2026 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

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Dean Germano, Chair

____
Date

ATTEST:

BY: ______________________________
Ashlyn Scott, Clerk

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 24, 2026

Agenda Item Number:
1.7

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
Mendocino County Board of Supervisors

Topic Description:
On April 21, 2026, DeDe Parker, Mendocino County Director of Social Services, was appointed by the Mendocino County Board of Supervisors to the Partnership HealthPlan of California Commission (known as the Board) as a County Representative.

DeDe Parker has been appointed for a four-year term.

Reason for Resolution:
To obtain Board approval to appoint DeDe Parker to the Partnership Board as a Mendocino County Representative.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of the Mendocino County Board of Supervisors, the Board is asked to approve the new appointment of DeDe Parker to the Partnership Board.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 24, 2026

Agenda Item Number:
1.7

Resolution Number:
26-

IN THE MATTER OF: APPROVING THE NEW MENDOCINO COUNTY APPOINTMENT OF DEDE PARKER TO THE PARTNERSHIP BOARD

Recital: Whereas,

A. Each county board of supervisors is responsible for appointing representatives to the Partnership Board of Commissioners.

B. Mendocino County has a vacancy on the Partnership Board.

C. The Board has authority to approve appointed Board members.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the new Mendocino County appointment of DeDe Parker to the Partnership Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 24th day of June, 2026 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

____
Dean Germano, Chair

____
Date

ATTEST:

BY: ______________________________
Ashlyn Scott, Board Clerk

Report from the Chief Executive Officer

June 24, 2026

UIS Update

Partnership continues to closely follow developments related to the state's budget proposal to remove those with uncertain immigration status ("UIS") out of Medi-Cal managed care effective January 1, 2027. For our health plan that would mean the loss of approximately 83,000 members. As I have described in my recent emails to the Board, our statewide association, the Local Health Pans of California, has developed an alternative proposal for consideration by the legislature and administration. Under this plan, services allowable under federal rules (pregnancy-related and emergency) would be carved out to the state fee-for-service system. Members with UIS would continue receiving all other care through Partnership. This would ensure they could remain with their current medical homes and that their primary, specialty care and other services are not interrupted. Our proposal has gained support from many stakeholders, such as the California Medical Association, First Five, and the California Primary Care Association. The budget the legislature sent to Governor Newsom included the possibility of our proposal being adopted. Now we await release of the final budget to see whether the LHPC proposal will be adopted. Given the frequent changes to the status of the LHPC proposal, the Board will be presented with the latest available information during the upcoming Board meeting.

Membership and Eligibility

We continue to see steady declines in membership amid ongoing confusion surrounding Medi-Cal eligibility. Partnership's "Keep Your Medi-Cal" campaign continues to engage members through text messages, radio spots, and updated information on our website. Currently, our staff participate in local convenings where stakeholders meet to create consistent messaging and develop strategies to assist people in maintaining eligibility. The California Health Care Foundation issued a request for letters of interest in a grant opportunity to support these local efforts. We hope to secure funds to support local collaboratives in this important work. CMS issued its draft regulation regarding the rules for community engagement that will go into effect on January 1, 2027, for those between the ages of 19-65. Staff are closely following California's approach to the new regulations so we can effectively communicate changes to our members. The primary areas of concern are how the medical frailty exemptions will be administered and supporting those who will have difficulty obtaining documentation of their work or volunteer hours. Partnership is supporting two pilot projects that will test the effectiveness of two technology solutions intended to assist members in the eligibility process. We have also provided grants to local CBOs and health centers who can support those who need special assistance.

Community Reinvestments

Partnership's Health Equity Officer has been leading the plan's Community Reinvestment work. Many internal teams have been involved, including:

- Population Health (CHIP/CHA)
- Finance (funding calculations)
- Member Services (coordinating Community Advisory Committee input and review)

While determining county by county funding allocations, Partnership received credit for some of the provider recruitment dollars expended throughout our service area. It was important that the state acknowledged the significant investments Partnership has made to bring new clinicians to our service area, which suffers from chronic provider shortages.

The Community Reinvestment All Plan Letter requires review and sign off by each county's behavioral health director and public health officer/director. This requirement has been completed for all fourteen participating. The county project proposals will soon be submitted to DHCS for review and approval.

Member Scholarship Program

As part of our workforce development program, Partnership created a scholarship opportunity for members enrolled in higher education programs focusing on health or social service careers. The Community Advisory Committee selected five awardees. One recipient received $10,000, while four recipients were awarded $5,000 scholarships. The recipients were from Lassen, Humboldt, Tehama, Sonoma and Napa counties. These talented folks will be invited to our August board meeting so that we can formally present them with the acknowledgment they deserve.

AGENDA REQUEST FOR RATIFICATION
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable) **Agenda Item Number:**
Meeting Date: May 20, 2026 2.1
Board Meeting Date: June 24, 2026

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
The Finance Committee and Partnership Staff

Topic Description:
On April 22, 2026, the Board approved Budget Assumptions for Fiscal Year (FY) 2026-2027 and directed staff to prepare a full operational budget. The Preliminary Health Care Expense Budget for FY 2026-2027 is being presented to the Finance Committee for approval. The final budget (health care, administrative, and operations) is presented to the Finance Committee and full Board for approval in June.

Reason for Resolution:
The purpose of this resolution is to present the Preliminary Health Care Expense Budget for FY 2026-2027 for review and approval.

Financial Impact:
The financial impact is material.

Requested Action of the Board:
Based on the approval of the Finance Committee and Partnership staff, the Board is asked to ratify the Preliminary Health Care Budget for FY 2026-2027.

AGENDA REQUEST FOR RATIFICATION
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable)
Meeting Date: May 20, 2026
Board Meeting Date: June 24, 2026

Agenda Item Number:
2.1

Resolution Number:
26-

IN THE MATTER OF: RATIFYING THE FINANCE COMMITTEE'S APPROVAL OF THE PRELIMINARY HEALTH CARE EXPENSE BUDGET FOR FY 2026-2027

Recital: Whereas,

A. The Board has responsibility for establishing budget policy and specific budget approval.

B. In prior meetings, Partnership staff, the Finance Committee, and the Board have provided direction and input into the development of the budget.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To ratify the Finance Committee's approval of the Preliminary Health Care Budget for FY 2026-2027.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 24th day of June 2026 by motion of Commissioner seconded by Commissioner and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

____
Dean Germano, Chair

____
Date

ATTEST:

BY: ____________________________
Ashlyn Scott, Clerk

FY 2026-27
Preliminary Health Care Budget

May 2026

Introduction

Each year, starting in January, Partnership HealthPlan of California (Partnership) begins building the annual budget for Board of Commissioner review and approval in June. Currently Partnership is developing its fiscal year (FY) 2026-27 budget for the period of July 1, 2026 through June 30, 2027. As part of this process, Partnership presents to the Finance Committee and the Board the key components of the budget. Specifically, in April the draft budget assumptions are presented, followed by the draft health care expense budget in May. In June, the final budget will reflect previously reviewed components which will be adjusted based on more recent available information. The June final budget will also include the administrative and capital components, all of which will be presented to the Board for final review and approval. This document outlines the Plan's draft budget assumptions that inform Partnership's revenue and cost projections as impacted by estimated changes in enrollment, health care costs, administrative costs, as well as disposition of reserves.

FY 2026-27 State Outlook – May Revise

As of the May Revise the State presented a total budget of $349.4 billion total fund ($246.6 billion State General Fund) for FY 2026-27, $1.8 billion lower than estimated in January). The May Revise does not propose any significant new ongoing expenditures. General Fund revenues (excluding transfers and loans) are projected to be $16.8 billion higher than what was assumed in January for FY 2025-26 and FY 2026-27, largely driven by personal income tax. The May Revise maintains reserves and reduces previously forecasted operating deficits. The increased revenue and the restraint of not introducing new sizeable ongoing expenditures have allowed the Governor to present a balanced budget for FY 2026-27 through FY 2027-28. The next Governor and State Administration will be tasked with addressing outyear budget deficits.

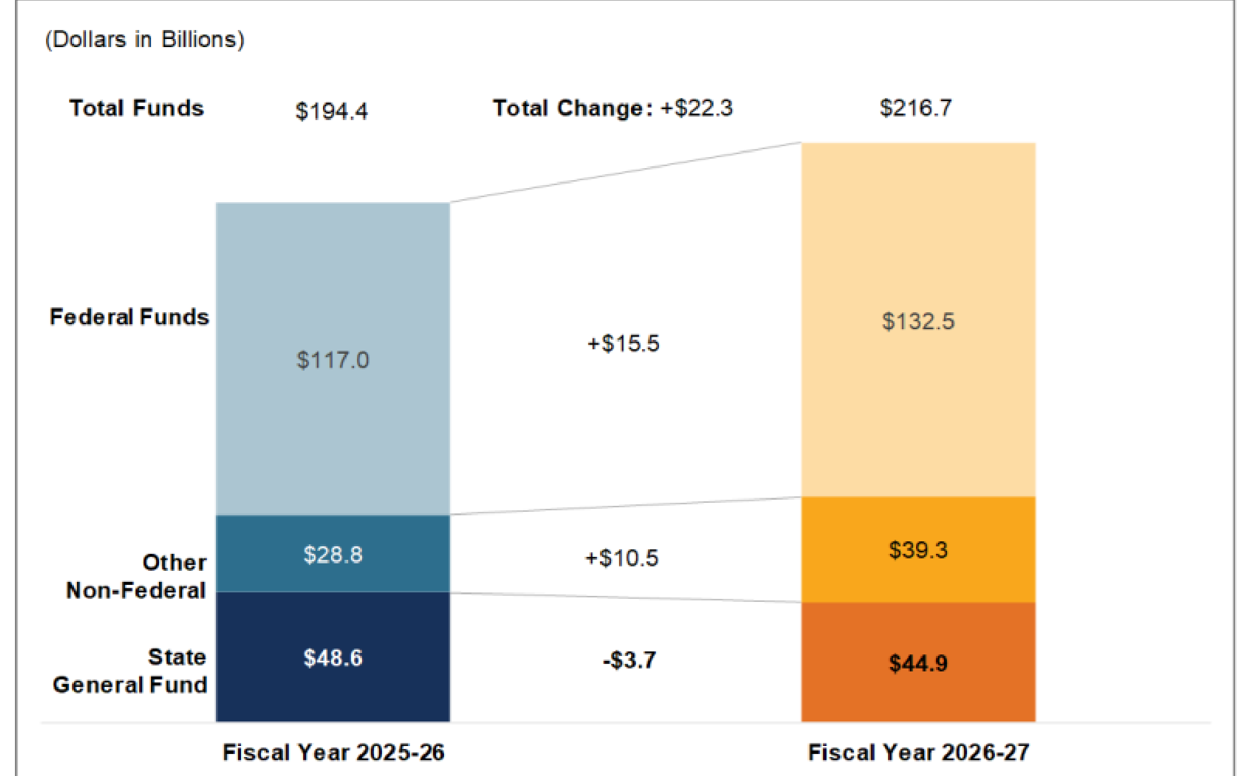
The May Revise combined reserves for FY 2026-27 are $29.9 billion, of which:

- $15.1 billion in the Budget Stabilization Account, an increase of $3.9 billion from the FY 2025-26 Enacted Budget.
- $4.5 billion in the Special Fund for Economic Uncertainties, no change from FY 2025-26 Enacted Budget.
- $10.3 billion deposit into the Public School System Stabilization Account, an increase of $6.2 billion from the January Budget.

Further the May Revises assumes a $9.7 billion transfer into the Surplus Holding Account, this account was established in 2024 and allows the State to set aside a portion of anticipated surplus funds and allocate them in a subsequent fiscal year.

Medi-Cal is a large portion of overall State expenditures and continues to be a focus of this Administration. The below Department of Health Care Services (DHCS) May Revise Highlights budget chart[1], outlines the May Revise year-over-year Medi-Cal program estimated expenditures.

Medi-Cal Year Over Year Change from FY 2025-26 to FY 2026-27



[1] https://www.dhcs.ca.gov/Budget/Documents/DHCS-FY-2026-27-May-Revise-Highlights.pdf

As displayed above, $216.7 billion total fund ($44.9 billion General Fund) was requested to operate the Medi-Cal program for FY 2026-27. This is a $5.7 billion total fund ($3.9 billion General Fund) decrease from the January Budget for FY 2026-27. The budget assumes 13.9 million individuals will receive coverage through the Medi-Cal program in FY 2026-27, which is a 3.75% membership decrease from revised FY 2025-26 membership. The DHCS Medi-Cal membership projections are inclusive of Managed Care and Fee-for-Service (FFS) members.

Notable May Revise Budget details that affect the Medi-Cal program are highlighted below.

- **Unsatisfactory Immigration Status (UIS) Members transitioned from Medi-Cal Managed Care to Medi-Cal FFS** - The May Revise proposes to transition all UIS members from Medi-Cal Managed Care to Medi-Cal FFS effective January 1, 2027. This change is a result of federal prohibitions tied to risk-based payments for federally eligible emergency services for these members. The budget proposes to transition these members to full scope Medi-Cal FFS. The only services these members would lose are Enhanced Care Management and Community Supports, which are available only through the Medi-Cal Managed Care delivery system. As of May 2026, Partnership serves nearly 90,000 UIS members.
- **Increased UIS Adult Member Medi-Cal Premiums** - The FY 2025-26 Budget included a $30 monthly premium for all UIS members aged 19 to 59 who are enrolled in full scope Medi-Cal. The May Revise proposed to increase the monthly premium to $50 effective

July 1, 2027. Questions have been raised about whether the State would consider providing counties with indigent care funding to cover health care costs for UIS members who lose Medi-Cal coverage due to the implementation of premiums and the UIS member enrollment freeze that took effect January 1, 2026. It is anticipated discussions surrounding indigent care funding will occur through budget negotiations.

- **Eligibility Changes for Qualified Non-Citizens** - H.R.1 implemented federal eligibility changes for qualified non-citizens and narrows eligibility for federal funding. As a result, effective October 1, 2026, this group will transition to state-only full scope Medi-Cal with no dental coverage. Effective January 1, 2027, these members that are enrolled in Managed Care will transition to limited-scope Medi-Cal FFS. Effective July 1, 2027, this group will shift to restricted-scope Medi-Cal FFS. The cost of this change is estimated to be $668.1 million General Fund in FY 2026-27.
- **Modify the Asset Test for Medi-Cal Eligibility** - The budget proposed to modify the asset limit for the Seniors and Persons with Disabilities population. As of January 1, 2026, Medi-Cal changed their asset test; limiting Medi-Cal eligibility to members with no more than $130,000 of assets for one person and an additional $65,000 for each additional family member. The budget proposed to modify the asset test effective January 1, 2027, Medi-Cal eligibility would be limited to members with assets of $2,000 for an individual and $3,000 for a couple. This change is expected to result in additional Partnership membership losses.
- **New Managed Care Organization (MCO) Tax** - The FY 2026-27 budget proposes adopting a new MCO Tax effective January 1, 2027, that would assess a higher tax rate on non-Medi-Cal plans. The new tax structure proposes to impose an $8.85 PMPM tax on Medi-Cal and Non-Medi-Cal plans. H.R. 1 and other federal changes require the tax rate of non-Medi-Cal and Medi-Cal plans to be uniform. The new tax revenue is expected to result in $575 million in FY 2026-27, $2.3 billion in FY 2027-28 and FY 2028-29, and $1.7 billion in FY 2029-30. Full details of the new MCO Tax have not been released at this time.
- **Existing MCO Tax Revenue Timing Adjustments** - The budget was adjusted to reflect changes in the timing of when existing MCO Tax revenues will be collected and expended. The budget proposes to spread this revenue over FY 2025-26, FY 2026-27, and FY 2027-28. Our understanding is the MCO tax revenue will be used to fund the Governor's May 2025 Proposition 35 spending plan. Subject to Centers for Medicare and Medicaid Services approval, the spending plan includes investments for the:
  - Continuation of Medi-Cal Targeted Rate Increases (TRI)
  - Time-limited supplemental payments, over and beyond TRI for primary care, specialty care, maternal health, and non-specialty mental health providers.
  - Behavioral Health Facility Throughputs
  - Graduate Medical Education
  - Medi-Cal Workforce
- **Elimination of the Adult Acupuncture Benefit** - This policy would eliminate the optional benefit for adult members effective January 1, 2027.
- **Implement Medi-Cal Efficiencies through Utilization Management** - This policy would implement applied behavioral analysis (ABA) and transportation utilization management controls. DHCS has established a joint Chief Financial Officer and Chief Medical Officer

workgroup to discuss these new policies. DHCS will consider the feedback from this workgroup to help shape final policy requirements.

- **Revisions to Community Supports and Enhanced Care Management (ECM)** - The current budget proposes to scale back California Advancing and Innovating Medi-Cal (CalAIM). Specifically, the May Revise assumes General Fund reductions of $41.4 million in FY 2026-27 and $99.2 million ongoing for ECM tied to refined eligibility criteria, service definitions, utilization management criteria, and payment adjustments. Further General Fund reductions of $26.9 million in FY 2026-27, $58.8 million in 2027-28, and $51 million ongoing were included for Community Supports tied to refined referral pathways, eligibility criteria, service definitions, and utilization management criteria for select Medi-Cal community supports. The proposed policy changes would be effective January 1, 2027.

Other notable items:

- **Reduced Medical Assistance Percentage for Emergency Services** - The May Revise includes $669 million in increased General Fund costs in FY 2026-27 due to the emergency services federal match reductions (match reduced from 90 percent to 50 percent) for UIS adult expansion members. This change goes into effective October 1, 2026.
- **Eliminate Prospective Payment System (PPS) funding for State-Only Services for UIS Members** - The May Revise proposes to eliminate PPS rate funding for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) for state-only-funded services for UIS members effective no sooner than July 1, 2026. If implemented clinics would be reimbursed at the applicable Medi-Cal managed care rate for the period of July 1, 2026 to December 31, 2026. Effective January 1, 2027, clinics would be reimbursed at the applicable Medi-Cal FFS rate. FQHCs and RHCs are safety net providers that serve as the primary care backbone of Medi-Cal, we expect budget negotiations on this proposed policy to ensue over the proceeding weeks.
- **Funding for Hospitals in Immediate Financial Distress** – The May Revise allows for an augmentation of up to $50 million General fund in FY 2026-27 for the Department of Health Care Access and Information. This funding will provide limited financial support to hospitals with less than 10 days of cash on hand, whose patient mix is at least 50 percent government funded or uninsured. Given the fiscal hardships hospitals and specifically rural hospitals have faced this funding can serve as a stopgap to keep hospitals afloat as longer term solutions are explored.

In previous times of budgetary hardship, the State has implemented a variety of cost cutting measures in the Medi-Cal program outside of the budget. Based on recent discussions with DHCS and history we expect:

- Additional Managed Care rate efficiency adjustments to be implemented by January 1, 2027. This will result in Partnership revenue reductions. DHCS has indicated the following new efficiency adjustments are being considered for implementation: readmissions, short hospital stays, cesarean mix, cellulitis, durable medical equipment and outlier radiology utilization. Implementation of new revenue reductions through efficiency adjustments will create additional fiscal pressure.
- DHCS will continue to focus on cost-effective spending in managed care and expect pressures to be amplified.

- As noted in our prior budgets, Partnership has faced increased scrutiny from DHCS on contracted heath care cost levels, some of which resulted in prior year's downward rate adjustments.

National Medicaid Changes and Other Potential Federal Changes

H.R.1 implemented sweeping changes to Medicaid Nationally. Notable eligibility and financing changes, and Medicaid policy pressures are highlighted below.

- **Medicaid Community Engagement and Work Requirements** - H.R. 1 mandated States to implement community engagement and work requirement for able-bodied adults aged 19 to 64 without children under 13. Effective January 1, 2027, these members must meet work, volunteer, school, or training requirements to keep Medi-Cal. Exemptions apply for pregnancy, disability, serious health conditions, and other circumstances. This change is expected to result in additional Partnership membership losses.
- **Semi-annual Adult Expansion Member Medicaid Eligibility** - Effective January 1, 2027, eligibility verification for the adult expansion population must occur every 6 months instead of annually as are result of H.R.1. This change is expected to result in additional Partnership membership losses.
- **Medicaid Retro Eligibility Changes** - Effective January 1, 2027, retroactive Medicaid eligibility will be reduced from 90 days to 30 days for the adult expansion population and reduced from 90 days to 60 days for all other members. This change is expected to result in additional Partnership membership losses.
- **Limit Medicaid Directed Payments to the Medicare Payment Levels** - Effective January 1, 2028, Medicaid State Directed Payments (SDPs) must be phased-down over a multiyear period to 100% of Medicare for expansion states while non-expansion States must be phased down to a 110% of Medicare. California hospitals heavily rely on supplement SDP funding. Each Medi-Cal hospital SDP program exceeds the new Medicare limit. DHCS has indicated they will not be able to backfill hospital SDP losses. The SDP funding reductions are expected to put significant financial strain on hospital systems.
- **Risk of Future Medicaid Changes** - There is risk that future CMS regulatory changes and additional rulemaking could further alter the Medicaid program without requiring federal legislative action. Additional uncertainty remains regarding whether federal lawmakers will pursue further Medicaid funding reductions.

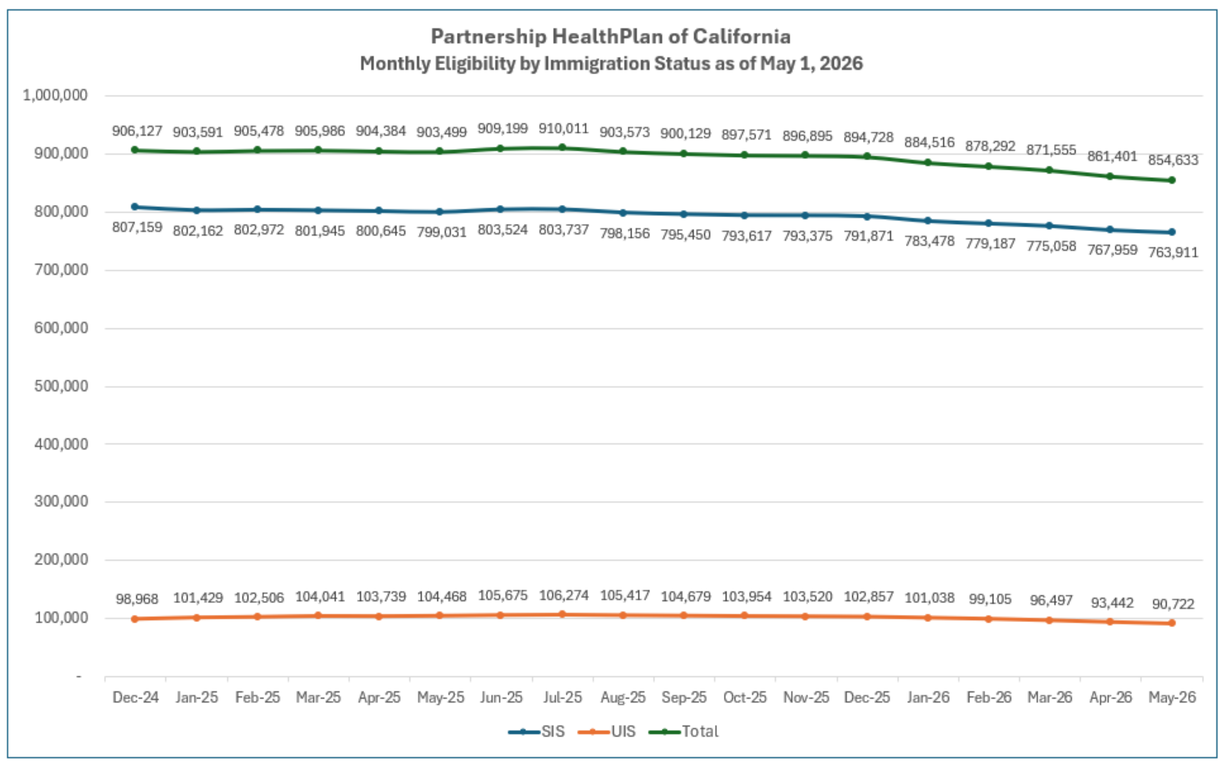
Partnership FY 2025-26 Health Care Expenses

Partnership lost 40,095 members (nearly a 4.5% membership reduction) between December 2025 and May 2026. As noted in our April assumptions, and as displayed in the membership chart on the subsequent page, sizeable declines outside of prior eligibility trends have been observed in both the UIS category and in the members with satisfactory immigration status (SIS) category.

UIS membership declines are largely explainable due to recent federal and state policy changes along with dual SIS membership declines which can be attributed to the increased Medi-Cal eligibility asset limits that went into effect on January 1, 2026. Outside of the explainable membership losses, Partnership continues to see declines in the Child, Adult, and ACA Adult

Expansion SIS categories which is concerning. We believe the required DHCS monthly eligibility data scrubbing against HHS eligibility lists, mixed immigration status households, and general confusion on when federal H.R. 1 policy changes go into effect are contributors to these declines.

Partnership's recent membership reductions and the proposed UIS members transition from Managed Care to Medi-Call FFS will significantly reduce the amount of revenue Partnership receives from DHCS. As of May 2026, Partnership serves 90,722 UIS members, the May Revise proposal would result in a 10.62% membership loss. Further, there is considerable uncertainty on how many members Partnership will lose as a result of upcoming January 1, 2027, H.R.1 eligibility changes.



Enrollment loss represents the plan's greatest fiscal risk in the coming year as declining membership directly reduces revenue and is expected to compress margins. Further financial risk is tied to revenue adequacy for CY 2026 and CY 2027. With the observed and anticipated future membership loss, Partnership expects to serve a higher-needs population. It is unclear if the State will adjust CY 2026 revenue and how the forthcoming CY 2027 revenue will account for these uncertainties. Rate advocacy efforts are underway through our health plan associations specific to rate adequacy and risk mitigation protective measures.

The preliminary health care cost projections for FY 2026-27 were forecasted based on historical claims experience, anticipated membership reductions, and further adjusted for anticipated member acuity. Partnership utilized cost experience from January 2025 through December 2025 when developing these projections. All UIS member expenses were removed for the period of January to June 2027 based on the May Revise proposal. Completion factors were applied to incomplete CY 2025 months where appropriate to account for incurred but not yet reported

claims. Partnership continues to closely monitor health care costs and membership changes and will adjust our budget methodology based on emerging information.

The revenue and membership uncertainty noted above cascades down to health care expense uncertainty. The preliminary health care expense projections will be further revised in June based on:

- June 2026 membership trends
- Incorporating actuarial analysis on levers and stayers
- Refined FY 2026-27 acuity assumptions
- Additional claims data and other emerging information.
- Changes in provider contracting such as new payment amendments.
- May Revise policy changes. Due to the timing of the May Revise release and our budget development process several of the proposed policy changes are not included in our estimates. Our estimates do account for the transition of all UIS members effective January 1, 2027 to Medi-Cal FFS.

Expenses for the new transitional rent benefit will be incorporated in June budget. Partnership will assess whether we have enough details to estimate the associated revenue and costs tied to Governor's Proposition 35 spending plan and other May Revise policy changes. If not, Partnership will incorporate these adjustments in an off-cycle budget.

Fiscal headwinds have already begun impacting DHCS. In fact, DHCS just recently requested a loan of $4.3 billion from the State given cost overruns and CMS announced they are withholding $1.3 billion in Medi-Cal funding for failure to combat fraud. DHCS has, at times, withheld monthly plan revenue payments in response to fiscal pressures.

Given the overall uncertainty related to membership, revenue adequacy, expenses, and the potential for DHCS to withhold monthly plan revenue payments, it is imperative that fiscal restraint be exercised in the coming fiscal years.

Historically, when the State has withheld monthly revenue payments, Partnership has continued to issue payments to providers despite not receiving corresponding revenue. As fiscal stewards, we must ensure that, should this situation arise again, we have the financial capacity to continue supporting our providers even in the absence of timely payments.

Maintaining and strengthening plan reserves must remain a priority in light of this uncertainty. Prudent spending and robust reserves will be essential to navigating the fiscal headwinds anticipated over the next several years.

The preliminary health care estimates by cost category are presented in more detail below.

Inpatient Hospital
2026-27: $1.3 billion | 2025-26 Δ: -$-297.9 million or -18.2%

The Inpatient Hospital line item includes inpatient FFS, hospital capitation, and stoploss expenses. The year-over-year decrease is primarily driven by the disenrollment of UIS members

from managed care effective January 1, 2027, as well as the implementation of H.R.1 related eligibility restrictions and more frequent eligibility redeterminations.

Despite the overall decline in enrollment, inpatient hospital costs are projected to increase on a PMPM basis due to higher acuity among the remaining membership. Anticipated impacts include longer average lengths of stay and increased severity, leading to higher unit cost trends.

Given ongoing uncertainty in Medicaid, Partnership must remain disciplined in managing health care expenses through appropriate medical management and prudent contracting decisions. As contract requests are evaluated, it is imperative to consider other hospital revenue sources that are afforded to contracted providers in Medi-Cal managed care, including the Private Hospital Directed Payment (PHDP) program and the District Hospital Directed Payment (DHDP) program. While we recognize a phase-down of funding for these programs will occur beginning in CY 2028, DHCS has advised they will not have the ability to backfill these program losses and neither will plans given our revenue comes directly from the State.

We continue to highlight that Partnership is an outlier in its inpatient contracting levels relative to other Medi-Cal plans statewide, this puts further strain on the ability to implement contracting increases. The State's actuaries assess the reasonableness of Partnership's contracting levels inclusive of the hospital directed payments and have raised concerns on our inpatient payment levels during each rating period, some of which has resulted in downward inpatient rate adjustments.

Partnership staff are continuing to evaluate our budget assumptions and the final inpatient hospital expense will be presented in June.

Physician Services
2026-27: $1.1 billion | 2025-26 Δ: -$74.2 million or -6.5%

Physician Services include Proposition 56 payments (Prop 56), specialty capitation, primary capitation, and physician FFS expenses. FFS expenses are decreasing year-over-year due to the disenrollment of UIS members from managed care and impacts of H.R.1. However, the disenrollment of historically younger and lower-utilizing UIS members increases the concentration of medically complex members requiring ongoing physician care.

Primary Care spending is expected to remain slightly elevated due to increased demand for preventative services and stabilization efforts associated with transitional care management following acute episodes. Specialty Physician costs are projected to increase, driven by a higher prevalence of comorbid conditions and resulting increases in cost per visit. In addition, utilization for Indian Health Service (IHS) reimbursement have risen significantly.

Effective January 1, 2024, TRI rate increases were implemented for eligible contracted providers. This brought eligible provider minimum reimbursement levels for TRI procedure codes to at least 87.5% of the lowest Medicare locality in the state for certain Medi-Cal services. Noting a subset of the TRI procedure code rates exceed Medicare payment levels. The CY 2024 TRI payment levels will continue for FY 2026-27.

TRI will be further be augmented by the Proposition 35 time-limited supplemental payments for primary care, specialty care, maternal health, and non-specialty mental health providers. Details surrounding these new augmentations are not known at this time and are not included in our health care expense estimates.

Over the coming weeks, Partnership staff will refine assumptions as additional paid claims run out becomes available and new policy details become available.

Long-Term Care
2026-27: $719.3 million | 2025-26 Δ: -$21.0 million or -2.8%

As noted in prior budget cycles, the Long-Term Care expense category is inherently difficult to forecast due to the timing and complexity of retroactive DHCS rate increases. Annual DHCS per diem rate increases remain the largest driver, reflecting inflationary pressures and cost-based reimbursement updates. Rates are often published several months after their effective dates and issued in multiple revisions. This requires Partnership staff to perform detailed analyses to reconcile and adjust prior payments. In addition, under Assembly Bill (AB) 86, DHCS established the Workforce Standards Program, through which participating facilities receive an enhanced per diem rate. Workforce-related investments, including the AB 86 Workforce Standards Program and the implementation of SB 525 minimum wage requirements, are further elevating provider labor costs and contributing to higher reimbursement levels.

Ancillary Services
2026-27: $1.1 billion | 2025-26 Δ: -$156.4 million or -12.6%

Ancillary Services is comprised of FFS and capitated ancillary services, Outpatient Facility, Emergency Department, ECM, and Community Supports. The budget assumes decreases primarily driven by the UIS disenrollment from managed care, tighter eligibility H.R.1 requirements, and utilization management initiatives. Additional offsets by a continued rise in high-cost specialty drug spend, particularly advanced cell and gene therapies that are episodic in nature but carry a substantial financial impact.

Other Medical
2026-27: $458.9 million | 2025-26 Δ: -$36.3 million or -7.3%

The Other Medical category includes transportation, quality assurance, health care investment fund, nurse advice line, and the DHCS voluntary rate range program. Transportation expense is also projected to decrease due to lower utilization association with UIS disenrollment from managed care, H.R.1 eligibility restrictions, and utilization management initiatives. These reductions are expected to be partially offset by Public Providers Ground Emergency Transportation (PP-GEMT) rate increases and ongoing inflationary pressures, including higher fuel and operating costs driven by global supply instability.

The voluntary rate range program is also expected to decrease as this is tied to overall managed care revenue, primarily due to the exclusion and carve-out of UIS populations from managed care and the broader eligibility tightening tied to H.R.1.

The quality assurance and medical administrative expenses costs were held constant from the prior year; Staff will provide updated cost assumptions for these expense categories in the June budget.

DHCS Facility Directed Payment Programs
2026-27: $899.1 million | 2025-26 Δ: -$527.3 billion or -37.0%

The following facility directed payments are included in this category: PHDP program, DHDP program, Designated Public Hospital Enhanced Payment program, the Designated Public Hospitals Quality Improvement programs, Health Equity Practice Transformation payments, and the new Children's Hospital Supplement Payment program. The significant decrease in directed payments is driven by reductions to the PHDP program statewide funding. These reductions were necessary to comply with H.R.1 grandfathering provisions. The June budget may include revised directed payments amounts based on emerging information.

Quality Improvement Programs (Incentives)
2026-27: $98.4 million | 2025-26 Δ: $9.2 million or 10.3%

The year-over-year increase in QIP expenses is due to the implementation of the Extended Care Facility QIP (EXT QIP) program on January 1, 2026. The EXT QIP, formerly known as the LTC QIP, was originally established in 2016. The program was suspended in August 2020 due to the COVID-19 pandemic, reinstated in January 2022, and subsequently sunset in December 2023 following the launch of the Skilled Nursing Facility Workforce Quality Incentive Program (WQIP) by DHCS. After WQIP was phased out of the State budget on December 31, 2025, Partnership's Board of Commissioners approved the EXT QIP, effective January 2026.

In addition, Partnership continues to invest in quality improvement programs and the member experience. The goal of these investments is to improve overall member experience and increase performance on quality metrics prioritized by the DHCS Quality Withhold program and to provide quality, equitable and cost-effective care for our members. As in previous periods, incentive funding remains contingent on final revenue projections.

Off-Cycle Budget

Partnership's enrollment projections reflect our best estimates of policy changes but are highly uncertain. They therefore depend on several assumptions about disenrollments, utilization, and costs. Given these uncertainties and the State's fiscal situation, Partnership staff expect to produce an off-cycle budget to account for any significant programmatic or cost changes after the June budget is finalized.

Health Care Budget FY 2026-27 to FY 2025-26 Comparison

Health Care Categories	Budget FY 2026-27	Budget FY 2025-26	Y-o-Y △ $	Y-o-Y △ %
Inpatient Hospital	$1,342,360,258	$1,640,259,094	($297,898,837)	(18.2%)
Physician Services	$1,070,455,955	$1,144,618,159	($74,162,203)	(6.5%)
Long Term Care	$719,325,240	$740,374,189	($21,048,949)	(2.8%)
Ancillary Services	$1,089,077,296	$1,245,475,022	($156,397,726)	(12.6%)
Other Medical	$458,872,239	$495,131,605	($36,259,366)	(7.3%)
DHCS Facility Directed Payment Programs	$899,054,927	$1,426,371,794	($527,316,867)	(37.0%)
Quality Improvement Programs	$98,412,000	$89,200,150	$9,211,850	10.3%
Total Health Care Expense	**$5,677,557,915**	**$6,781,430,013**	**($1,103,872,098)**	**(16.3%)**

AGENDA REQUEST FOR RATIFICATION
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable)
Meeting Date: May 20, 2026
Board Meeting Date: June 24, 2026

Agenda Item Number:
2.2

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
The Finance Committee and Partnership Staff

Topic Description:
Partnership Board Commissioner Jayme Bottke, Tehama County Executive Director of Health Services, has resigned from the Partnership Board and Finance Committee.

Commissioner Bottke has made numerous outstanding contributions to Partnership HealthPlan of California and the Commission (known as the Board) since February 2024. She has provided excellent leadership and has been a dedicated volunteer. Her knowledge has been of great value to Partnership, and she has kept the needs of our members, providers and the community as a guiding principle.

Reason for Resolution:
To obtain Board approval to accept the resignation of Tehama County Representative, Jayme Bottke, from the Partnership Board.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of the Finance Committee and Partnership staff, the Board is asked to accept the resignation of Tehama County Representative, Jayme Bottke from the Partnership Board.

AGENDA REQUEST FOR RATIFICATION
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable)
Meeting Date: May 20, 2026
Board Meeting Date: June 24, 2026

Agenda Item Number: 2.2

Resolution Number: 26-

IN THE MATTER OF: ACCEPTING THE RESIGNATION OF BOARD COMMISSIONER JAYME BOTTKE

Recital: Whereas,

A. The Board has authority to accept Commissioner Resignations.

B. Commissioner Bottke has resigned from the Partnership Board and Finance Committee.

C. Jayme Bottke was a faithful and active member of the Board.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To accept Jayme Bottke's resignation from the Partnership Board and Finance Committee.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 24th day of June 2026 by motion of Commissioner seconded by Commissioner and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

____
Dean Germano, Chair

____
Date

ATTEST:

BY: ______________________________
Ashlyn Scott, Clerk

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 24, 2026

Agenda Item Number:
3.1

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
Partnership Advisory Groups and Committees

Topic Description:
Partnership HealthPlan of California has a number of advisory groups and committees established by the Commission (known as the Board) with direct reporting responsibilities. These are the Compliance / Governance Committee, Consumer Advisory Committee, Finance Committee, Personnel Committee, Physician Advisory Committee and Strategic Planning Committee.

The Physician Advisory Committee (PAC) has responsibility for oversight and monitoring of quality and cost-effectiveness of medical care provided to Partnership's members. A number of other advisory groups and committees have direct reporting responsibilities to PAC. These include the Credentials Committee, Internal Quality Improvement Committee, Member Grievance Review Committee, Over/Under Utilization Workgroup, Pediatric Quality Committee, Peer Review Committee, Pharmacy & Therapeutics Committee, Population Health Management & Health Equity Committee, Member Grievance Review Committee, Quality/Utilization Advisory Committee, Substance Use Services Internal Quality Improvement Subcommittee and Provider Engagement Group.

The Board is responsible for reviewing and accepting all minutes and packets approved by the various advisory groups and committees, and approving the policies, program descriptions, and QIP changes that were approved by the PAC, in April through June 2026.

Reason for Resolution:
To provide the Board the opportunity to review and accept Partnership advisory committee minutes and packets. In addition, to provide the Board with all Partnership policy and program description changes approved and recommended by PAC.

Financial Impact:
Any financial impact to the HealthPlan is included in the budget.

Requested Action of the Board:
Based on the recommendation of Partnership's advisory groups & committees, the Board is asked to accept receipt of all Partnership's committee minutes and committee packets and to approve all policy and program description changes approved by PAC, linked in the agenda.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:	**Agenda Item Number:**
June 24, 2026	3.1
	Resolution Number:
	26-

IN THE MATTER OF: ACCEPTING ALL PARTNERSHIP HEALTHPLAN OF CALIFORNIA ADVISORY COMMITTEE MINUTES AND COMMITTEE PACKETS AND TO APPROVE POLICY AND PROGRAM DESCRIPTION CHANGES APPROVED BY THE PHYSICIAN ADVISORY COMMITTEE (PAC)

Recital: Whereas,

A. The Board has fiduciary responsibility for the operation of the organization.

B. The Board has responsibility to review and accept all Partnership committee minutes and packets and to review and approve all policy and program description changes approved by PAC.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To accept receipt of all Partnership committee minutes and committee packets.
2. To obtain approval for policy and program description changes approved and recommended by PAC.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 24th day of June 2026 by motion of Commissioner seconded by Commissioner and by the following votes:

AYES: Commissioners:

NOES: Commissioners

ABSTAINED: Commissioners

ABSENT: Commissioners

EXCUSED: Commissioners

____
Dean Germano, Chair

____
Date

ATTEST:

BY: ____________________________
Ashlyn Scott, Clerk

Partnership

Policy & Procedure Updates

June 2026

Policy Number	Policy/Procedures/Guidelines	Version Links
*The following documents were reviewed by the Quality / Utilization Advisory Committee (Q/UAC) in **May 2026.*** ***All policy versions hyperlinked for review.* *Highlighted policies have significant changes, new attachments, or were amended during the Q/UAC meeting. Redline versions contain attachments.* *Please review all drafts and the detailed **Synopsis of Changes.***		
Behavioral Health		
MPBP8003	Mental Health Services	
MPBP8005	Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services	
MPXG5003	Major Depression in Adults Clinical Practice Guidelines *Updates to Attachment A*	
Care Coordination		
MPCP2023	New Member Needs Assessment	
MPCP2026	Diabetes Prevention Program	
MPCP2034	Transitional Care Services (TCS)	
Enhanced Health Services		
MPAP7004	Community Health Worker (CHW) Services Benefit	
MPAP7005	Street Medicine	
Network Services		
MPNET101	Wellness and Recovery Access Standards and Monitoring	
Quality Improvement		
MPQP1038	Physician Orders for Life-Sustaining Treatment (POLST) *Attachment A*	
MPQP1047	Advance Directives	
MPQP1055	Provider Preventable Condition (PPC) Reporting	

Policy Number	Policy/Procedure/Guidelines	Version Links
Utilization Management		
MPUP3144	Residential Substance Use Disorder Treatment Authorization	
MPUP3137	Palliative Care: Intensive Program (Adult) *Updates to Attachment A*	
MPUP3136	Microbiota-Based Therapeutics (MBT)	
MPUP3047	Tuberculosis Related Treatment *Updates to Attachment A*	
MCUP3104	Transplant Authorization Process	

Partnership

Policy & Procedure Updates

May 2026

Policy Number	Policy/Procedures/Guidelines	Version Links		
*The following documents were reviewed by the Quality / Utilization Advisory Committee (Q/UAC) in **April 2026.*** ***All policy versions hyperlinked for review.* *Highlighted policies have significant changes, new attachments, or were amended during the Q/UAC meeting. Redline versions contain attachments.* *Please review all drafts and the detailed **Synopsis of Changes**.*				
Behavioral Health				
MPBP8003	Mental Health Services	C	CD	RD
MPBP8011	Scope of Primary Care – Behavioral Health Indications for Referral Guidelines	C	CD	RD
Care Coordination				
MCCP2036	Memorandum of Understanding (MOU) Requirements For	C	CD	RD
Pharmacy Operations				
MCRP4068	Medical Benefit Medication TAR Policy	C	CD	RD
MPRP4034	Pharmaceutical Patient Safety	C	CD	RD
MPRP4065	Drug Utilization Review (DUR) Program *(Internal Policy)*		CD	RD
Quality Improvement				
MPQP1006	Clinical Practice Guidelines	C	CD	RD
MPXG5001	Clinical Practice Guidelines for the Diagnosis & Management of Asthma	C	CD	RD
MPXG5002	Clinical Practice Guidelines for Diabetes Cellulitis	C	CD	RD
MPQP1022	Site Review Requirements and Guidelines – Site Review *New Attachments – No Changes to A - E*	C	CD	RD
Utilization Management				
MPUD3001	Utilization Management Program Description	C	CD	RD
MCUP3133	Wheelchair Mobility, Seating and Positional Components	C	CD	RD
MCUP3037	Appeals of Utilization Management/ Pharmacy Decisions	C	CD	RD
MPUP3026	Inter-Rater Reliability Policy	C	CD	RD

Provider Manual: Medi-Cal

C = Current Policy *CD = Clean Draft* *RD = Redline Draft*

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:	**Agenda Item Number:**
June 24, 2026	3.2

Resolution Sponsor:
Dr. Moore, CMO, Partnership HealthPlan of CA

Recommendation by:
The Physician Advisory Committee (PAC)

Topic Description:
Dr. Vanessa Walker, Chief Medical Executive, Sutter-Roseville, has resigned from PAC as a voting member.

Dr. Leigh Vall-Spinosa, Family Medicine, Medical Director for Santa Rosa Community Health Center, Dutton Clinic, has been appointed to PAC as a voting member.

Dr. Phuong Luu, Public Health Officer for Sutter and Yuba, resigns her position as a Q/UAC voting member.

Reason for Resolution:
To accept the resignation of Dr. Vanessa Walker from the Physician Advisory Committee.
To accept the appointment of Dr. Leigh Vall-Spinosa to the Physician Advisory Committee.
To accept the resignation of Dr. Phuong Luu, from the Quality/Utilization Advisory Committee.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of the Physician Advisory Committee, the Board is asked to approve the appointment of Dr. Leigh Vall-Spinosa to the Physician Advisory Committee (PAC), accept the resignation of Dr. Vanessa Walker from the PAC, and accept the resignation of Dr. Phuong Luu from the Quality/Utilization Advisory Committee (Q/UAC).

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 24, 2026

Agenda Item Number:
3.2

Resolution Number:
26-

IN THE MATTER OF: APPROVING PHYSICIAN ADVISORY COMMITTEE MEMBERSHIP AND QUALITY/UTILIZATION ADVISORY COMMITTEE CHANGES

Recital: Whereas,

- **A.** Dr. Vanessa Walker, Chief Medical Executive, Sutter-Roseville, has resigned from PAC as a voting member.
- **B.** Dr. Leigh Vall-Spinosa, Family Medicine, Medical Director for Santa Rosa Community Health Center, Dutton Clinic, has been appointed to PAC as voting member.
- **C.** Dr. Phuong Luu, Public Health Officer for Sutter and Yuba, resigns her position as a Q/UAC voting member.
- **D.** The Board has authority to approve advisory committee membership changes.

Now, Therefore, It Is Hereby Resolved as Follows:

1. To accept the resignation of Dr. Vanessa Walker from the Physician Advisory Committee.
2. To accept the appointment of Dr. Leigh Vall-Spinosa to the Physician Advisory Committee.
3. To accept the resignation of Dr. Phuong Luu, from the Quality/Utilization Advisory Committee.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 24th day of June 2026 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

____
Dean Germano, Chair

____
Date

ATTEST:

BY: ______________________________

Ashlyn Scott, Clerk

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date: June 24, 2026

Agenda Item Number: 3.3

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
Quality / Utilization Advisory Committee & Physician Advisory Committee

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Topic Description:
The Utilization Management Program Description serves to implement a comprehensive integrated process that actively evaluates and manages utilization of health care resources delivered to all members, and to pursue identified opportunities for improvement. The program description is updated annually by the Health Services team.

Reason for Resolution:
To allow the full Board the opportunity to review and approve the Utilization Management Program Description on an annual basis.

Financial Impact:
There is no measurable financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of the Quality/Utilization Advisory Committee & Physician Advisory Committee, the full board is asked to approve changes to the Utilization Management Program Description, MPUD3001.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 24, 2026

Agenda Item Number:
3.3

Resolution Number:
26-

IN THE MATTER OF: APPROVING THE UTILIZATION MANAGEMENT PROGRAM DESCRIPTION, MPUD3001

Recital: Whereas,

A. The Board has the authority and responsibility for ensuring Partnership has a comprehensive and integrated UM Program.

B. The Board has ultimate responsibility for approving the Utilization Management Program Description.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To obtain Board approval for changes to the Utilization Management Program Description, MPUD3001.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 24th day of June 2026 by motion of Commissioner seconded by Commissioner and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

____
Dean Germano, Chair

____
Date

ATTEST:

BY: ____________________________
Ashlyn Scott, Clerk

Partnership HealthPlan of California

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

Policy and Procedure MPUD3001

~~March~~ May 2026

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PROGRAM PURPOSE

Partnership HealthPlan of California is a County Organized Health System (COHS) contracted by the State of California to provide Medi-Cal Beneficiaries with a health care delivery system to meet their medical needs.

The mission of Partnership HealthPlan of California is "To help our Members, and the Communities we serve, be healthy." Our vision is to be "the most highly regarded health plan in California."

Partnership has program descriptions and policies to describe the structures needed to provide high quality health care while being stewards of taxpayer resources. In the Utilization Management Program Description, Partnership outlines the structure of our measurement and management of utilization of health care services within our system.

The Partnership Utilization Management (UM) program serves to implement a comprehensive integrated process that actively evaluates and manages utilization of health care resources delivered to all M~~m~~embers, and to actively pursue identified opportunities for improvement.

The utilization program resides within the Health Services Department, which consists of ~~seven~~ eight (8~~7~~) teams including:

- Utilization Management
- Behavioral Health
- Care Coordination
- Population Health
- Pharmacy
- Quality Improvement
- Health Equity
- Enhanced Health Services

The Partnership UM program serves to accomplish the following:

- Ensure that M~~m~~embers receive the appropriate quality and quantity of healthcare services
- Ensure that healthcare service is delivered at the appropriate time
- Ensure that the setting in which the service is delivered is consistent with the medical care needs of the individual

The UM program provides a reliable mechanism to review, monitor, evaluate, recommend and implement actions on identification and correction of potential and actual utilization and resource allocation issues.

Partnership recognizes the potential for under-utilization and takes appropriate steps and actions to monitor for this. The processes for UM decision making are based solely on the appropriateness of care and services and existence of coverage. Partnership does not reward practitioners or other individuals for issuing denials of coverage. 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.

PROGRAM OBJECTIVES

UM Program Objectives

The Partnership UM program serves to ensure that appropriate, high quality cost-effective utilization of health care resources is available to all M~~m~~embers. This is accomplished through the systematic and consistent application of utilization management processes based on current, relevant medical review criteria and expert clinical opinion when needed. The utilization management process provides a system that ensures equitable access to high quality health care across the network of providers for all eligible M~~m~~embers as follows:

- Ensures authorized medically necessary services are covered under contract with the State of California Department of Health Services (DHCS) California Code of Regulations (CCR) Title 22 - For Medi-Cal Members (Title 22)

- Coordinates thorough and timely investigations and responses to Member and provider reconsideration and appeals associated with utilization issues

- Initiates needed operational revisions to prevent problematic issues from reoccurring

- Ensures that services which are delivered are medically necessary, which is defined as "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," and that those services are consistent with diagnosis and level of care required for each individual, taking into account any co-morbid condition that exists and the ability of the local delivery system to meet the need. Other examples of service-types requiring medical necessity review include (but are not limited to):
  - Services where continuing previously established care is necessary
  - Pharmaceuticals covered under Partnership's medical benefit
  - Out-of-network services that are only covered in clinically appropriate circumstances

- Educates Members, practitioners, providers and internal staff about Partnership's goals for providing quality, cost-effective, managed health care

- Defines the methods by which utilization criteria and clinical practice guidelines are selected, developed, reviewed, and modified based upon appropriate and current standards of practice and professional review

- Promotes and ensures the integration of utilization management with quality monitoring and improvement, risk management, and case management activities

- Ensures a process for critical review and assessment of the UM program and plan on, at minimum, an annual basis, with updates occurring more frequently if needed. The process incorporates provider, practitioner and Member input along with any regulatory changes, changes to current standards of care, and technological advances

- Evaluates the ability of delegates to perform UM activities and to monitor performance

Program Structure

This section outlines the individual program staff and their assigned activities and responsibilities, including approval authority and the involvement of the designated physician.

PROGRAM STAFF

Office of CMO Program Staff

Chief Medical Officer (CMO) – MD/DO

The Chief Medical Officer is responsible for the implementation, supervision, oversight and evaluation of the UM Program.

This position provides guidance and overall direction of UM activities and has the authority to make decisions based on medical necessity which result in the approval or denial of coverage. The assigned activities for this position include but are not limited to:

- Assuring that the UM program fulfills its purpose, works towards measurable goals, and remains in regulatory compliance

- In collaboration with the Chief Health Services Officer, the Senior Director of Care Management, and the Director(s) and Associate Directors of Utilization Management; oversees UM program operations and assists in the development and coordination of UM policies and procedures.
- Reviews for the consistent application of UM decision criteria at least annually and implements corrective actions when needed
- In collaboration with the Health Equity Officer (HEO), oversees Quality Improvement and Health Equity Transformation Program (QIHETP) operations and serves as Co-Chair of the Quality Improvement and Health Equity Committee (QIHEC)
- Serves as the Committee Chair for the Quality/Utilization Advisory Committee (Q/UAC) and regularly attends the Physician Advisory Committee (PAC). CMO (or designee) also serves as the Pharmacy and Therapeutics (P&T) Committee Chair.
- Ensures timely medical necessity review and decisions are made by daily staffing physicians for medical review consultation
- Guides and assists in the development and revision of Partnership medical policy, criteria, clinical practice guidelines, new technology assessments, and performance standards for Q/UAC review, adaptation and PAC approval
- As the chairman of the Q/UAC, presents UM activities on a regular basis to the Q/UAC and provides periodic updates on utilization management activities to the PAC and the Board of Commissioners
- Evaluates the overall effectiveness of the UM program
- Evaluates and uses provider and Member experience data when evaluating the UM program in collaboration with the Chief Health Services Officer and appropriate committees

Deputy Chief Medical Officer (Deputy CMO) – MD/DO
The Deputy CMO assists the CMO in being responsible for the implementation, supervision, oversight and evaluation of the UM Program.

This position provides guidance and overall direction of UM activities and has the authority to make decisions based on medical necessity which result in the approval or denial of coverage. The assigned activities for this position include but are not limited to:

- Serves on Quality/Utilization Advisory Committee (Q/UAC), Pharmacy & Therapeutics (P&T) Committee, Credentials Committee and Internal Quality Improvement (IQI) Committee as requested by the CMO. May work with community provider committees and Advisory boards on medical issues and policies.
- Supervises and evaluates other Medical Directors as assigned (direct reports)

Medical Director for Quality - MD/DO
The Medical Director for Quality is a physician who provides clinical and operational guidance for Quality and Performance Improvement activities and is responsible for supervision and oversight of the Quality Assurance & Patient Safety, Clinical Quality & Patient Safety and Quality Measurement–HEDIS teams. This physician also has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for UM activities.

The assigned activities for this position include but are not limited to:

- Serves as the Committee Vice Chair for the Quality/Utilization Advisory Committee (Q/UAC)
- Serves as the Chair for the Peer Review Committee
- Serves as the Chair for the Credentials Committee
- Regularly attends the Physician Advisory Committee (PAC)
- Regularly attends the Internal Quality Improvement (IQI) Committee
- Regularly attends the Quality Improvement and Health Equity Committee (QIHEC)
- Directs the two Member Safety Teams for Clinical Compliance and Quality Investigations
- Works with the Grievance and Appeals team to review Member Grievances with possible clinical care elements
- Evaluates the appropriateness and quality of medical care delivered through Partnership in all regions

- Participates in enterprise-wide projects that require physician involvement, especially as related to Quality and Performance Improvement activities
- Assists with coverage in the UM Department for medical necessity reviews, applying evidence-based UM decision criteria to the review process in determining medical appropriateness and necessity of services for Partnership M~~m~~embers
- Other duties as assigned by the Senior Director of Quality or by the Chief Medical Officer

Medical Director of Medicare Services – MD/DO

The Medical Director of Medicare Services is a physician that oversees the appropriateness and quality of care delivered through Partnership and the cost-effective utilization of services. This physician also has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for UM activities.

- Participates in Medicare Dual Special Needs Plan (D-SNP) policy, strategy and tactical activities, with the Medicare leads in other departments
- Providing medical leadership for Partnership's Medicare activities, including utilization management, quality, care coordination, pharmacy grievances, and compliance activities
- Assists with coverage in the UM Department for medical necessity reviews, applying evidence-based UM decision criteria to the review process in determining medical appropriateness and necessity of services for Partnership M~~m~~embers
- Other duties, as assigned

Medical Director – MD/DO

The Medical Director is a physician who oversees the appropriateness and quality of care delivered through Partnership and the cost-effective utilization of services. This physician also has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for UM activities.

- Coordinates with the Directors, Associate Directors, and Managers of UM to provide daily support and appropriate direction to staff on issues pertaining to UM

Regional Medical Director - MD/DO

The Regional Medical Director is a physician with the authority to make decisions based on medical necessity which result in the approval or denial of coverage.

The assigned activities for this position include but are not limited to:

- Evaluates the appropriateness and quality of medical care delivered through Partnership in the designated regional area
- Participates in enterprise-wide projects that require Physician involvement
- Other duties as assigned by the Chief Medical Officer.

Associate Medical Director - MD/DO

This Physician has the authority to make decisions based on medical necessity that result in the approval or denial of coverage. The assigned activities for this position include:

- Coverage in the UM Department for medical necessity reviews applying evidence-based UM decision criteria to the review process in determining medical appropriateness and necessity of services for Partnership M~~m~~embers
- Provides review of quality of care issues and serves on Q/UAC
- Other duties as assigned by the Chief Medical Officer

Executive Assistant to CMO - Administrative

Provides administrative support to the Chief Medical Officer. Responsible for maintaining and updating online policy and procedure manuals and managing appointment calendars. Coordinates setup and executes minutes for designated meetings.

Continuing Education Program Coordinator - Administrative
Provides administrative support to the Chief Medical Officer. Responsible for coordinating the Continuing Education program, including planning meetings and trainings. Audits each CME/CE activity to ensure all elements required by organizations overseeing Partnership's educational programs are documented. Maintains organized electronic versions of all continuing education records.

Health Services Administrative Assistant II – CMO - Administrative
Responsible for administrative support to the Associate and Regional Medical Directors. Responsible for managing appointment calendars, scheduling daily UM and pharmacy workload coverage for the MDs, developing weekly and monthly schedules for distribution to other departments, and coordinating Peer-to-Peer requests from providers. Coordinates setup and executes minutes for designated meetings.

Utilization Management Program Staff

Chief Health Services Officer - RN
Provides executive leadership on current and new Health Services programs, operations, projects, policies and procedures to ensure high quality results across the continuum. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Provides oversight and guidance for the UM program across all regions including daily support and appropriate direction to staff on issues pertaining to UM.
- Provides after-hours clinical coverage for providers requesting authorization for services pursuant to health plan policies and procedures.
- Reports to the Q/UAC on Health Services activities
- Coordinates departmental UM and Quality Improvement efforts
- Oversees the design and implementation of Quality Improvement and UM programs in order to meet Medicare Model of Care standards as well as National Commission on Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) accreditation for both Medi-Cal and future Medicare lines of business (D-SNP).
- Has a lead role in regulatory audits (DHCS, DMHC, CMS, NCQA)
- Collaborates with providers and facilities
- Monitors and analyzes UM data to inform decision making
- Develops recommendations based on data analysis and strategic planning
- Collaborates with the Chief Medical Officer and the Q/UAC on UM activities
- Evaluates and uses provider and Mmember experience data when evaluating the UM program in collaboration with the Chief Medical Officer
- Serves as Chairperson of the Benefit Review Evaluation Workgroup (BREW)

~~*Director of Health Equity – MD/DO/PharmD/RN*~~
~~The Director of Health Equity serves as the Health Equity Officer (HEO) and is responsible for the co-implementation, co-supervision, co-oversight and evaluation of the Quality Improvement and Health Equity Transformation Program (QIHETP). This position provides guidance and overall direction of QIHETP activities and has the authority to make decisions based on the health equity annual plan. The assigned activities for this position include but are not limited to:~~

- ~~Assuring that the QIHETP program fulfills its purpose, works towards measurable goals, and remains in compliance with regulatory requirements.~~
- ~~In collaboration with the Chief Medical Officer (CMO); oversees QIHETP program operations and assists in the development and coordination of QIHETP policies and procedures.~~
- ~~Serves as a Co-Chair for the Quality Improvement, Health Equity Committee (QIHEC) and the Population Needs Assessment (PNA) committee and regularly attends the Quality/Utilization Advisory Committee (Q/UAC) as a standing member~~

- ~~Guides and assists in the development and revision of QIHETP medical policy, criteria, clinical practice guidelines, new technology assessments, and performance standards for QIHEC review~~
- ~~Other duties as assigned the Chief Executive Officer (CEO)~~
- ~~Provides guidance to in staff trainings and on-site continuing education regarding diversity, equity, and inclusion and health equity~~
- ~~Provides support for obtaining recommended accreditations that support diversity, equity, inclusion, and health equity (e.g. NCQA Health Equity Accreditation)~~

Senior Director of Care Management- RN
Under the direction of the Chief Health Services Officer, this position is responsible for setting and carrying out the overarching strategic direction and goals of the Utilization Management and Care Coordination Departments. This position maintains and oversees proper delivery, coordination and execution of all related services and activities to improve the health outcomes of M~~m~~embers and has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Oversees and manages a large team of clinical and non-clinical staff while working in cross collaboration with both Medical Directors and other senior departmental leaders
- Responsible for overseeing the operations, programming and alignment of Utilization Management and Care Coordination department programs and activities
- Proactively works with key internal and external stakeholders to implement policies, procedures and/or initiatives that fulfill the organization's goals, strategic priorities and mission
- Provides clinical leadership in the design and implementation of programs and procedures for all lines of business; demonstrates decisiveness and communicates decisions and rationale clearly
- Stays abreast of health care policies, regulations and changes as they relate to those issued by CMS, DHCS, NCQA and/or other associated agencies
- Utilizes data to analyze and support quality patient outcomes and ongoing evaluation of the organization's Care Coordination and Utilization Management programs; ensuring effective and efficient health and quality outcomes, improving care coordination and meeting requirements of contracts

Director of Utilization Management - RN
Under the direction of the Senior Director of Care Management, the Director of Utilization Management (UM) is ~~position is~~ responsible for the day-to-day oversight, implementation, and continuous improvement ~~-~~of Partnership's Utilization Management Program. This role ensures the consistent development, implementation, and maintenance of health services programs. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Serves as the Director of Utilization Management program, ensuring effective operations and alignment with organizational goals
- Implements and operationalizes the UM Program, ensuring compliance with regulatory and accreditation requirements
- Evaluates and approves recommended UM process improvements
- Provides daily leadership and ~~y- to- day~~ direction to UM Associate Directors, Managers and Supervisors, ensuring ~~to meet~~ departmental ~~-~~goals and objectives are met. ~~and is available to staff on-site or by telephone~~
- Conducts annual performance evaluations for assigned UM staff
- Responsible for oversight and ~~Conducts~~ monitoring of UM activities~~Participates in staff trainings and on-site continuing education~~
- Responsible for oversight ~~Participates in~~ of clinical audits of health services programs and services; oversees the nursing component of the audits and assists with development of corrective action plans when necessary
- Participates in staff trainings
- Is available to UM staff on site or by telephone
- ~~Reports to the Q/UAC on UM activity~~

- Works ~~C~~collaborat ively~~es~~ with providers, ~~and~~ facilities, and internal departments to ensure coordinated, high-quality member care
- Collaborates with the Provider Relations, Network Services and Contracting teams to identify strategic opportunities and develop recommendations
- Develops recommendations to enhance UM processes, procedures, and program effectiveness~~for program improvement~~
- Partners ~~Coordinates activities~~with Quality Improvement, Behavioral Health, Care Coordination, Population Health, Health Equity, Enhanced Health Services, Member Services, and Claims~~, and Provider Relations departments~~ to identify, track, and monitor quality of care outcomes and trends
- Participates in establishing and maintaining reports which relay the efficacy of UM activities and summarizes, at least annually, the UM activity, quality improvement activities and utilization outcomes, with supporting statistical data at IQI and Q/UAC

Director of Enhanced Health Services

Under the direction of the Chief Health Services Officer, plans, monitors and evaluates utilization management activities to identify strategic initiatives to enhance the efficacy of the ~~UM~~ CalAIM program, while improving health outcomes, in a ~~cost effective~~cost-effective manner. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Serves as Director of CalAIM program
- Responsible for oversight of housing and incentive payment programs
- Responsible for connecting with Street Medicine programs
- Collaborates with the ~~provider relations~~ contracting team to identify strategic opportunities and develops recommendations
- Participates in contract review and negotiations
- In collaboration with the Chief Health Services Officer and ~~Senior~~ Director of Provider Relations, reviews and processes provider grievances in accordance with appropriate regulatory requirements and participates in provider grievance meetings
- Works with county agencies and community-based organizations to facilitate the DHCS CalAIM initiative related to Enhanced Care Management (ECM) and Community Support (CS) Services with focus on improving medical health outcomes and healthcare costs
- Works collaboratively with claims and configuration department leaders and team members to identify systematic issues or opportunities for staff and/or provider education
- Ensures timely monitoring and oversight of Partnership-contracted ECM and CS providers, pursuant to DHCS regulations and Partnership policies and procedures
- Attends claims configuration meetings and Benefit Review Evaluation Workgroup (BREW) as well as IQI, Q/UAC and PAC
- Works with providers and/or vendors to facilitate issue resolution and ensure a consistent UM process
- Develops, reviews, and/or revises Partnership UM policies and procedures in collaboration with the Chief Health Services Officer as appropriate.
- Develops expertise in housing services funded through the Medi-Cal program including 1915(c) Home and Community Based Services Waivers and other Medicaid housing related opportunities such as Assisted Living Waivers.
- ~~Leads Partnership discussions regarding state and federal housing/homeless policy, legislative, and regulatory strategy and implementation, and oversee and support regional and local policy initiatives, with a strong economic equity lens.~~
- Works with local agencies, state networks, and community organizations to identify issues and develop consensus positions on policy issues related to CalAIM and housing.
- ~~Carries out research and policy analyses on issues and opportunities related to state housing policy and low-income housing programs, gathers Mmember input, and establishes policy priorities and a legislative and regulatory agenda on an annual and ongoing basis.~~
- ~~Interacts with housing advocacy groups and other organizations to identify emerging issues and opportunities.~~

Associate Director of Utilization Management - RN

Under the direction of the Director of Utilization Management, manages and provides direction to the Utilization Management department Managers, Supervisors and staff for all product lines ensuring consistent development, implementation, and maintenance of health services programs. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Implements the UM program
- Provides day-to-day direction to UM Managers and Supervisors to meet department goals and objectives and is available to staff on-site or by telephone
- Conducts annual performance evaluations for assigned UM staff
- Conducts monitoring activities
- Participates in staff trainings and on-site continuing education
- Audits medical records as appropriate and monitors for consistent application of UM criteria by UM staff, for each level and type of UM decision
- Collaborates with providers and facilities
- Develops recommendations for program improvements
- Coordinates activities with Care Coordination, Population Health, Quality Improvement, Member Services, Claims, and Provider Relations departments to identify, track, and monitor quality of care outcomes and trends
- Participates in establishing and maintaining reports which relay the efficacy of UM.

Associate Director of Utilization Management Regulations

Under the direction of the Director of Utilization Management, provides oversight of the UM Program to ensure compliance with regulatory requirements including, but not limited to, requirements of DHCS, CMS, and the National Committee for Quality Assurance (NCQA) . Assigned activities include:

- Coordinates activities with External and Regulatory Affairs Compliance, Member Services, Claims, and Provider Relations departments to identify, track, and monitor quality of care issues and trends related to UM Department processes
- Prepares reports on departmental activities according to established schedules and format. Identifies patterns and trends, conducts retrospective review as needed and works with UM Leadership to develop corrective action plans.
- Gathers UM program information and incorporates updates into the annual UM evaluation and program description
- Prepares and presents the annual evaluation, program description to IQI and Q/UAC
- Participates in the grievance process
- Acts as primary contact and support to each UM Delegate, providing training and support as necessary
- Conducts delegation oversight through regular auditing of each UM Delegate, prepares audit reports for review by the Director of Utilization Management, and prepares information for the Delegation Oversight Review Sub-Committee (DORS) and NCQA Steering Committee.
- Collaborates with Department leaders to ensure that all policies and procedures related to regulatory requirements are updated at least annually, or as needed, and presented to appropriate committees for review. Assists Partnership staff and providers with the interpretation of Partnership policies, procedures, and regulatory requirements.
- Works with UM Leadership and UM Trainer to develop standardized training content and materials for new staff and ongoing education for existing staff
- Participates in the planning and development of new/ enhanced Health Services plan benefits or product lines as needed. Attends Benefits Review and Evaluation Workgroup meetings
- Participates in audits by various regulatory agencies as necessary

Associate Director of Enhanced Health Services

Under the direction of the Director of Enhanced Health Services, is responsible for managing the CalAIM program. Provides strategic support and management/supervisory support for the CS and ECM staff, including but not limited to, strategic goal setting, program planning, budget/account management, and supervision of team members.

- Participates in internal and external meetings, providing input and guidance to community stakeholders and partners regarding the CalAIM program
- Fosters cross-departmental collaboration in shared operational activities related to the ECM benefit and CS services (ex: Provider Relations, Care Coordination, Claims, etc.)
- ~~In collaboration with Provider Relations, prepares~~Prepares and reviews provider and M~~m~~ember education materials related to CalAIM
- ~~Ensures timely monitoring and oversight of Partnership-contracted ECM and CS providers, pursuant to DHCS regulations and Partnership policies and procedures~~
- Identifies trends, patterns and/or opportunities for enhancements to workflows, tools and/or systems to promote efficiency, cost, and quality of ECM and CS services
- As directed, prepares or provides updates on DHCS deliverables and reports associated with CalAIM, including but not limited to the DHCS Model of Care template, DHCS ECM Exception Request(s), and/or DHCS ECM and CS reporting guidelines
- Maintains knowledge of CalAIM requirements and shares updates with appropriate internal/external stakeholders, as necessary

Senior Manager of Justice Involved Programs – RN

Under the direction of the Director of Enhanced Health Services, is responsible for working directly with justice-involved agencies and providers who serve justice-involved M~~m~~embers in Partnership HealthPlan of California's county network. The assigned activities include:

- Serves as the Justice Liaison for the HealthPlan
- Facilitates communication with external stakeholders including: network providers, county staff, state prison system, probation offices, police/sheriff departments and other stakeholders as appropriate
- Oversees and develops a system for care coordination for this designated population on behalf of the HealthPlan, ensuring providers and staff are capable of serving this M~~m~~ember population.
- Serves as the HealthPlan lead for oversight of any applicable MOUs between the HealthPlan and other entities as directed by DHCS and supports MOU activities and requirements to ensure HealthPlan compliance.
- Establishes systems to ensure connections with county behavioral health plans for the delivery of specialty mental health services on behalf of this specific population.
- Serves as a point of escalation for care managers if they face operational obstacles when working with County and/or community partners.

Manager of Utilization Management - RN

Responsible for the implementation, management and evaluation of an effective and systematic UM Program. Provides day-to-day guidance to UM staff and manages all aspects of utilization review activities and is available to staff on-site or by telephone. Working with the Chief Medical Officer, Chief Health Services Officer, Directors of UM, Associate Directors of UM, utilization committees, and Health Plan Directors, promotes efficient resource utilization throughout the organization, providing leadership, teambuilding and direction needed to ensure attainment of UM goals. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Coordinates completion of activities
- Monitors for consistent application of UM criteria by UM staff for each level and type of UM decision
- Participates in staff trainings and on-site continuing education
- Provides recommendations for interventions designed to improve utilization management issues
- Coordinates implementation of interventions
- Develops UM policy and procedures for Q/UAC approval
- Develops, or coordinates development of, documentation of UM activities
- Conducts annual performance evaluations for assigned UM staff

Manager of Long Term Support Services (LTSS) – RN

Provides leadership and clinical oversight for operational aspects of Utilization Management for Long Term Support Services (LTSS); including the responsibility for providing daily oversight, leadership, support and

management of assigned staff. Collaborates with departmental and Health Services leadership to oversee and monitor the provision of LTSS benefits and services; coordinating with Partnership providers and/or community stakeholders as necessary. This position has the authority to make decisions on coverage not relating to medical necessity.

- Provides day-to day direction to licensed clinical staff regarding utilization review, care coordination, discharge planning, and other services across the continuum of care for Members in need of LTSS
- Ensures compliance with regulatory/accreditation requirements related to UM by collaborating with other departments and maintaining survey and audit readiness
- Leads, develops and operationalizes evidence-based best practices and activities to address LTSS benefits and/or services (ex: Transitional Care Services, facility placements, care coordination, etc.)
- Identifies and incorporates quality-monitoring activities to improve the quality of care, outcomes, and/or costs for Members receiving one or more LTSS (ex: Skilled Nursing, Community Based Adult Services, In-Home Support Services, etc.)

Clinical Manager, Enhanced Health Services - RN

Assists the Director and Associate Director of Enhanced Health Services (EHS) in the development, implementation, management and evaluation of an effective and systematic CalAIM Program. Provides day-to-day guidance to nursing staff and manages all aspects of utilization review activities and is available to staff on-site or by telephone. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Monitors for consistent application of UM criteria by EHS staff for each level and type of EHS decision
- Participates in staff trainings and on-site continuing education
- Provides recommendations for interventions designed to improve utilization management issues
- Coordinates implementation of interventions
- Oversees auditing and oversight of CalAIM providers
- Collaborates with departmental leadership to oversee and maintain a cohesive team with a high level of productivity, accuracy and quality to achieve goals and objective
- Maintains updated policies and procedures, workflows, documentation, desktops, reports, etc.
- Fosters cross-departmental leadership in shared operational activities related to the CalAIM initiatives. (ex: Provider Relations, Utilization Management, Claims, etc.)
- Maintains knowledge of the CalAIM initiatives and shares updates with appropriate internal /external stakeholders when necessary

Manager of Utilization Management Operations

Responsible for the operational aspects of Utilization Management, including responsibility for providing daily oversight, leadership, support, and management of assigned staff. Ensures compliance with established criteria, regulations, standards, best practices and Health Plan benefits. The assigned activities include:

- Provides daily operations oversight and direction to the team Supervisor(s) and Data Coordinators
- Manages day to day functions including coordination of assignments, monitoring of call volume and adherence to Partnership workplace policy and is available to staff on-site or by telephone
- Assists in the refinement/improvement of the HS programs
- Provides performance feedback to the Data Coordinator staff and conducts staff trainings as needed.
- Monitors UM Data Coordinator activity for consistent application of desktop processes and procedures by UM Data Coordinator staff
- Provides leadership, direction, training, and support to the assigned staff
- Participates in staff trainings and on-site continuing education
- Conducts annual performance evaluations for assigned UM staff

Manager of Enhanced Health Services Operations

Responsible for the operational aspects of Enhanced Health Services, including responsibility for providing daily oversight, leadership, support, and management of assigned staff. Ensures compliance with established criteria, regulations, standards, best practices and Health Plan benefits. The assigned activities include:

- Provides daily operations oversight and direction to the team Supervisor(s), Program Manager and Project Coordinators
- Manages day-to-day functions including coordination of assignments, reporting and adherence to Partnership workplace policy and is available to staff on-site or by telephone
- Assists in the refinement/improvement of the CalAIM programs
- Provides performance feedback to the EHS staff and conducts staff trainings as needed
- Monitors staff activity for consistent application of desktop processes and procedures by EHS staff
- Provides leadership, direction, training, and support to the assigned staff
- Participates in staff trainings and on-site continuing education
- Conducts annual performance evaluations for assigned EHS staff

Senior Programmer Analyst

This position supports the design, development, and documentation of Partnership's core claims processing, TAR processing, and claims processing platforms. Provides technical support and problem resolution to UM Department end users.

- Maintains in-depth knowledge of various Partnership systems
- Tests, schedules, and implements new releases and upgrades of software
- Tests, schedules, and implements interface changes to systems, when needed
- Supports development of business requirements for various system implementations
- Uses sound technical judgment and makes appropriate systems decisions
- Assists in development and maintenance of policies and procedures to document new and changed elements of UM Operations

Inpatient/Outpatient/LTSS Nurse Supervisor UM - RN

This position is responsible for the daily mentorship and oversight of the staff assigned to inpatient, outpatient or LTSS services. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Works collaboratively with all levels of leadership within the department to efficiently coordinate workflow and individual staff assignments
- Provides day to day supervision to the assigned team, overseeing daily operations of the inpatient, outpatient or LTSS review process
- Participates in staff trainings and on-site continuing education. With UM Leadership, conducts annual performance evaluations for assigned UM staff
- Audits medical records as appropriate and monitors for consistent application of UM Criteria by UM staff, for each level and type of UM decision.
- This position, in addition to his/her own case load, may be assigned cases in the area of oversight as deemed necessary to provide coverage

Clinical Supervisor of Enhanced Health Services - RN

Provides daily supervision and program support to designated staff. Assists departmental leadership in developing and maintaining a cohesive team with a high level of productivity, accuracy and quality to achieve goals and objectives

- Provides daily leadership, direction, resources, training, evaluation, coverage, and program support to assigned staff
- Performs supervisory functions such as timecard management, directing work activities, conducting annual reviews and training to staff
- Maintains active participation with inbound and outbound provider reporting and other related duties, adjusting assignments as necessary to meet business needs and/or regulations
- Facilitates meetings with Partnership providers and/or external community partners as necessary
- Participates in oversight and audit of CalAIM providers
- Supports organizational collaboration and communication regarding CalAIM initiatives through active collaboration

Inpatient/Outpatient Nurse Lead UM - RN/ LVN

This position is responsible for assisting with oversight of daily operations of the inpatient or outpatient review process (as assigned). This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Provides direction and support, to staff concerning daily assignments.
- Participates in interview process and provides training in inpatient or outpatient review for new hires.
- Evaluates appropriateness of care through interpretation of benefits as outlined in Title 22, Medi-Cal Provider Manual using Partnership policies and procedures, and InterQual® criteria.
- Documents and maintains patient-specific records in the data collection software system.
- Assists in the refinement/improvement of the Health Services programs. Participates in continuous process improvement endeavors.
- Works with other Partnership departments to resolve issues relating to authorization of medical services.
- Participates in Inter-rater Reliability studies, reviewing medical records as assigned.
- Communicates regularly with the UM Team Manager and works collaboratively to resolve issues.

Nurse Auditor - RN

Under the direction of the UM ~~Manager of~~ Supervisor or higher, the Training & Education Nurse Auditor (RN) ~~, this position~~ conducts audits of assigned areas, assists in department audit initiatives and performs audits in accordance with the department audit plan. As an integral member of the Training and Education Team, this position helps the audit function keep pace with the audit needs of the UM Department.

Nurse Coordinator/ UM/EHS II - RN/ LVN

Work collaboratively with all levels of UM leadership and other Partnership staff to develop, implement, and evaluate health outcomes, provider performance and other performance indicators pertinent to quality of care. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Assist in training and orientation of new staff to the department upon request
- Review and authorization of DME, Ancillary and Medical TARs based on established guidelines
- Review and authorization of Long Term Care TARs based on established guidelines
- Review and authorization of inpatient Hospital TARs based on established guidelines
- Review and authorization of Enhanced Care Management (ECM) and Community Supports TARs based on established guidelines
- Reviews residential placement authorization requests for substance use disorder (SUD) treatment services according to the specific terms of the contract with the provider and in accordance with the medical necessity requirements for Medi-Cal eligible beneficiaries. Licensed staff who operate in the capacity of behavioral health authorizations (for Substance Use Disorder (SUD) treatment services as outlined in the Regional Drug Medi-Cal Model) are required to complete specialized ASAM[1] training annually.
- Retrospective review of services to determine medical necessity
- Refer cases to the Chief Medical Officer for requests that may not appear to meet evidence- based medical necessity criteria
- Determines if requested services are part of the M~~m~~ember's benefit package
- Work collaboratively with the Care Coordination, Population Health, Pharmacy and Quality Improvement staff on UM issues

Nurse Coordinator/ UM/EHS I - RN/ LVN

Work collaboratively with all levels of UM leadership and other Partnership staff to develop, implement, and evaluate health outcomes, provider performance and other performance indicators pertinent to quality of care.

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

This position has the authority to make decisions on coverage not relating to medical necessity. Activities assigned include:

- Review and authorization of DME, Ancillary and Medical TARs based on established guidelines.
- Review and authorization of Long Term Care TARs based on established guidelines.
- Review and authorization of inpatient Hospital TARs based on established guidelines.
- Review and authorization of Enhanced Care Management (ECM) and Community Supports TARs based on established guidelines
- Reviews residential placement authorization requests for SUD treatment services according to the specific terms of the contract with the provider and in accordance with the medical necessity requirements for Medi-Cal eligible beneficiaries. Licensed staff who operate in the capacity of behavioral health authorizations (for Substance Use Disorder (SUD) treatment services as outlined in the Regional Drug Medi-Cal Model) are required to complete specialized ASAM[1] training annually.
- Retrospective review of services to determine medical necessity
- Refer cases to the Chief Medical Officer for requests that may not meet medical necessity criteria
- Determine if requested services are part of the Member's benefit plan
- Work collaboratively with the Care Coordination, Population Health, Pharmacy, and Quality Improvement staff on UM issues

Data Coordinator/ Supervisor UM – Administrative

Works closely with UM Leadership to establish consistent evaluation of Data Coordinators' work performance. Responsible for oversight of Data Coordinators.

- Monitors day-to-day functions including coordination of assignments, monitoring of call volume and adherence to Partnership workplace policy and is available to staff on-site or by telephone
- Assists in the refinement/improvement of the HS programs
- Provides performance feedback to the Data Coordinator staff and conducts staff trainings as needed
- Monitors UM Data Coordinator activity for consistent application of desktop processes and procedures by UM Data Coordinator staff
- Provides leadership, direction, training, and support to the assigned staff
- Participates in staff trainings and on-site continuing education
- Conducts annual performance evaluations for assigned UM staff

Policy Analyst - (Regulatory/Delegation)

This position is responsible for drafting, editing, reviewing, auditing, tracking, monitoring and maintaining utilization management policies and procedures for Partnership. Under the supervision of the Associate Director of Utilization Management Regulations, ensures compliance with governing rules, regulations, and/or accreditation standards.

- Prepares UM policies and/or related materials for appropriate committees' review and attends meetings of the Internal Quality Improvement Committee and Quality/Utilization Advisory Committee.
- Performs policy research to analyze current and/or new regulations by applicable Partnership regulators and/or accrediting agencies (ex: DHCS, DMHC, CMS, NCQA, etc.)
- Reviews both draft and final All Plan Letters (APLs) and/or regulatory changes and supports leaders with the research, planning, implementation and/or operational readiness submissions across the organization.
- Participates in audits with Partnership's regulatory and/or accreditation bodies by preparing policies, documents and/or reports as needed.
- Conducts analysis, collects information, and evaluates impact of regulatory and compliance issues to inform auditing and monitoring activities.
- Analyzes the impact of new programs/benefits and efficacy of existing processes, policies, procedures and trainings.

Program Manager II – (Regulatory/Delegation)

Under the direction of the Associate Director of UM Regulations, this position conducts business analysis and program analytics and participates in strategic planning and administrative oversight of the UM authorization platform
Assigned activities include:

- Responsible for day-to-day duties associated with oversight of UM delegated entities
- Responsible for successful implementation of new activities and processes with delegated entities
- Ensures efficient and appropriate collaboration between the Utilization Management staff and UM delegated entities
- Provides oversight of the UM authorization platform

Program Manager I – (Regulatory/Delegation)
Under the direction of the Associate Director of UM Regulations, assigned activities include:

- Responsible for day-to-day duties associated with oversight of UM delegated entities
- Responsible for successful implementation of new activities and processes with delegated entities
- Identifies and resolves issues and concerns with UM delegation to ensure risk is mitigated in a timely manner and recommends solutions to Leadership for final decision, as necessary
- Responsible for collecting and tracking required document submissions from delegated entities
- Coordinates and participates in both desktop and onsite audits of delegated entities
- Ensures efficient and appropriate collaboration between the Utilization Management staff and UM delegated entities

Program Manager I – (EHS)
Under the direction of ~~an Associate Director~~the Manager of Enhanced Health Services, develops, implements, improves, and manages assigned programs related to CalAIM. Participates in the design, implementation, and/or expansion of strategic programs and departmental initiatives. Supports the development and execution of program goals, outcome measures, and program reporting.

- Creates and delivers CalAIM program information and reports to both internal and external stakeholders
- Supports the development and execution of strategies to engage stakeholders.
- Responsible for program evaluation and continuous improvement activities
- Responsible for successful implementation of CalAIM activities.
- Reviews program data accuracy, completeness, and required submissions.

Program Manager I – (LTSS)
Under the direction of the Manager of Long Term Support Services (LTSS), supports operational aspects of Utilization Management related to LTSS including monitoring and reporting of the provision of LTSS benefits and services. Assigned activities include:

- Serves as the In-Home Supportive Services (IHSS) Specialist
- Serves as the Community Provider Advisory Council (CPAC) Coordinator
- Facilitates Point Click Care discharge reporting
- Monitors and tracks Letters of Agreement (LOAs)
- Coordinates with Health Analytics for Dashboard reporting
- Coordinates Critical Incident Review
- Creates specialized documents (Desktops, Info sharing with facilities and other departments, etc)
- Acts as a point of contact for the team for additional reporting needs

Program Coordinator II - (UM Regulations)
Under the direction of the Associate Director of UM Regulations, provides coordination and implementation support of defined tasks.

- Coordinates, facilitates, and leads program meetings
- Supports the successful management of program initiatives
- Customarily and regularly compiles, reviews and analyzes project data and results.
- Develops expertise in program focus areas and stays informed of key developments

Project Coordinator II - (EHS)
Under the direction of an Associate Directorthe Manager of Enhance Health Services, provides coordination and implementation support of defined tasks for CalAIM programs. Conducts business analysis to evaluate programs, exercises independent judgement in leading assigned projects, tracks and reports data to a higher complexity level, coordinates daily activities, communicates program status to stakeholders.

- Coordinates, facilitates, and leads both internal and external meetings for CalAIM Providers.
- Supports the successful implementation of CalAIM projects.
- Customarily and regularly compiles, reviews and analyzes project data and results.
- Develops expertise in program focus areas and stays informed of key developments and training/development opportunities within our network and across the healthcare industry, maintains accurate provider listing for CalAIM Providers.

Project Coordinator I - (EHS)
Under the direction of the Manager ofan Associate Director of Enhanced Health Services, provide coordination and implementation support of defined tasks for CalAIM program.

- Coordinates and facilitates both internal and external meetings for CalAIM Providers.
- Develops and publishes agendas, meeting minutes, and necessary documentation
- Attends project meetings, follows up on assigned tasks, and communicates the status of projects to the supervisor
- Manages, tracks, and processes CS or ECM referrals

Program Coordinator I - (Training & Education)
Under the direction of the UM Supervisor or higher, this position provides coordination and implementation support of defined tasks for the UM Training & Education team. Assigned responsibilities include:

- Attends program meetings, prepares agendas and minutes, and follows up with stakeholders on assigned action items
- Assists with planning, coordination, and execution of events, webinars, trainings, and user demos
- Coordinates with program leadership and internal units to support implementation of new programs/trainings and related processes

Health Services Analyst I
Performs routine and ad-hoc reporting and data management for the UM department for both internal and external users; assists in maintaining reporting systems within the department. Prepares, analyzes, reports, and manages data used for both the UM department as well as plan-wide and regional decision making for evaluating performance in key quality measures and the effective use of health plan resources on a routine and ad hoc basis. Works collaboratively with departments company-wide to identify data needs, develop and maintain data queries and tools, and complete accurate reporting to support performance and process improvements.

Executive Assistant to the Chief Health Services Officer - Administrative
Provides administrative support to the Chief Health Services Officer. Manages appointment calendar, develops agendas, organizes meetings and executes minutes for designated meetings.

Health Services Administrative Assistant II – UM, EHS - Administrative
Provides administrative support to the Utilization Management Director or EHS Director and/or other UM or EHS Leadership. Manages appointment calendars, coordinates setup and executes minutes for designated meetings.
Health Services Administrative Assistant I – UM - Administrative
Provides administrative support to UM Leadership. Manages appointment calendars and works closely with the Information Technology Department to ensure appropriate electronic functioning for the Utilization Management Department.

Authorization Specialist/ UM Trainer – Administrative

Responsible for providing training on all appropriate software platforms for new hires. Creates and maintains current training materials for the UM department. In conjunction with UM leadership team, prepares and delivers retraining of identified topics as deemed necessary.

- Facilitates independent DME consultant evaluation visits to Members for specialty equipment needs as needed or directed by UM Leadership.
- Acts as a resource regarding UM department software programs and special projects upon request and is available to staff on-site or by telephone
- Coordinates with Member Services Call Center system to place Members into appropriate Direct Member status related to their care.

Data Coordinator/ UM Lead - Administrative

Under the direction of the Data Coordinator Supervisor and UM Leadership:

- Monitors Data Coordinator documentation for accuracy
- Ensures Data Coordinator staff have the resources required for completing TAR entry and using good judgment and is available to staff on-site or by telephone
- Enters both manual and electronic submitted data into Partnership systems for RAF and TAR authorizations
- Monitors UM Data Coordinator staff for consistent application of desktop processes and procedures
- Responsible for assisting with ongoing staff education in proper use of systems and Partnership UM Departmental policies and procedures
- Participates in staff trainings and on-site continuing education

Coordinator II - Administrative

Under the direction of applicable UM/ EHS leadership:

- Serves as a resource to other departments who have inquiries into the UM/ CalAIM process
- Responsible for the input of data and information concerning UM/ CalAIM Referrals and Authorizations
- Receives and responds to telephonic inquiries from providers regarding status of authorization requests and other questions or concerns
- Performs triage and transfers calls to appropriate professional staff when indicated
- Responsible for clerical processing of appeals (as applicable) in accordance with policy, procedures, timeframes and requirements of various regulatory bodies for all lines of business
- Acts as liaison to Claims Department in coordinating timely response to all claims inquiries
- Participates in special projects, tasks and assignments as directed

Coordinator I - Administrative

Under the direction of applicable UM/ EHS leadership - responsible for the input of data and information concerning UM/CalAIM Referrals and Authorizations.

- Maintains departmental documents
- Receives and responds to telephonic inquiries from providers regarding status of authorization requests and other questions or concerns
- Performs triage and transfers calls to appropriate professional staff when indicated
- Responsible for clerical processing of appeals (as applicable) in accordance with policy, procedures, timeframes and requirements of various regulatory bodies for all lines of business
- Acts as liaison to Claims Department in coordinating timely response to all claims inquiries
- Participates in special projects, tasks and assignments as directed

Behavioral Health Program Staff

Behavioral Health Clinical Director - MD/DO/PhD/ PsyD

The Partnership Behavioral Health Clinical Director is an MD, DO, clinical PhD, or PsyD who is actively involved in the behavioral health aspects of the UM program. This Director provides clinical oversight of Partnership's behavioral health activities including substance use services and the activities of Partnership's

delegated managed behavioral health organization for the administration of certain mental health services~~(s)~~. The Behavioral Health Clinical Director has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for behavioral health or substance use services. The assigned activities for this position include:

- Establishes ~~UM~~ policies and procedures for mental health services ~~in collaboration with Partnership's delegated managed behavioral health organization(s)~~
- Oversees and monitors quality improvement activities
- Facilitates network adequacy
- Participates in the peer review process
- Evaluates behavioral health care and substance use disorder (SUD) treatment services requests ~~in collaboration with Partnership's delegated managed behavioral health organization(s)~~
- Oversees and monitors utilization of behavioral health services~~functions of Partnership's delegated managed behavioral health organization(s)~~
- Serves on Quality/Utilization Advisory Committee; Quality Improvement and Health Equity Committee (QIHEC); Pharmacy and Therapeutics Committee; Credentials Committee and Internal Quality Improvement Committee including the Substance Use Internal Quality Improvement Subcommittee.

Senior Director of Behavioral Health - MHA

This position is responsible for oversight and management of Partnership activities involving behavioral health (mental health and substance use) services and community projects which support access to and improvement of behavioral health.

- Responsible for the oversight activities involving the coordination of care for children and youth receiving child welfare services.
- Manages relationships with delegated entities and community stakeholders.
- Works with Partnership leadership, M~~m~~ember counties, providers and the community to develop the Plan's approach to behavioral health services to the Medi-Cal population and the related projects focused on the range of social and community factors that affect Members' behavioral health.
- Participates in network development, contracting and outreach efforts within the Partnership network.
- Monitors M~~m~~ember utilization and ensures coordination between Partnership's system of care for Non-Specialty Mental Health and the county Behavioral Health's system of care for Specialty Mental Health and Substance Use Services under Drug Medi-Cal

Senior Manager of Behavioral Health

Under the direction of the Senior Director of Behavioral Health, responsible for the management of a major division/service area referred to as the DMC-ODS Regional Model, which includes multiple work groups of significant depth and complexity. Responsibilities include overall management and administration of a large service area, including development of a division's objectives and design and implementation of supporting and expansion programs, processes, policies, and/or procedures to successfully achieve those objectives.

Sr. Manager of Behavioral Health Access

Under the direction of the Senior Director of Behavioral Health, responsible for directing and coordinating medically necessary behavioral health treatment services for members seeking behavioral health services. Oversees operations of Behavioral Health Call Center and staffing. Oversees staff to ensure the coordination of care for members seeking behavioral health services for both carved in and carved out services. Ensures regulatory compliance with call center performance requirements.

Sr. Manager of Child Welfare Program

Under the direction of the Senior Director of Behavioral Health, responsible for working directly with local county child welfare agencies, foster care agencies and providers who work directly with children and youth involved in the child welfare system, and former foster youth through age 25, in Partnership HealthPlan of California (Partnership) assigned counties. The goal of this position is to ensure child welfare involved youth obtain the health services they are entitled to and that services are closely coordinated with other services. This position will assist in the design, implementation, and/or expansion of strategic programs and departmental initiatives in relation to this population and regulatory deliverables. Develops and delivers

program goals, measures, and reports. The Liaison will be responsible for a range of systems to strengthen coordination and support for children and youth involved in child welfare. Facilitates communication with external stakeholders including network providers, county staff, CASA, foster care agencies, foster parents, birth families and other stakeholders as appropriate.

Manager of First 5 Commissions
Under the direction of the Sr. Manager of Child Welfare Programs and the Senior Director of Behavioral Health, responsible for working directly with local First Five Commissions and agencies and providers who work directly with children, in Partnership HealthPlan of California (Partnership) assigned counties. The goal of this position is to ensure youth obtain the health services they are entitled to and that services are closely coordinated with other services. This position will assist in the design, implementation, and/or expansion of strategic programs and departmental initiatives in relation to this population and regulatory deliverables. Develops and delivers program goals, measures, and reports. This position will be responsible for a range of systems to strengthen coordination and supports for children and youth and will facilitate communication with external stakeholders including: First Five Commissions, network providers, county staff, birth families and other stakeholders as appropriate.

Manager of Mental Health Programs
Under the direction of the Senior Director of Behavioral Health, responsible for the management of mental health services, which includes multiple work groups of significant depth and complexity. Responsibilities include overall management of this service area, including working with the Behavioral Health Administrator for the development of the service areas objectives and design and implementation of supporting and expansion programs, processes, policies, and/or procedures to successfully achieve those objectives.

County Child Welfare Liaison
Under the direction of the Sr. Manager of Child Welfare Program and the Senior Director of Behavioral Health, supports a range of social work services as a county child welfare liaison in collaboration with Partnership staff to meet the psycho-social and care coordination needs of members involved in the child welfare system. Responsible for the assessment and care coordination of the psychosocial needs of these members, families and/or caregivers to help promote positive coping skills, reduce the risk of premature institutionalization, assist individuals in maintaining independence in the community and increase stabilization of social determinants.

Pharmacy Program Staff

Pharmacy Services Director – Pharm.D.
This position is responsible for overseeing all HealthPlan activities related to medication benefit and pharmacy services and supervising the Partnership Pharmacy management team, Partnership Clinical Pharmacists, and support staff. The assigned activities for this position include but are not limited to:

- Medication coverage management
- Development of applicable policies and guidelines
- Serves on the Pharmacy and Therapeutics (P&T) Committee (serving as Chair when designated by the CMO), the Global Medi-Cal Drug Utilization Review (DUR) Board and the Pediatric Quality Committee (PQC)
- Drug utilization review
- Regularly attends the Quality Improvement and Health Equity Committee (QIHEC)
- Drug prior authorization for medications covered under the medical benefit
- Implementation of cost effective utilization management measures for medications covered under the medical benefit
- Participation in provider education initiatives such as academic detailing with plan physicians
- Medical education meetings
- Assisting with development of Clinical Practice Guidelines
- Other duties as assigned by the Chief Medical Officer

Clinical Pharmacist – Pharm.D., RPh
Work collaboratively with all levels of Pharmacy leadership to review medication Treatment Authorization Requests (TARs) to promote safe, appropriate, and cost-effective drug therapy. Pharmacists have the authority to make decisions based on medical necessity that result in the approval or denial of coverage of medications.

- Communicates and educates prescribers on TAR processes, TAR determination, and Partnership medication coverage policies
- Provides oversight to the pharmacy technician staff in the daily TAR review process
- Participates in P&T meetings and conduct drug utilization reviews to identify treatment gaps and optimize medication therapy outcomes based on national treatment guidelines and evidence-based medicine
- Participates in the development of technician drug review guidelines and creation of authorization criteria for medical benefit medications
- Participates and works with other departments on cross-departmental initiatives that require Clinical Pharmacy input/participation
- Support HEDIS and other clinical quality improvement work through provider academic detailing and Member engagement activities
- Ensures compliance with regulatory and quality standards/requirements including, but not limited to, the standards of the National Committee for Quality Assurance (NCQA) and the requirements for the California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS)
- Other duties as assigned by the Pharmacy Services Director

Pharmacy Technician – CPhT, RPhT
Work collaboratively with all levels of Pharmacy leadership to review medication Treatment Authorization Requests to promote safe, appropriate, and cost-effective drug therapy.

- Reviews and approves TARs based on established internal pharmacy technician review guidelines &/or Partnership drug TAR requirements (prior authorization criteria for use). If a TAR cannot be approved based on guidelines/criteria, the pharmacy technician will refer the TAR to the Clinical Pharmacist for an escalated review.
- Educates prescribers on TAR processes, TAR determination, and Partnership medication coverage policies.
- Supports HEDIS and other clinical quality improvement work through provider academic detailing and Member engagement activities.

Committees

Board of Commissioners
The Board of Commissioners on Medical Care (the Commission) promotes, supports, and has ultimate accountability, authority and responsibility for a comprehensive and integrated UM program. The Commission is ultimately accountable for the efficient management of healthcare resources and services provided to Members. The Commission has delegated direct supervision, coordination, and oversight of the UM program to the Q/UAC which reports to the PAC, the committee with overall responsibility for the program. Members of the Commission are appointed by the county Boards of Supervisors for each geographic service area and include representation from the community as follows: consumers, businesses, physicians, providers, hospitals, community clinics, HMOs, local government, and County Health Departments. The Commission meets six times a year.

The purpose of the Commission is to negotiate exclusive contracts with DHCS and to arrange for the provision of health care services to qualifying individuals, as well as other purposes set forth in the enabling ordinances established by the respective counties.

Community Advisory Committee (CAC)

The CAC is composed of Partnership M~~m~~embers, advocates and stakeholders who represent the diversity and geographic areas of Partnership's membership, including hard-to-reach populations. The CAC is a liaison group between our M~~m~~embers and Partnership, advocating for M~~m~~embers by ensuring that the health plan is responsive to the health care and information needs of all M~~m~~embers. Additionally, the CAC provides Partnership M~~m~~embers with a forum to discuss common issues of interest and importance, while creating a supportive and informative environment. The CAC meets quarterly, reviews and makes recommendations regarding Member Services' quality improvement activities, provides feedback on quality and health equity initiatives and serves in the capacity of a focus group. Three CAC members are selected to serve on the Board of Commissioners to provide member input and report back to the CAC.

Pharmacy and Therapeutics Committee (P&T)

The P&T Committee is chaired by Partnership's Chief Medical Officer (CMO), or designee such as the Director of Pharmacy, and is comprised of Partnership's Pharmacy Director, Associate and Regional Medical Directors, Partnership staff and network practitioners including pharmacists, primary care physicians, behavioral health and other specialists. P&T makes decisions and recommendations on development and review of the physician administered drugs (PADs) provided under the medical drug benefit, medication policy and procedures, and drug approval criteria. P&T Committee also serves as Partnership's Drug Utilization Review (DUR) Board to review Partnership's DUR program and activities and make recommendations where necessary to improve Partnership's drug utilization. The P&T meets quarterly, providing regular activity reports and recommendations to the PAC, the approval authority for P&T related activities.

Physician Advisory Committee (PAC)

The PAC monitors and evaluates all Health Services activities and is directly accountable to the Board of Commissioners for the oversight of the UM program. The PAC meets at least ten (10) times a year and may not convene in the months of July and December, with the option to add additional meetings if needed. Voting membership includes external Primary Care Providers (PCPs), board certified high-volume specialists, behavioral health practitioners and non-physician clinicians. A voting provider member of the committee chairs the PAC. The Partnership Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Chief Medical Officer (CMO), Deputy CMO, Medical Director for Medicare Services, Medical Director for Quality, Regional Medical Director(s), Behavioral Health Clinical Director, Chief Health Services Officer and leadership from the following departments, Quality and Performance Improvement, Provider Relations, Care Coordination, Utilization Management, Pharmacy, and Network Services, ~~departments~~ attend the PAC meetings regularly. Other Partnership staff attend on an ad hoc basis to provide expertise on specific agenda items. The PAC oversees the activities of the Q/UAC and other quality-related committees and reports activities to the Board of Commissioners.

Quality/Utilization Advisory Committee (Q/UAC)

The Q/UAC is responsible to assure that quality, comprehensive health care and services are provided to Partnership Members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. Q/UAC voting membership includes consumer representative(s) and external ~~providers~~ clinicians who are contracted primary care providers (PCPs) and board-certified specialists in the areas of internal medicine, family medicine, pediatrics, OB/GYN, neonatology, behavioral health, and representatives from other high-~~-~~volume specialties. These external providers represent hospitals, medical groups, and practice sites in geographic sections of Partnership's service area. The Partnership Chief Medical Officer (CMO) (chair of the committee), Behavioral Health Clinical Director, Director of Health Equity, Medical Director for Quality, Manager of Member Safety-Quality Investigations, Associate and Regional Medical Directors and leadership from the Health Services departments (*e.g. Quality and Performance Improvement, Utilization Management, Care Coordination, Pharmacy, Population Health, Health Equity, Enhanced Health Services*), Grievance and Appeals, and Provider Relations departments attend the Q/UAC meetings regularly. Other Partnership staff attend on an ad hoc basis to provide expertise on specific agenda items. The committee meets- monthly at least ten (10) times per year, with the option to add additional meetings if needed. Q/UAC activities and recommendations are reported to the PAC and at least quarterly to the Commission. The Q/UAC provides guidance and direction to the UM program by coordinating activities and by functioning as the expert panel when needed. Coordination includes but is not limited to:

- Annual oversight of the UM Program
- Annual evaluation of the UM program structure, scope, processes, and information used to determine benefit coverage and medical necessity.
- Annual identification of actions needed (based on evaluation)
- Annual review of the UM rates (as prescribed in the NCQA standards) for each of the following:
  - Non-Behavioral Health UM rates
  - Behavioral Health UM rates
  - Pharmacy UM rates
  - UM Appeals rates
  - Identification of actions to address opportunities identified
- Assuring individual Member needs are taken into consideration when determinations for care are rendered and in the development of medical policy and procedures.
- Analyzing summary data and making recommendations for action
- Reviewing action plans for quality improvements of UM activities and providing ongoing monitoring and evaluation
- Reviewing medical policy, protocol, criteria and clinical practice guidelines
- Approving and ensuring implementation of evidence-based guidelines and policies of medical practice including preventive, chronic care, and behavioral health initiatives
- Providing oversight of delegated activities

Quality Improvement and Health Equity Committee (QIHEC)
The Quality Improvement and Health Equity Committee (QIHEC) meets bimonthly for analyzing and evaluating the results of Health Equity related Quality Improvement activities. This includes annual review of the results of performance measures, utilization data, grievance and appeal data, consumer satisfaction surveys, and findings and activities of other Partnership specific committees. (e.g. Community Advisory Committee, ~~Population Needs Assessment (PNA) Committee~~, etc). This committee shall also be responsible for instituting actions to address health equity performance deficiencies, including policy recommendations, and ensuring appropriate measurement and follow-up of identified performance deficiencies.

The QIHEC provides recommendations to the Quality/Utilization Advisory Committee (Q/UAC) Committee. The Q/UAC provides recommendations to the Physician Advisory Committee (PAC). ~~PAC is responsible for oversight and monitoring of the quality and cost-effectiveness of medical care provided to Partnership Members and is comprised of the Chief Medical Officer (CMO) and participating clinician representatives from primary and specialty care disciplines.~~
Partnership Members of the QIHEC include (but are not limited to): CMO, Director of Health Equity, Director of Grievance and Appeals, COO, Director of Communications, Director of Health Analytics, Senior Director of Quality and Performance Improvement, Director(s) of Care Coordination, Director(s) of Utilization Management, Director(s) of Population Health, Senior Health Educator, Chief Health Services Officer (CHSO), Director of Pharmacy Services, Regional Medical Director(s), Associate Medical Director(s), Senior Provider Relations Representative Manager, and Senior Director of Member Services. In addition, a broad range of network providers (e.g. Hospitals, Clinics, County Partners, Subcontractors, Downstream Subcontractors, and Members are solicited to actively participate in the QIHEC.

Substance Use Services Internal Quality Improvement Subcommittee (SUIQI)
A committee comprised of appropriate Partnership and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for ~~the~~ Partnership's administration of Substance Use Services on behalf of Regional Model counties.~~oversight.~~ The SUIQI meets at least quarterly. Activities and progress are reported to the IQI. This also includes

- Review of Utilization Management retroactive and appeals review
- Review of inter-rater reliability for peer review and utilization management
- Review of quality of service, quality of facility, and access complaints and grievances
- Investigation of potential overuse, underuse, and misuse of services.
- Review of policies related to provision of ~~SU~~ Substance Use ~~S~~services

Members of the committee include the Behavioral Health Clinical Director, the CMO, Senior Director of Behavioral Health, Senior Manager of Behavioral Health and representatives from the Provider Relations, Member Services, Claims, Compliance, Behavioral Health and Quality Improvement Departments.

UTILIZATION MANAGEMENT PROGRAM SCOPE

UM activities are developed, implemented and conducted by the Partnership Health Services Department under the direction of the Chief Medical Officer and the Chief Health Services Officer. The UM staff performs specific activities.

Specific functions include:

- Prospective, concurrent and retrospective utilization review for medical necessity, appropriateness of hospital admission, level of care and continued inpatient confinement on a frequency consistent with evidence-based criteria and Partnership guidelines, Partnership criteria/ medical policy and the Member's condition. This review is performed cooperatively with the facility care team which may consist of the attending physician(s) and any associated health care personnel who can provide information that will substantiate medical necessity and level of care.
- Discharge planning in collaboration with the facility care team
- Review inpatient and outpatient UM data to determine appropriateness of Member and provider utilization patterns
- Use of most current edition of InterQual® Criteria for medical authorization, and other Partnership UM guidelines and medical policy as developed and approved by the Quality / Utilization Advisory Committee (Q/UAC)
- Use of California Department of Health and Welfare Code of Regulations Title 22, Center for Medicare & Medicaid Services (CMS) Code of Federal Regulations (CFR) Title 42 and National and Local Coverage Determinations
- Review certification requests for skilled nursing care, home health care, durable medical equipment, ambulatory surgery, ambulatory diagnostic and treatment procedures such as physical, occupational and speech therapies.

The UM program incorporates the monitoring and evaluation for the subsequent services and reviews and updates policies and procedures as appropriate but at least annually.

- Acute hospital services
- Subacute care
- Ambulatory care
- Emergency and urgent care services
- Durable Medical Equipment and supplies
- Ancillary care services, including but not limited to home health care, skilled nursing care, subacute care, pharmacy, laboratory and radiology services
- Long-term care including Skilled Nursing Facility (SNF) Care and Rehabilitation Facility Care
- Residential Substance Use Disorder (SUD) treatment
- Behavioral Health ~~Therapy~~ Treatment (BHT) services
- Community Supports
- Enhanced Care Management
- Physician administered drugs (medical drug benefit)

PHARMACY PROGRAM SCOPE

The Pharmacy Department within Health Services is responsible for the utilization management of the medical drug benefit – those medications administered to a Member directly during a medical stay/visit at a clinic, office, or hospital, and billed to Partnership as part of a medical service claim; this includes drugs administered at time of service by physicians, dentists, podiatrists, nurse practitioners and physician assistants. Drugs and other prescription services provided to a Member by a pharmacy are not within the scope of Partnership's Pharmacy Program because the pharmacy benefit is carved-out to State Medi-Cal through the Medi-Cal Rx Program.

Out of Scope for Partnership Pharmacy Program:

- Pharmacy benefits and services pursuant to Executive Order N-01-19 and the Medi-Cal Rx program. The Medi-Cal pharmacy benefits and services administered by DHCS in the FFS delivery system is identified collectively as Medi-Cal Rx. This includes:
  - Covered Outpatient Drugs, as defined by SSA 1927(k)(2): prescription drugs which are not provided as part of *medical* service and thus are under the scope of the Pharmacy Benefit.
  - Self-administered medications provided to a Member to take/inject/inhale/apply/insert (or otherwise administer) at home.
  - Medication and supply services provided to Members at long-term care and skilled nursing facilities.
  - Medications administered by an infusion pharmacy or home health agency in a pharmacy infusion suite or in the Member's home
- Medications and services statutorily defined as a non-Medi-Cal benefit
- Medications provided in a medical setting which are carved out of the Managed Care Plan (MCP) capitation agreement: antivirals for HIV/AIDs, drugs and blood factor products for Hemophilia, drug and alcohol substance use disorder treatment (prescribed outside a narcotic treatment program), antipsychotics, and certain antidepressants (MAOI).

In Scope for Partnership Pharmacy Program:

- Utilization management of drugs administered in a medical setting and billed by the medical provider under the medical benefit, which includes:
  - Drugs other than Covered Outpatient Drugs. The SSA 1927(k)(2) definition of a Covered Outpatient Drug does not include any drug, biological product, or insulin provided as part of, or as incident to, the provision of and billing for medical or institutional services [SSA 1927(k)(3)]
  - Development of coverage criteria for injectable drugs requiring prior authorization based on current nationally accepted treatment guidelines, current medical literature, and input from specialists. These criteria may be drug-specific or class-specific.
  - Application of billing limits, restrictions, or requirements based on FDA approved indications and dosing &/or State Medi-Cal billing requirements. Such utilization management examples include maximum daily dose, allowed dosing frequency, age limits, place of service (e.g. dialysis centers) and current ICD (diagnosis) requirements.
  - The medical provider submits prior authorization requests directly to the pharmacy department. See policy MCRP4068 *Medical Benefit Medication TAR Policy* for further details.
  - Pre-service, Concurrent, and Post-Service (Retrospective) pharmaceutical utilization reviews of medical necessity using established prior authorization criteria requirements set forth by Partnership Pharmacy & Therapeutics (P&T) Committee, or as required by State Policy (All Plan Letters), or in accordance with Partnership case-by-case review guideline (below) when Partnership criteria are not yet established. Timeliness standards mirror those for UM Program Timeliness (see page 26).
  - Case-by-case review shall consider:
    - The Member's individual medical needs (allergies, disease history, treatment history, concurrent medications, concurrent disease states, contraindications) and assessment of access and local delivery system
    - Prescriber's scope of practice/areas of specialization
    - The FDA approved package labeling for indication(s), maximum safe & effective dosing, appropriate age group, recommended screenings and monitoring,
    - Prescribed drug's recommended place in therapy according to indication &/or nationally recognized treatment guidelines
    - Availability & effectiveness of preferred treatments for the same indication

    - Industry-standard clinical resources including (but not limited to): Lexi-Drug, Elsevier/Gold Standard Clinical Pharmacology, National Comprehensive Cancer Network (NCCN), UpToDate, IPD Analytics, and Facts & Comparisons
    - Trials of preferred alternatives: There is no set number of preferred medications that must be tried before a non-preferred medication can be approved. Trials of preferred alternatives is unique to each drug and may depend on factors including but not limited to available treatment alternatives, pharmacologic and therapeutic similarities between different treatments, indication, and Member's reason for failure with previous treatments. The number of trials required will be based on the clinical judgement of the physician or clinical pharmacist reviewer.
- Retrospective Drug Utilization Review (DUR) (post-claim analysis, educational programs)
    - Improve medication therapy outcome and reduce and prevent inappropriate use, fraud, or abuse.
- AB 1114 Pharmacist Services pursuant to APL ~~22-012 *Revised*~~25-013 "~~Governor's Executive Order N-01-19, Regarding Transitioning~~ Medi-Cal Rx Pharmacy Benefits and Cell and Gene Therapy Coverage ~~from Managed Care to Medi-Cal RX~~" (~~12/30/2022~~09/18/2025)
- Disease/Medication Management Programs
    - Improve medication adherence, address therapeutic gaps, and optimize medication therapy outcome.
- Support of Care Coordination and Case Management
    - Support Members with complex medication regimen, multiple health conditions, behavioral and substance use disorder.
- Support of Quality Improvement (e.g. HEDIS, outcomes measures)
    - Performance improvement in medication related quality measures

Mental Health

Members may self-refer for mental health services to mental health providers using Partnership's toll-free Behavioral Health referral number (855) 765-9703 or by contacting the preferred behavioral health provider directly. Members do not need a referral or prior authorization to receive mental health services.

In an effort to coordinate the Member's overall health care, mental health providers are instructed to ask Members to sign a release of information so that the mental health provider can contact the Member's PCP or other providers. However, the release of information is not a condition for the approval or provision of services.

Mental health services for Members with Medi-Cal as their primary insurance are provided as follows:

- Members determined to have Non-Specialty Mental Health Services (NSMHS) needs that require mild to moderate mental health treatment are served by Partnership's behavioral healthcare department which can be reached by calling (855) 765-9703.
- Members determined to require Specialty Mental Health Services (SMHS) for moderate to severe mental health conditions are referred to the County Behavioral Health Plan (BHP) in the Member's county of residence. The administration of such referrals is addressed in the respective Memorandum of Understanding (MOU) with each respective County Behavioral Health Plan, consistent with California statutes and regulations.
- DHCS requires Managed Care Plans (MCPs) and BHPs to use specific Screening and Transition of Care Tools for Members under age 21 (youth) and for Members age 21 and over (adults) to determine the appropriate mental health delivery system referral for Members who are not currently receiving mental health services when they contact the MCP or BHP seeking mental health services. These tools can be found on the DHCS website on this page: https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-Medi-Cal-Mental-Health-Services.aspx

County Behavioral Health Plans provide crisis assessments and authorizations for care. Immediate access to the crisis service remains an option throughout all phases of treatment by any provider. Each County operates crisis services ~~which~~ to address clients in crisis; crisis services also act as a backup after hours and on weekends as well as at other times of provider unavailability. Members may call the County crisis line directly, without a referral. Members eligible for mental health services from Partnership will be re-directed to appropriate County crisis services as needed.

A certain level of mental health services is appropriately dealt with in a primary care practice, including screening and referrals to services. Primary Care Providers may contact each county's Behavioral Health Plan or Partnership, as applicable, for telephone consultation. For detailed referral and consultation procedures, PCPs can refer to Partnership p~~P~~olicy ~~MPCP2017~~ MPBP8011 *Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines*.

Partnership is responsible for the delivery of non-specialty mental health services for children under age 21 and outpatient mental health services for adult beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM). Outpatient mental health services are delivered as specified in policy MPBP8003 *Mental Health Services* whether they are provided by PCPs within their scope of practice or through Partnership's provider network. Partnership continues to be responsible for the arrangement and payment of all medically necessary, Medi-Cal-covered physical health care services, not otherwise excluded by contract, for Partnership beneficiaries who require specialty mental health services.

In compliance with Mental Health Parity requirements on October 1, 2017, as required by Title 42, CFR Section 438.930, Partnership ensures direct access to an initial mental health assessment by a licensed mental health provider within the Partnership provider network. No referral from a PCP or prior authorization is required for an initial mental health assessment to be performed by a network mental health provider.

Partnership meets the general parity requirement (Title 42, CFR, §438.910(b)) which stipulates that treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. Neither a referral from the PCP, nor prior authorization, is required for a beneficiary to seek any mental health service, including the initial mental health assessment from a network mental health provider.

If a dispute occurs between the local County Behavioral Health plan and Partnership HealthPlan of California, both parties will participate in a dispute resolution process as defined in Partnership p~~P~~olicy MPBP8005 Dispute Resolution Between Partnership and BHPs in Delivery of Behavioral Health Services. This is consistent with the dispute resolution process outlined by State regulations and the individual County/Partnership Memoranda of Understanding.

Triage and Referral for Mental Health

Partnership monitors triage and referral protocols to ensure they are appropriately implemented, monitored and managed. Protocols utilized are based on sound clinical evidence and accepted industry practice. They must define the level of urgency and appropriateness of the care setting.

Triage and referrals are performed by the Behavioral Health Access Line with oversight by Partnership's Senior Director of Behavioral Health and Behavioral Health Clinical Director. Partnership works collaboratively with the respective County Behavioral Health Plans to coordinate and ensure Members receive care at the appropriate level in a timely manner.

Substance Use Disorder Treatment Services/ Wellness & Recovery Program

Partnership works to ensure that Members receive effective and appropriate behavioral health care services for both mental health and substance use disorders. Partnership provides Substance Use Disorder (SUD) treatment services as outlined in the Regional Drug Medi-Cal Model (Regional Model). SUD services are administered either by Partnership or through individual counties not participating in the Regional Model.

The range of services in the Wellness & Recovery Program include:

- Outpatient treatment (licensed professional or certified counselor, up to nine hours per week for adults)
- Intensive outpatient treatment for individuals with greater treatment needs (licensed professional or certified counselor, structured programming, 9-19 hours per week for adults)
- Detoxification services (withdrawal management)
- Residential treatment (Prior authorization is required as per policy MP~~C~~UP3144 *Residential Substance Use Disorder Treatment Authorization*)
- Medication assisted treatment (MAT) (methadone, buprenorphine, disulfiram, and naloxone). *Partnership is financially responsible for the dispensing of these medications when services occur in a contracted Narcotic Treatment Program (NTP)/ Opioid Treatment Program (OTP) facility. When MAT is prescribed outside of a NTP/OTP (e.g. dispensed through a pharmacy) the medications will be authorized through the state Medi-Cal Rx program.*
- Care Coordination
- Recovery services (aftercare)

Behavioral Health Treatment (BHT) for Members Under 21 Years of Age

Partnership has provided benefits for Behavioral Health Therapy for children diagnosed with Autism Spectrum Disorder (ASD) since September 2014. Effective July 1, 2018, Partnership expanded its benefit coverage to include Behavioral Health Treatment (BHT) for eligible Medi-Cal Members under the age of 21 as required by the Early and Periodic Screening and Diagnostic Treatment (EPSDT) mandate.

Treatment services may include Applied Behavioral Analysis (ABA) and other services known as 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 include a variety of behavioral interventions that have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence that are designed to be delivered primarily in the home and in other community settings.

Partnership will provide medically necessary BHT services covered under Medicaid (Medi-Cal) for all Members who meet the eligibility criteria for services as stated in 1905® of the Social Security Administration (SSA) and outlined in DHCS All Plan Letter (APL) 23-010 *Revised*.

- Additional detailed information regarding the BHT benefit can be found in the following Partnership Policies and Procedures:
  - MC~~P~~UP3126 *Behavioral Health Treatment (BHT) for Members Under the Age of 21*
  - MP~~C~~CP2014 *Continuity of Care*

Quality Improvement Collaboration

The UM team works collaboratively with the Quality Improvement (QI) Department to enhance the care provided to our Members through venues such as the Internal Quality Improvement Committee (IQI), the Quality/ Utilization Advisory Committee (Q/UAC) and daily UM activities.

In the committee environment, the UM team takes an analytical, evaluative and strategic look at predetermined metrics to evaluate and offer recommendations which further enhance the UM program. Data is reviewed and discussed at least bi-annually during the IQI and Q/UAC meetings. The Q/UAC provides guidance and direction to the UM program by coordinating activities and by functioning as the expert panel when needed. Collaboration includes but is not limited to:

- Reviewing, making recommendations to, and approving the *UM Program Description* annually
- Assuring individual Member needs are taken into consideration when determinations for care are rendered
- Analyzing summary data and making recommendations for action
- Reviewing the recommendations of Process Implementation Teams to develop UM improvement action plans, ongoing monitoring, and evaluation
- Recommending medical policy, protocol, and clinical practice guidelines based on provider and Member experience information.

During daily activities, the UM team supports QI efforts in the identification of potential quality of care issues, reporting adverse occurrences identified while conducting UM case review, improvement of Healthcare Effectiveness Data and Information Set (HEDIS®) scoring by referrals to care coordination, and care coordination efforts to ensure Members are seen by the appropriate provider for their condition.

UTILIZATION MANAGEMENT PROCESS

Partnership applies written, objective, evidence-based criteria (InterQual® and pharmaceutical criteria) and considers the individual Member's circumstance and community resources when making medical appropriateness determinations for behavioral health and physical health care services.

Appropriately licensed professionals supervise all medical necessity decisions as described in the UM Program Staff section starting on page four (4). 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 UM decision making is based only on appropriateness of care and service.

Furthermore, Partnership does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service. 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.

Working with practitioners and providers of care, the following factors are taken into consideration when applying guidelines to a particular case in review:

- Input from the treating practitioner
- Age of Member
- Comorbidities in existence
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment
- Consideration of the local delivery system, ~~and~~ availability of services and their ability to meet the Member's specific health care needs to include but not be limited to:

- Availability of inpatient, outpatient, transitional and residential treatment (SUD) facilities
  - Availability of outpatient services
  - Availability of highly specialized services, such as transplant facilities or cancer centers
  - Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge
  - Local hospitals' ability to provide all recommended services
- Benefit coverage

Referrals and requests for prior authorization of services are to be submitted by the provider of service to the Partnership UM department by fax or through Partnership's Online Services portal, which is a Secure Electronic Internet system. The following information must be provided on all requests.

- Member demographic information
- Provider demographic information
- Requested service/procedure to include specific CPT/HCPCS code(s)
- Member diagnosis (Using current ICD Code sets)
- Clinical indications necessitating service or referral
- Pertinent medical history, treatment or clinical data
- Location of service to be provided
- Requested length of stay for all inpatient requests
- Proposed date of procedure for all outpatient surgical requests

Pertinent data and information is required to enable a thorough assessment of medical necessity.
If information is missing or incomplete, the requestor will be notified and given an opportunity to submit additional information.

Addition of Benefits and Modifications of TAR Requirements
The process for adding a new Partnership benefit and specifying TAR requirements, as well as the process for adding or removing TAR requirements for existing benefits, both begin when a request is submitted by a Provider, Member, or Staff. The following information should be included:

- Justification for the new benefit and/or change in TAR requirements
- Identification of Member population that would benefit
- Relevant clinical information
- TAR requirements (e.g. Will a TAR be required? Will TAR requirements be removed?)

The Chief Medical Officer (CMO) or Physician Designee reviews the request, with input from the Chief Health Services Officer. Feedback may also be sought from relevant specialists, physician committees, or advisory committees to determine whether new benefits and/or TAR requirements should be added, and under what criteria, or if existing requirements should be removed.

Operational review is conducted through the Benefit Review and Evaluation Workgroup (BREW), which includes leaders from clinical, operational, financial, and regulatory areas. BREW examines the medical, financial, and operational implications and presents findings to the Executive Committee. The Executive Committee may consult the Physician Advisory Committee (PAC), approve minor changes such as single CPT codes, or recommend larger benefit changes to the Board for approval. They also oversee necessary IT, claims, and financial adjustments, including potential recommendations to state regulators. This structured process ensures medical necessity, operational feasibility, and financial sustainability are carefully considered before new benefits are adopted and TAR requirements are applied.

Elective Admission Precertification
The UM department evaluates every proposed treatment plan, and determines benefit eligibility, suitability of location and level of care prior to the approval of service delivery for select diagnoses and procedures.

Utilizing written criteria such as InterQual®, Medi-Cal c~~C~~riteria and Partnership medical policy approved by the Q/UAC, licensed and professional UM staff review and approve completed Treatment Authorization Requests (TARs).

Only the Chief Medical Officer or physician designee may make a medical necessity determination and have the authority to deny a service request based on lack of medical necessity. Partnership offers the practitioner the opportunity to discuss any medical necessity denial determination with the physician reviewer rendering the decision.

Referral Management
Referrals are generated by the primary care provider and submitted to Partnership's Online Services (OLS) portal (or by fax or mail). Partnership monitors and analyzes requests to identify trends and assist in follow-up care. Requests for out-of-network referrals are reviewed to determine if the service is available and can be provided within Partnership's network. Out-of-Network requests are also used to evaluate provider access and to determine if the local network requires enhancements to meet Member needs.

Continued Stay/Concurrent Review
Acute care hospitalization reviews are performed by licensed professionals to ensure medical necessity of continued stay, the appropriateness of level of care, and care duration. This review is conducted either on site, by accessing the facility electronic medical record through a secure portal, or telephonically using written Partnership medical policy, InterQual®, and/or Medi-Cal guidelines.

Requests for authorization are reviewed within 24 hours of notification of admission and concurrently throughout the stay. The UM team facilitates discharge planning in collaboration with the facility care team and makes referrals to Partnership case management and social services as appropriate.

Consideration of available services in the local service area or delivery system and the ability to meet the Member's specific health care needs are evaluated as part of application of criteria and the development of an ongoing plan of care and discharge plan.

Only the Chief Medical Officer or physician designee has the authority to deny a request for service based on lack of medical necessity. Partnership offers the practitioner with clinical expertise in the area being reviewed the opportunity to discuss the application of criteria in determining medical necessity or any determination based on lack of clinical justification with the physician reviewer.

In addition to individual conversations with practitioners on specific case reviews, Partnership conducts several committees for the purpose of hearing and incorporating practitioner input in the development of medical policy. Partnership, through the Physician Advisory Committee (PAC), the Quality/ Utilization Advisory Committee, and the Pharmacy and Therapeutics Committee (P&T), provides practitioners with clinical expertise in several areas the opportunity to advise or comment on the development and/or adaptation of UM criteria and provide feedback or instruction on the application of ~~that~~ those criteria. Within the previously stated committees, Partnership evaluates UM criteria and procedures against current clinical and medical evidence and updates them accordingly.

Skilled Nursing/Sub acute/ Long-Term Acute/Rehabilitation Facility Review
Review of all Skilled Nursing and Rehabilitation Facility confinements are performed by licensed professionals to ensure medical necessity of continued stay and the appropriateness of level and duration of care. This review is conducted telephonically using written Partnership medical policy, Title 22 criteria, and/or InterQual® criteria. Requests for authorization are reviewed within 24 hours of notification of admission. The UM team facilitates discharge planning in collaboration with the facility care team and makes referrals to Partnership case management and social services as appropriate.

Consideration of available services in the local service area or delivery system, and the ability to meet the Member's specific health care needs are evaluated as part of applying criteria and the development of an ongoing plan of care and discharge plan.

Discharge Planning
Discharge planning is a critical component of the utilization management process and begins upon admission with an assessment of the patient's potential discharge needs. It includes preparation of the family and the patient for continuing care needs and initiation of arrangements for services or placement needed after acute care discharge.

Partnership Nurse Coordinators work with hospital discharge planners, case managers, admitting/attending physicians and ancillary service providers to assist in making necessary arrangements for post-discharge needs.

Post-Service Retrospective Review
Post-service retrospective reviews may occur when a Member is retroactively granted Medi-Cal benefits by the State of California, when a provider does not realize an authorization is required prior to rendering a service, when the rendered service code billed does not match the code authorized, or the service may have been rendered after the expiration of the authorization. TARs must be received by Partnership within 15 business days of the date of service or within 60 calendar days of either a denial from the primary insurance carrier or retrospective eligibility. (TARs submitted beyond these timeframes are considered late but will still be reviewed for medical necessity.)

All retrospective reviews are completed within 30 calendar days of receipt of request. 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.

Services requiring an authorization can be retrospectively reviewed for medical necessity, appropriateness of setting, and length of stay up to one year after services are rendered and may result in an adverse determination.

Emergency Room Visits
Emergency room visits where a prudent layperson, acting reasonably, would believe an emergency condition exists, DO NOT require prior authorization.

Timeliness of UM and Pharmacy Decisions

Partnership makes UM and Pharmacy decisions in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of care. Partnership measures the timeliness of decisions from the date when the organization receives the request from the Member or PCP, even if the Partnership does not have all the information necessary to make a decision. Partnership documents the date when the request is received and the date a decision is rendered in the UM documentation system.

Partnership has communicated to both providers and Members the practice of processing non-urgent requests during the next business day if the request is received after business hours.

Partnership Utilization Management abides by the following timeliness guidelines when processing health services requests.

Urgent Requests
A request for medical care or services where application of the time frame for making routine or non-life threatening care determinations could jeopardize the live, health or safety of the Member or others due to the Member’s psychological state or, in the opinion of the practitioner with knowledge of the Member’s medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment requested.

Concurrent Review 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 the organization did not previously approve the earlier care.

Pre-Service Request
A request for medical care or services that Partnership must approve in advance, in whole or in part.

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.

Post-Service Request / Retrospective Review
A request for medical care or services that have been received.

Non-Behavioral Healthcare Decisions~~, Pharmacy Decisions,~~ and Behavioral Healthcare Decisions

Type of Request	Decision Time Frame	Notification[1] Time Frame	Extended Time Frame
Urgent concurrent review	72 hours of receipt of request	72 hours of receipt of request	May be extended one time up to 14 calendar days from receipt of request
Urgent pre-service	72 hours of receipt of request	72 hours of receipt of request	May be extended one time up to 14 calendar days from receipt of request
Non-urgent pre-service	~~5 business~~7 calendar days of receipt of request	24 hours of determination date[1]	May be extended ~~*two (2*~~one~~)~~ time~~s~~ ~~for~~ up to 14 calendar days ~~each period (28 days total~~ from receipt of request~~)~~ ~~[2]~~
Post-service	30 calendar days of receipt of request	30 calendar days of receipt of request	N/A

[1] Notification: Give electronic or written notification of decision to practitioner (and Member when required). *Per DHCS requirement, written notification must be mailed to a Member within two (2) business days of the decision.*
~~[2] Per DHCS regulations~~

Pharmacy Decisions

Type of Request	Decision Time Frame	Notification Time Frame	Extended Time Frame
Urgent concurrent review	24 hours of receipt of request	24 hours of receipt of request[3]	May be extended one time up to 14 calendar days from receipt of request [4]
Urgent pre-service	24 hours of receipt of request	24 hours of receipt of request [3]	May be extended one time up to 14 calendar days from receipt of request [4]
Non-urgent pre-service	24 hours of receipt of request	24 hours of receipt of request [3]	May be extended one time up to 14 calendar days from receipt of request [4]
Post-service	30 calendar days of receipt of request	30 calendar days of receipt of request	N/A

[3] Notification Time Frame: Per DHCS regulations
[4] Extended Time Frame: Per DHCS regulations

Review Criteria
Current InterQual® criteria sets are used as the main review guidelines. Additional criteria are selected or developed using other resources as necessary to help in determining review decisions which include, but are not limited to, Medi-Cal (State of California) guidelines and State policy letters (see policy MP~~C~~UP3139 *Criteria and Guidelines for Utilization Management*). InterQual® criteria are produced using a rigorous development process based on evidence-based medicine and reviewed at least annually, but as frequently as quarterly, by a panel of board-certified specialists. All UM policies are based on InterQual® criteria and are reviewed annually by the Quality/Utilization Committee (Q/UAC) and the Physician Advisory Committee (PAC) which also include board-certified specialists who are practicing network physicians. All Pharmacy policies are reviewed annually by the Pharmacy and Therapeutics (P&T) Committee and PAC. Refer to pharmacy policies MCRP4068 *Medical Benefit Medication TAR Policy* and MPRP4001 *P&T Committee* for further details regarding pharmaceutical criteria.

In the absence of applicable criteria, the Partnership UM medical staff refers the case for review to a licensed, board-certified practitioner in the same or similar specialty as the requested service. The reviewing practitioners base their determinations on their training, experience, the current standards of practice in the community, published peer-reviewed literature, the needs of the individual patients (age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable), and characteristics of the local delivery system. Board-certified consultants are available through our providers on our Quality/Utilization Advisory Committee (Q/UAC). Partnership also contracts with a third-party independent medical review organization which provides objective, unbiased medical determinations to support effective decision making based only on medical evidence. (See policy MP~~C~~UP3138 *External Independent Medical Review*.)

Criteria are selected, reviewed, updated or modified using feedback from the Q/UAC and PAC as well as Member feedback identified in Member survey results and the Community Advisory Committee (CAC), State policy letters, State Memorandums of Understanding and/or medical literature, among other sources. In collaboration with actively practicing practitioners, criteria are evaluated on at least an annual basis. Relevant clinical information is obtained when making a determination based on medical appropriateness and the treating practitioner is consulted as appropriate. All information obtained to support decision-making is documented in the utilization management documentation system.

Decisions are based on information derived from the following sources:

- Clinical records
- Medical care personnel
- Facility utilization management staff
- Attending physician (attending physician can be the primary care physician, hospitalist or the specialist physician (or all three as necessary)
- Board-certified specialists are consulted when medically necessary

When applying criteria to a treatment request, reviewers consider the needs of the individual patient (age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable) as well as the availability of services in the local delivery system and their ability to meet the Member's specific health care needs.

Inter-Rater Reliability (IRR)
Partnership assesses the consistency with which physician and non-physician reviewers apply UM criteria in decision making and evaluates Inter-Rater Reliability. The Inter-Rater Reliability mechanism uses live cases to ensure medical management criteria are appropriately and consistently applied in making UM determinations. The methodology employed is designed to annually assess 50 cases or 5% of reviewer case load, whichever is less, over the course of a year period.

The following types of reviews/reviewers are audited:

- Nurse Coordinator Review of Inpatient Services
- Nurse Coordinator Review of Outpatient Services

- Nurse Coordinator Review of Long Term Care Services
- Behavioral Health (BH) Nurse Coordinator Review of Residential Substance Use Disorder Treatment Authorizations
- Physician Review of Medical Necessity Authorizations
- Pharmacist and Pharmacy Technician Review of Pharmacy TARs

A performance target of 90% accuracy is set for inter-rater reliability. An audit summary is reported at least annually or more often as needed to the Internal Quality Improvement (IQI) Committee. If a reviewer falls below the targeted threshold, a corrective action plan is initiated and monitored and results are presented to the Quality/Utilization Advisory Committee (Q/UAC) for review and discussion. Please refer to policy MPUP3026 *Inter-Rater Reliability Policy* for a full description of the IRR process.

Availability of Criteria

All criteria used to review authorization request are available upon request. In the case of an adverse determination, the criteria used are made part of the determination file. Access to and copies of specific criteria utilized in the determination are also available to any requesting practitioner by mail, fax, email, or on our website: http://www.partnershiphp.org. To obtain a copy of the UM criteria, practitioners may call the Partnership UM Department at (800) 863-4155.

Members may request criteria used in making an authorization determination by calling the Member Services department to request a copy of the criteria. The UM team will work with Member Services to provide the criteria used in the review decision.

Partnership's Provider Relations Department notifies providers in writing and electronically through the New Provider Credentialing Packet and the provider's contract that UM criteria is available online at http://www.partnershiphp.org in the Provider Manual section. Providers are also notified quarterly ~~in writing~~through electronic mail and fax via the Quarterly Provider Newsletter about the on-line availability of UM criteria and policies at http://www.partnershiphp.org in the Medi-Cal Provider Manual section.

Partnership's UM Program plans include development and implementation of its CMS Final Rule Interoperability plan during CY 2026. This plan will include steps for the implementation of practitioner access to criteria electronically at point of service. Implementation is planned for January 2027.

Communication Services

Partnership provides access to UM staff for Members and practitioners seeking information about the UM process and the authorization of care in the following ways:

- 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 HealthPlan is in operation (Monday - Friday 8 a.m. - 5 p.m.).
- For after-hours communication regarding UM issues, telephonic voicemail service is available. Members and practitioners may leave a message which is communicated to the appropriate person on the next business day. Calls received after normal business hours are returned on the next business day, hence, calls received after midnight on Monday - Friday are returned on the same business day.
- After normal business hours, Members may contact the advice nurse line at (866) 778-8873 for assistance with clinical concerns.
- Practitioners, both in-network and out-of-network, may contact UM staff directly either through secure email or voicemail. Each voicemail box is confidential and will accept messages after normal business hours. Communications received after normal business hours are returned on the next business day, hence communications received after midnight on Monday - Friday are responded to on the same business day.
    - Partnership has a dedicated after-hours phone number local (707) 430-4808 or toll free (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 staff are available 24 hours per day, 7 days per week to coordinate the transfer of a Member whose emergency medical condition is stabilized.

- Partnership 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 the Program Staff section of this document starting on page four (4) above.
- Partnership maintains a toll-free number (800) 863-4155 that is available to both Members and practitioners.
- Members can view information about Partnership's language assistance services and disability services in the Member Handbook which is made available to Members upon enrollment and is always viewable online at http://www.partnershiphp.org/Members/Medi-Cal/Documents/MCMemberHandbook.pdf Additionally, Partnership provides annual written notice to Members about our language assistance services and disability services (e.g. TTY for hearing impaired) in our Member Newsletter.

Linguistic services are provided by Partnership to monolingual, non-English speaking or limited English proficiency (LEP) Medi-Cal beneficiaries as well as eligible Members with disabilities for population groups as determined by contract. These services include the following:

No Cost Linguistic Services:

- 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
- Written information and materials (to include notice of action, grievance acknowledgement and resolution letters) are fully translated by qualified translators into threshold languages for Partnership Members according to regulatory timeframes, and into other languages or accessible formats upon request. Alternative material formats available to Members include audio format, Braille, large-size print format, and accessible electronic format for Members with hearing and/or visual disabilities. Auxiliary aids are also available upon request. Please refer to MPND9002 Cultural and Linguistic Program Description for more information. 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.
- Use of California Relay Services for hearing impaired [TTY/TDD: (800) 735-2929 or 711]

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. (See policy MPND9002 *Cultural and Linguistic Program Description*)

Denial Determinations

Denial determinations may occur at any time in the course of the review process. Only the Chief Medical Officer, or a physician designee acting through the designated authority of the Chief Medical Officer, has the authority to render a denial determination based on medical necessity which is defined as "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."

A denial determination may occur during continued stay/concurrent review in which case notification and/or discussion with the treating practitioner and the Health Plan physician adviser/Chief Medical Officer or physician designee is offered.

Denial determinations may occur at different times and for various reasons including but not limited to:

- At the time of prior authorization; when the requested service is not medically indicated or not a covered benefit.
- When timely notification was not received from a facility for an inpatient stay to foster transfer of a medically stable patient
- When an inpatient facility fails to notify the Health Plan of admission within one business day of the admission or appropriate clinical information is not received
- When out-of-network services are not clinically appropriate
- Or after services are rendered at claims review when the services were not authorized, or are medically unnecessary

A denial may also occur for inappropriate levels of care or inappropriate care. Notwithstanding previous authorization, payment for services may be denied if it is found that information previously given in support of the authorization was inaccurate.

Partnership offers the practitioner the opportunity to discuss any denial or potential denial determination based on lack of medical necessity with the Health Plan Chief Medical Officer, or a physician designee.

The denial notification states the reason for the denial in terms specific to the Member's condition or service request and in language that is easy to understand and references the criterion used in making the determination so the Member and provider have a clear understanding of the Health Plan's rationale and enough information to file an appeal.

Partnership HealthPlan of California is aware of the need to be concerned about under-utilization of care and services for our Members. Partnership monitors over and under-utilization through the Over/Under Utilization Workgroup which reviews annual utilization patterns. Decisions made by Partnership's Utilization Reviewers are solely based on the appropriateness of the care or service.

The Health Plan does not compensate any individual involved in the utilization process to deny care or services for our Members nor do we encourage or offer incentives for denials.

Process for a Member or a Provider on Behalf of a Member to Appeal an Adverse Benefit Determination ~~on Behalf of a Member~~

Members and providers are provided fair and solution-oriented means to address perceived problems in exercising rights as a Medi-Cal beneficiary or provider, in accordance with requirements of Partnership's contract with the Department of Health Care Services (DHCS). This process is entirely separate from that of State Fair Hearings, to which Members retain their access. The Member or their authorized representative may submit a request for appeal verbally or in writing. The Member or the authorized representative may submit additional information for review and may request copies of all documents considered as part of the review. The time for resolution begins when the request is received, even if the information provided is incomplete. Partnership makes appropriate attempts to obtain any needed information for review within the required timelines, in order to make an informed decision within required timeframes based on clinical urgency and according to our policies and procedures. Please refer to Partnership policy MCUP3037 *Appeals of Utilization Management/ Pharmacy Decisions* for a full description of the process.

Data Sources

Utilization Management supports the effective, efficient, and appropriate utilization of Member benefits through ongoing review, evaluation and monitoring of the Member's personal health information in making medical necessity determinations.

Data sources may include, but are not limited to:

- Medical records, from outpatient provider offices and hospital records (including accessing hospital Electronic Medical Records (EMR); for current and historical data
- Member handbook/Evidence of Coverage
- Consultations with treating physicians
- Network adequacy information
- Local delivery system capacity information
- Specialist referrals
- Recent Physical exam results
- Diagnostic testing results
- Treatment plans and progress notes
- Operative and pathological reports
- Rehabilitation evaluations
- Patient characteristics and information
- Patient psychosocial history
- Information from family / social support network
- Prospective/concurrent/retrospective utilization management activities
- Claim/encounter (administrative) data

Data Collection, Analysis, and Reporting

Data collection activities for analysis and reporting are coordinated by the UM department. At the data gathering/performance measurement phase, participants in the process include programmers and analysts in the Finance and Health Services departments, staff nurses, and any other personnel required for the collection and validation of data. All data collection activities are documented and reported to the Q/UAC twice a year and more often if requested. Data collection activities may include, but are not limited to:

- Member satisfaction surveys
- Provider satisfaction surveys
- Readmission statistics
- Potential quality incident data
- Member appeal data
- Provider appeal data
- Internally developed databases
- Pharmacy utilization data
- Other administrative or clinical data
- Member utilization data
- Provider prescribing data

EVALUATION OF NEW MEDICAL TECHNOLOGY

Partnership evaluates the inclusion of new medical technologies and the new application of existing technologies in its benefit packages. While the basic benefits are set by the State of California Department of Health Care Services (DHCS) and outlined in Title 22 of the Health and Welfare Code, Partnership has the option of adding to this basic package of benefits for its Members.

Partnership's Policy M~~C~~PUP3042 *Technology Assessment* outlines the steps taken during the determination process. The Partnership Physician Advisory Committee will review all cases and make a final recommendation to the Board of Commissioners as to new benefits. The Commission is the only entity that can add benefits.
Once a new benefit is added, the information is disseminated to all Primary Care Providers and appropriate specialists in the form of a mail notification of benefit addition, and to all Members in the next Member newsletter.

New technologies are handled on a case-by-case basis which includes obtaining information regarding the safety, efficacy and indications that support the use of the intervention. There must be evidence that the proposed intervention will add to improved outcomes as compared to what is currently available. The service provider must have a record of safety and success with the intervention and cannot be part of a funded research protocol. The Chief Medical Officer works closely with the requesting physician and specialists as needed in researching these cases.

DELEGATION

UM activities that are delegated to contract providers are reviewed and approved on an annual basis by the Quality/Utilization Advisory Committee (Q/UAC). A delegation agreement, including a detailed list of activities delegated and reporting requirements is signed by both the delegate and Partnership.

- Providers to whom UM activities have been delegated are responsible for reporting results and analyses to Partnership on a quarterly or annual basis. Reports are summarized for review and evaluation by Partnership's Delegation Oversight Review Sub-Committee (DORS) and Q/UAC.
- Audits are conducted no less than annually and evaluation includes a review of both the processes applied in carrying out delegated UM activities, and the outcome achieved in accordance with the respective policy(s) and agreement governing the delegated responsibility.
- The Q/UAC reviews evaluations and make recommendations regarding opportunities for improvement and continuation of delegated functions.

A pre-delegation evaluation is conducted when delegation of functions to providers is being considered.

Protected Health Information (PHI)

The Privacy Rule, described in 45 CFR Parts 160 and 165, applies to covered entities. The Privacy Rule allows covered providers, entities, and health plans to disclose PHI in order to carry out their health care functions.

Partnership HealthPlan of California is fully compliant with the general rules, regulations and implementation specified in The Privacy Rule. Partnership also provides reasonable administrative, technical, and physical safeguards to ensure PHI confidentiality, integrity and availability and to prevent unauthorized or inappropriate access, use or disclosure of PHI.

The Partnership Director of Regulatory Affairs and Program Development also serves as the Partnership Privacy Officer. Partnership has implemented a comprehensive program that includes "Notice of Privacy Practices" (NPP) sent to all Members, as well as implementation of a confidential toll-free complaint line available to Members, providers and Partnership staff. For non-covered entities, Partnership requires Business Associate Agreements (BAA). Additionally, there is training on an annual basis for the Partnership workforce and Partnership providers/networks, and Partnership maintains policies and procedures around documentation of complaints of violations or suspected privacy incidents.

STATEMENT OF CONFIDENTIALITY

Confidentiality of provider and Member information is ensured at all times in the performance of UM activities through enforcement of the following:

- Members of the Q/UAC and PAC are required to sign a confidentiality statement that will be maintained and securely stored in the QI files.
- UM documents are restricted solely to authorized Health Services Department staff, members of the PAC, Q/UAC, and Credentials Committee, and reporting bodies as specifically authorized by the Q/UAC.
- Confidential documents may include, but are not limited to, Q/UAC and Credentials Committee meeting minutes and agendas, QI and Peer Review reports and findings, UM reports, or any

correspondence or memos relating to confidential issues where the name of a provider or Member are included.

- Confidential documents are stored in locked file cabinets with access limited to authorized persons only, or they are electronically archived and stored on protected drives.
- Confidential paper documents are destroyed by shredding.
- Partnership has designated a Privacy Officer responsible to oversee compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other state and federal privacy laws.
- Partnership maintains administrative structure, reporting procedures, due diligence procedures, training programs and other methods to ensure effective compliance in use and disclosure of Members' Protected Health Information (PHI).

Non-Discrimination Statement

Partnership complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin (including limited English proficiency (LEP) and primary language), age, disability, or sex (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes).

Partnership will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily are exclusively available. Also, Partnership will not otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.

Partnership provides free aids and services to people with disabilities to communicate with us, such as:

- Qualified sign language interpreters or Video Remote Interpreters (VRI)
- Written information in other formats (large print, audio, Braille, accessible electronic formats, other formats)

Partnership provides free language services to people whose primary language is not English or those with limited English proficiency (LEP). These services include the following:

- Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact
- Information written in other languages
- Use of California Relay Services for hearing impaired

Statement of Conflict of Interest

Any individual who has been personally involved in the care and/or service provided to a patient, an event or finding undergoing quality evaluation may not vote or render a decision regarding the appropriateness of such care. All members of the Q/UAC are required to review and sign a conflict of interest statement, agreeing to abide by its terms.

Provider and Member Satisfaction

Partnership conducts satisfaction surveys ~~on~~ with both Members and providers. Included in the evaluation are questions that deal with both Member and provider satisfaction with the UM program. The responses to the survey are reviewed by staff from Health Services, Member Services, and Provider Services. Thresholds are set and responses that fall below are considered for corrective action by the HealthPlan. The results, as well as plans for corrective action, are developed in conjunction with the Q/UAC. Corrective actions that were in place are evaluated at the time the follow-up annual survey is done unless the committee feels an expedited time frame needs to be implemented.

Annual Program Evaluation

The Utilization Management program undergoes a written evaluation of its overall effectiveness annually by the Q/UAC, which is reviewed and approved by the PAC.

At a minimum the evaluation considers UM department activities and outcomes, the review of Key Performance Indicator metrics such as Productivity, Timeliness, Bed-days, readmission rates and denial rates along with resource effectiveness and barriers to performance.

Preparation for the Annual Program Evaluation involves participation by all Utilization Management, ~~and~~ Pharmacy and Behavioral Health leadership including but not limited to:

- Chief Health Services Officer
- Senior Director of Care Management
- Senior Director of Behavioral Health
- Director, Pharmacy Services
- Director of Enhanced Health Services
- Directors of UM
- Associate Directors of UM
- UM Managers

Elements of the program evaluation include an objective assessment of meeting targeted goals to ensure appropriate, efficient utilization of resources/services for Partnership Members across the continuum of care in compliance with requirements of state/federal and regulatory entities.

- Annual UM Program Description update
- Annual review and evaluation of UM processes (meeting goals and identifying opportunities for process improvements)
- Timely review and update of UM policies and procedures
- Obtain approval of UM policies and procedures at Q/UAC

Inter-Rater Reliability (IRR) scoring and TAR timeliness are compared with regulatory compliance standards and internal benchmarks.

To determine if the UM program remains current and appropriate, the organization annually evaluates:

- The program structure
- The program scope, processes, and information sources used in the determination of benefit coverage and medical necessity
- The level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program
- Consideration of Member and practitioner experience data when evaluating the UM program

The organization updates the UM program and its description annually based on the evaluation.

To ensure the provision of healthcare services at the appropriate level of care the evaluation considers:

- Inpatient bed day rate
- Inpatient average length of stay
- SNF admit rate
- SNF average length of stay
- Readmission rate
- Denial rate
- Timely completion of notifications of denial of care
- Timely completion of notifications of authorization of care
- Rate of referrals to Care Coordination

- Effectively integrating feedback - the program reflects on Member/Provider satisfaction results concerning the UM program looking at:
  - Daily Work Flow Monitoring
  - Call Abandonment rates
  - Call Volume
  - Average caller wait time

An assessment of Department resources is determined by looking at the impact of staffing changes, learning curves and system limitations which impede work effectiveness. There is a review of Inter-Rater Reliability scoring in relation to staff training/re-education, acclimation to new technology such as documentation software/ hardware based on evaluating user acceptance, and the assessment of appropriate staffing ratio to ensure adherence to regulatory and internal performance standards.

A summary of the program evaluation, including a description of the program, is provided to Members or practitioners upon request.

REFERENCES:

- Department of Health Care Services (DHCS) standards
- National Committee for Quality Assurance (NCQA) Guidelines UM Standards
- Covered Outpatient Drugs, SSA 1927(k)(2), SSA 1927(k)(3)
- California State Department of Health Care Services (DHCS) Medi-Cal Rx Resources and Reference Materials:
- https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/Medi-CalRX.aspx
- State Medi-Cal Managed Care Plans: https://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx

Original Date: QI/UM Program 04/22/1994 effective 05/01/1994**Revision Date(s): 08/16/95**
Revision Date(s): UM Program Description - 04/17/97; Board Approval January 28, 1998; 06/10/98; 01/20/99; 05/2000; 05/01/01; (UD100301) 03/20/02; 08/20/03; 10/20/04; 10/13/05; 06/21/06; (MPUD3001) 04/16/08; 08/03/10; 11/19/14; 02/17/16; 04/19/17; *06/13/18; 04/10/19, 06/12/19 *(Amended)*, 11/13/19 *(Amended);* 04/08/20; 06/10/20 (*Amended*); 04/14/21; 01/12/22; 05/11/22; 05/10/23; 05/08/24; 05/14/25; 10/08/25; 03/11/26; 05/13/26

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

UM Program Description Approval

	~~02/18/2026~~04/15/2026

Robert Moore, MD, MPH, MBA — *Date Approved*
Quality/Utilization Advisory Committee Chairperson

	~~03/11/2026~~05/13/2026

Angela Brennan, DO — *Date Approved*
Physician Advisory Committee Chairperson

	~~04/22/2026~~06/24/2026

Dean Germano — *Date Approved*
Board of Commissioners Chairperson

Partnership HealthPlan of California

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

Policy and Procedure MPUD3001

May 2026

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Program Purpose

Partnership HealthPlan of California is a County Organized Health System (COHS) contracted by the State of California to provide Medi-Cal Beneficiaries with a health care delivery system to meet their medical needs.

The mission of Partnership HealthPlan of California is "To help our Members, and the Communities we serve, be healthy." Our vision is to be "the most highly regarded health plan in California."

Partnership has program descriptions and policies to describe the structures needed to provide high quality health care while being stewards of taxpayer resources. In the Utilization Management Program Description, Partnership outlines the structure of our measurement and management of utilization of health care services within our system.

The Partnership Utilization Management (UM) program serves to implement a comprehensive integrated process that actively evaluates and manages utilization of health care resources delivered to all Members, and to actively pursue identified opportunities for improvement.

The utilization program resides within the Health Services Department, which consists of eight (8) teams including:

- Utilization Management
- Behavioral Health
- Care Coordination
- Population Health
- Pharmacy
- Quality Improvement
- Health Equity
- Enhanced Health Services

The Partnership UM program 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
- Ensure that the setting in which the service is delivered is consistent with the medical care needs of the individual

The UM program provides a reliable mechanism to review, monitor, evaluate, recommend and implement actions on identification and correction of potential and actual utilization and resource allocation issues.

Partnership recognizes the potential for under-utilization and takes appropriate steps and actions to monitor for this. The processes for UM decision making are based solely on the appropriateness of care and services and existence of coverage. Partnership does not reward practitioners or other individuals for issuing denials of coverage. 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.

Program Objectives

UM Program Objectives

The Partnership UM program serves to ensure that appropriate, high quality cost-effective utilization of health care resources is available to all Members. This is accomplished through the systematic and consistent application of utilization management processes based on current, relevant medical review criteria and expert clinical opinion when needed. The utilization management process provides a system that ensures equitable access to high quality health care across the network of providers for all eligible Members as follows:

- Ensures authorized medically necessary services are covered under contract with the State of California Department of Health Services (DHCS) California Code of Regulations (CCR) Title 22 - For Medi-Cal Members (Title 22)

- Coordinates thorough and timely investigations and responses to Member and provider reconsideration and appeals associated with utilization issues
- Initiates needed operational revisions to prevent problematic issues from reoccurring
- Ensures that services which are delivered are medically necessary, which is defined as "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," and that those services are consistent with diagnosis and level of care required for each individual, taking into account any co-morbid condition that exists and the ability of the local delivery system to meet the need. Other examples of service-types requiring medical necessity review include (but are not limited to):
  - Services where continuing previously established care is necessary
  - Pharmaceuticals covered under Partnership's medical benefit
  - Out-of-network services that are only covered in clinically appropriate circumstances
- Educates Members, practitioners, providers and internal staff about Partnership's goals for providing quality, cost-effective, managed health care
- Defines the methods by which utilization criteria and clinical practice guidelines are selected, developed, reviewed, and modified based upon appropriate and current standards of practice and professional review
- Promotes and ensures the integration of utilization management with quality monitoring and improvement, risk management, and case management activities
- Ensures a process for critical review and assessment of the UM program and plan on, at minimum, an annual basis, with updates occurring more frequently if needed. The process incorporates provider, practitioner and Member input along with any regulatory changes, changes to current standards of care, and technological advances
- Evaluates the ability of delegates to perform UM activities and to monitor performance

Program Structure

This section outlines the individual program staff and their assigned activities and responsibilities, including approval authority and the involvement of the designated physician.

PROGRAM STAFF

Office of CMO Program Staff

Chief Medical Officer (CMO) – MD/DO
The Chief Medical Officer is responsible for the implementation, supervision, oversight and evaluation of the UM Program.

This position provides guidance and overall direction of UM activities and has the authority to make decisions based on medical necessity which result in the approval or denial of coverage. The assigned activities for this position include but are not limited to:

- Assuring that the UM program fulfills its purpose, works towards measurable goals, and remains in regulatory compliance
- In collaboration with the Chief Health Services Officer, the Senior Director of Care Management, and the Director(s) and Associate Directors of Utilization Management; oversees UM program operations and assists in the development and coordination of UM policies and procedures.

- Reviews for the consistent application of UM decision criteria at least annually and implements corrective actions when needed
- In collaboration with the Health Equity Officer (HEO), oversees Quality Improvement and Health Equity Transformation Program (QIHETP) operations and serves as Co-Chair of the Quality Improvement and Health Equity Committee (QIHEC)
- Serves as the Committee Chair for the Quality/Utilization Advisory Committee (Q/UAC) and regularly attends the Physician Advisory Committee (PAC). CMO (or designee) also serves as the Pharmacy and Therapeutics (P&T) Committee Chair.
- Ensures timely medical necessity review and decisions are made by daily staffing physicians for medical review consultation
- Guides and assists in the development and revision of Partnership medical policy, criteria, clinical practice guidelines, new technology assessments, and performance standards for Q/UAC review, adaptation and PAC approval
- As the chairman of the Q/UAC, presents UM activities on a regular basis to the Q/UAC and provides periodic updates on utilization management activities to the PAC and the Board of Commissioners
- Evaluates the overall effectiveness of the UM program
- Evaluates and uses provider and Member experience data when evaluating the UM program, in collaboration with the Chief Health Services Officer and appropriate committees

Deputy Chief Medical Officer (Deputy CMO) – MD/DO

The Deputy CMO assists the CMO in being responsible for the implementation, supervision, oversight and evaluation of the UM Program.

This position provides guidance and overall direction of UM activities and has the authority to make decisions based on medical necessity which result in the approval or denial of coverage. The assigned activities for this position include but are not limited to:

- Serves on Quality/Utilization Advisory Committee (Q/UAC), Pharmacy & Therapeutics (P&T) Committee, Credentials Committee and Internal Quality Improvement (IQI) Committee as requested by the CMO. May work with community provider committees and Advisory boards on medical issues and policies.
- Supervises and evaluates other Medical Directors as assigned (direct reports)

Medical Director for Quality - MD/DO

The Medical Director for Quality is a physician who provides clinical and operational guidance for Quality and Performance Improvement activities and is responsible for supervision and oversight of the Quality Assurance & Patient Safety, Clinical Quality & Patient Safety and Quality Measurement–HEDIS teams. This physician also has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for UM activities.

The assigned activities for this position include but are not limited to:

- Serves as the Committee Vice Chair for the Quality/Utilization Advisory Committee (Q/UAC)
- Serves as the Chair for the Peer Review Committee
- Serves as the Chair for the Credentials Committee
- Regularly attends the Physician Advisory Committee (PAC)
- Regularly attends the Internal Quality Improvement (IQI) Committee
- Regularly attends the Quality Improvement and Health Equity Committee (QIHEC)
- Directs the two Member Safety Teams for Clinical Compliance and Quality Investigations
- Works with the Grievance and Appeals team to review Member Grievances with possible clinical care elements
- Evaluates the appropriateness and quality of medical care delivered through Partnership in all regions
- Participates in enterprise-wide projects that require physician involvement, especially as related to Quality and Performance Improvement activities

- Assists with coverage in the UM Department for medical necessity reviews, applying evidence-based UM decision criteria to the review process in determining medical appropriateness and necessity of services for Partnership Members
- Other duties as assigned by the Senior Director of Quality or by the Chief Medical Officer

Medical Director of Medicare Services – MD/DO

The Medical Director of Medicare Services is a physician that oversees the appropriateness and quality of care delivered through Partnership and the cost-effective utilization of services. This physician also has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for UM activities.

- Participates in Medicare Dual Special Needs Plan (D-SNP) policy, strategy and tactical activities, with the Medicare leads in other departments
- Providing medical leadership for Partnership's Medicare activities, including utilization management, quality, care coordination, pharmacy grievances, and compliance activities
- Assists with coverage in the UM Department for medical necessity reviews, applying evidence-based UM decision criteria to the review process in determining medical appropriateness and necessity of services for Partnership Members
- Other duties, as assigned

Medical Director – MD/DO

The Medical Director is a physician who oversees the appropriateness and quality of care delivered through Partnership and the cost-effective utilization of services. This physician also has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for UM activities.

- Coordinates with the Directors, Associate Directors, and Managers of UM to provide daily support and appropriate direction to staff on issues pertaining to UM

Regional Medical Director - MD/DO

The Regional Medical Director is a physician with the authority to make decisions based on medical necessity which result in the approval or denial of coverage.

The assigned activities for this position include but are not limited to:

- Evaluates the appropriateness and quality of medical care delivered through Partnership in the designated regional area
- Participates in enterprise-wide projects that require Physician involvement
- Other duties as assigned by the Chief Medical Officer.

Associate Medical Director - MD/DO

This Physician has the authority to make decisions based on medical necessity that result in the approval or denial of coverage. The assigned activities for this position include:

- Coverage in the UM Department for medical necessity reviews applying evidence-based UM decision criteria to the review process in determining medical appropriateness and necessity of services for Partnership Members
- Provides review of quality of care issues and serves on Q/UAC
- Other duties as assigned by the Chief Medical Officer

Executive Assistant to CMO - Administrative

Provides administrative support to the Chief Medical Officer. Responsible for maintaining and updating online policy and procedure manuals and managing appointment calendars. Coordinates setup and executes minutes for designated meetings.

Continuing Education Program Coordinator - Administrative
Provides administrative support to the Chief Medical Officer. Responsible for coordinating the Continuing Education program, including planning meetings and trainings. Audits each CME/CE activity to ensure all elements required by organizations overseeing Partnership's educational programs are documented. Maintains organized electronic versions of all continuing education records.

Health Services Administrative Assistant II – CMO - Administrative
Responsible for administrative support to the Associate and Regional Medical Directors. Responsible for managing appointment calendars, scheduling daily UM and pharmacy workload coverage for the MDs, developing weekly and monthly schedules for distribution to other departments, and coordinating Peer-to-Peer requests from providers. Coordinates setup and executes minutes for designated meetings.

Utilization Management Program Staff

Chief Health Services Officer - RN
Provides executive leadership on current and new Health Services programs, operations, projects, policies and procedures to ensure high quality results across the continuum. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Provides oversight and guidance for the UM program across all regions including daily support and appropriate direction to staff on issues pertaining to UM.
- Provides after-hours clinical coverage for providers requesting authorization for services pursuant to health plan policies and procedures.
- Reports to the Q/UAC on Health Services activities
- Coordinates departmental UM and Quality Improvement efforts
- Oversees the design and implementation of Quality Improvement and UM programs in order to meet Medicare Model of Care standards as well as National Commission on Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) accreditation for both Medi-Cal and future Medicare lines of business (D-SNP).
- Has a lead role in regulatory audits (DHCS, DMHC, CMS, NCQA)
- Collaborates with providers and facilities
- Monitors and analyzes UM data to inform decision making
- Develops recommendations based on data analysis and strategic planning
- Collaborates with the Chief Medical Officer and the Q/UAC on UM activities
- Evaluates and uses provider and Member experience data when evaluating the UM program in collaboration with the Chief Medical Officer
- Serves as Chairperson of the Benefit Review Evaluation Workgroup (BREW)

Senior Director of Care Management- RN
Under the direction of the Chief Health Services Officer, this position is responsible for setting and carrying out the overarching strategic direction and goals of the Utilization Management and Care Coordination Departments. This position maintains and oversees proper delivery, coordination and execution of all related services and activities to improve the health outcomes of Members and has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Oversees and manages a large team of clinical and non-clinical staff while working in cross collaboration with both Medical Directors and other senior departmental leaders
- Responsible for overseeing the operations, programming and alignment of Utilization Management and Care Coordination department programs and activities
- Proactively works with key internal and external stakeholders to implement policies, procedures and/or initiatives that fulfill the organization's goals, strategic priorities and mission
- Provides clinical leadership in the design and implementation of programs and procedures for all lines of business; demonstrates decisiveness and communicates decisions and rationale clearly
- Stays abreast of health care policies, regulations and changes as they relate to those issued by CMS, DHCS, NCQA and/or other associated agencies

- Utilizes data to analyze and support quality patient outcomes and ongoing evaluation of the organization's Care Coordination and Utilization Management programs; ensuring effective and efficient health and quality outcomes, improving care coordination and meeting requirements of contracts

Director of Utilization Management - RN

Under the direction of the Senior Director of Care Management, the Director of Utilization Management (UM) is responsible for the day-to-day oversight, implementation, and continuous improvement of Partnership's Utilization Management Program. This role ensures the consistent development, implementation, and maintenance of health services programs. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Serves as the Director of Utilization Management program, ensuring effective operations and alignment with organizational goals
- Implements and operationalizes the UM Program, ensuring compliance with regulatory and accreditation requirements
- Evaluates and approves recommended UM process improvements
- Provides daily leadership and direction to UM Associate Directors, Managers and Supervisors, ensuring departmental goals and objectives are met.
- Conducts annual performance evaluations for assigned UM staff
- Responsible for oversight and monitoring of UM activities
- Responsible for oversight of clinical audits of health services programs and services; oversees the nursing component of the audits and assists with development of corrective action plans when necessary
- Participates in staff trainings
- Is available to UM staff on site or by telephone
- Works collaboratively with providers, facilities, and internal departments to ensure coordinated, high-quality member care
- Collaborates with the Provider Relations, Network Services and Contracting teams to identify strategic opportunities and develop recommendations
- Develops recommendations to enhance UM processes, procedures, and program effectiveness
- Partners with Quality Improvement, Behavioral Health, Care Coordination, Population Health, Health Equity, Enhanced Health Services, Member Services, and Claims to identify, track, and monitor quality of care outcomes and trends
- Participates in establishing and maintaining reports which relay the efficacy of UM activities and summarizes, at least annually, the UM activity, quality improvement activities and utilization outcomes, with supporting statistical data at IQI and Q/UAC

Director of Enhanced Health Services

Under the direction of the Chief Health Services Officer, plans, monitors and evaluates utilization management activities to identify strategic initiatives to enhance the efficacy of the CalAIM program, while improving health outcomes, in a cost-effective manner. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Serves as Director of CalAIM program
- Responsible for oversight of housing and incentive payment programs
- Responsible for connecting with Street Medicine programs
- Collaborates with the contracting team to identify strategic opportunities and develops recommendations
- Participates in contract review and negotiations
- In collaboration with the Chief Health Services Officer and Director of Provider Relations, reviews and processes provider grievances in accordance with appropriate regulatory requirements and participates in provider grievance meetings
- Works with county agencies and community-based organizations to facilitate the DHCS CalAIM initiative related to Enhanced Care Management (ECM) and Community Support (CS) Services with focus on improving medical health outcomes and healthcare costs

- Works collaboratively with claims and configuration department leaders and team members to identify systematic issues or opportunities for staff and/or provider education
- Ensures timely monitoring and oversight of Partnership-contracted ECM and CS providers, pursuant to DHCS regulations and Partnership policies and procedures
- Attends claims configuration meetings and Benefit Review Evaluation Workgroup (BREW) as well as IQI, Q/UAC and PAC
- Works with providers and/or vendors to facilitate issue resolution and ensure a consistent UM process
- Develops, reviews, and/or revises Partnership UM policies and procedures in collaboration with the Chief Health Services Officer as appropriate.
- Develops expertise in housing services funded through the Medi-Cal program including 1915(c) Home and Community Based Services Waivers and other Medicaid housing related opportunities such as Assisted Living Waivers.
- Works with local agencies, state networks, and community organizations to identify issues and develop consensus positions on policy issues related to CalAIM and housing.

Associate Director of Utilization Management - RN

Under the direction of the Director of Utilization Management, manages and provides direction to the Utilization Management department Managers, Supervisors and staff for all product lines ensuring consistent development, implementation, and maintenance of health services programs. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Implements the UM program
- Provides day-to-day direction to UM Managers and Supervisors to meet department goals and objectives and is available to staff on-site or by telephone
- Conducts annual performance evaluations for assigned UM staff
- Conducts monitoring activities
- Participates in staff trainings and on-site continuing education
- Audits medical records as appropriate and monitors for consistent application of UM criteria by UM staff, for each level and type of UM decision
- Collaborates with providers and facilities
- Develops recommendations for program improvements
- Coordinates activities with Care Coordination, Population Health, Quality Improvement, Member Services, Claims, and Provider Relations departments to identify, track, and monitor quality of care outcomes and trends
- Participates in establishing and maintaining reports which relay the efficacy of UM.

Associate Director of Utilization Management Regulations

Under the direction of the Director of Utilization Management, provides oversight of the UM Program to ensure compliance with regulatory requirements including, but not limited to, requirements of DHCS, CMS, and the National Committee for Quality Assurance (NCQA) . Assigned activities include:

- Coordinates activities with External and Regulatory Affairs Compliance, Member Services, Claims, and Provider Relations departments to identify, track, and monitor quality of care issues and trends related to UM Department processes
- Prepares reports on departmental activities according to established schedules and format. Identifies patterns and trends, conducts retrospective review as needed and works with UM Leadership to develop corrective action plans.
- Gathers UM program information and incorporates updates into the annual UM evaluation and program description
- Prepares and presents the annual evaluation, program description to IQI and Q/UAC
- Participates in the grievance process
- Acts as primary contact and support to each UM Delegate, providing training and support as necessary
- Conducts delegation oversight through regular auditing of each UM Delegate, prepares audit reports for review by the Director of Utilization Management, and prepares information for the Delegation Oversight Review Sub-Committee (DORS) and NCQA Steering Committee.
- Collaborates with Department leaders to ensure that all policies and procedures related to

regulatory requirements are updated at least annually, or as needed, and presented to appropriate committees for review. Assists Partnership staff and providers with the interpretation of Partnership policies, procedures, and regulatory requirements.

- Works with UM Leadership and UM Trainer to develop standardized training content and materials for new staff and ongoing education for existing staff
- Participates in the planning and development of new/ enhanced Health Services plan benefits or product lines as needed. Attends Benefits Review and Evaluation Workgroup meetings
- Participates in audits by various regulatory agencies as necessary

Associate Director of Enhanced Health Services

Under the direction of the Director of Enhanced Health Services, is responsible for managing the CalAIM program. Provides strategic support and management/supervisory support for the CS and ECM staff, including but not limited to, strategic goal setting, program planning, budget/account management, and supervision of team members.

- Participates in internal and external meetings, providing input and guidance to community stakeholders and partners regarding the CalAIM program
- Fosters cross-departmental collaboration in shared operational activities related to the ECM benefit and CS services (ex: Provider Relations, Care Coordination, Claims, etc.)
- Prepares and reviews provider and Member education materials related to CalAIM
- Identifies trends, patterns and/or opportunities for enhancements to workflows, tools and/or systems to promote efficiency, cost, and quality of ECM and CS services
- As directed, prepares or provides updates on DHCS deliverables and reports associated with CalAIM, including but not limited to the DHCS Model of Care template, DHCS ECM Exception Request(s), and/or DHCS ECM and CS reporting guidelines
- Maintains knowledge of CalAIM requirements and shares updates with appropriate internal/external stakeholders, as necessary

Senior Manager of Justice Involved Programs – RN

Under the direction of the Director of Enhanced Health Services, is responsible for working directly with justice-involved agencies and providers who serve justice-involved Members in Partnership HealthPlan of California's county network. The assigned activities include:

- Serves as the Justice Liaison for the HealthPlan
- Facilitates communication with external stakeholders including: network providers, county staff, state prison system, probation offices, police/sheriff departments and other stakeholders as appropriate
- Oversees and develops a system for care coordination for this designated population on behalf of the HealthPlan, ensuring providers and staff are capable of serving this Member population.
- Serves as the HealthPlan lead for oversight of any applicable MOUs between the HealthPlan and other entities as directed by DHCS and supports MOU activities and requirements to ensure HealthPlan compliance.
- Establishes systems to ensure connections with county behavioral health plans for the delivery of specialty mental health services on behalf of this specific population.
- Serves as a point of escalation for care managers if they face operational obstacles when working with County and/or community partners.

Manager of Utilization Management - RN

Responsible for the implementation, management and evaluation of an effective and systematic UM Program. Provides day-to-day guidance to UM staff and manages all aspects of utilization review activities and is available to staff on-site or by telephone. Working with the Chief Medical Officer, Chief Health Services Officer, Directors of UM, Associate Directors of UM, utilization committees, and Health Plan Directors, promotes efficient resource utilization throughout the organization, providing leadership, teambuilding and direction needed to ensure attainment of UM goals. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Coordinates completion of activities

- Monitors for consistent application of UM criteria by UM staff for each level and type of UM decision
- Participates in staff trainings and on-site continuing education
- Provides recommendations for interventions designed to improve utilization management issues
- Coordinates implementation of interventions
- Develops UM policy and procedures for Q/UAC approval
- Develops, or coordinates development of, documentation of UM activities
- Conducts annual performance evaluations for assigned UM staff

Manager of Long Term Support Services (LTSS) – RN

Provides leadership and clinical oversight for operational aspects of Utilization Management for Long Term Support Services (LTSS); including the responsibility for providing daily oversight, leadership, support and management of assigned staff. Collaborates with departmental and Health Services leadership to oversee and monitor the provision of LTSS benefits and services; coordinating with Partnership providers and/or community stakeholders as necessary. This position has the authority to make decisions on coverage not relating to medical necessity.

- Provides day-to day direction to licensed clinical staff regarding utilization review, care coordination, discharge planning, and other services across the continuum of care for Members in need of LTSS
- Ensures compliance with regulatory/accreditation requirements related to UM by collaborating with other departments and maintaining survey and audit readiness
- Leads, develops and operationalizes evidence-based best practices and activities to address LTSS benefits and/or services (ex: Transitional Care Services, facility placements, care coordination, etc.)
- Identifies and incorporates quality-monitoring activities to improve the quality of care, outcomes, and/or costs for Members receiving one or more LTSS (ex: Skilled Nursing, Community Based Adult Services, In-Home Support Services, etc.)

Clinical Manager, Enhanced Health Services - RN

Assists the Director and Associate Director of Enhanced Health Services (EHS) in the development, implementation, management and evaluation of an effective and systematic CalAIM Program. Provides day-to-day guidance to nursing staff and manages all aspects of utilization review activities and is available to staff on-site or by telephone. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Monitors for consistent application of UM criteria by EHS staff for each level and type of EHS decision
- Participates in staff trainings and on-site continuing education
- Provides recommendations for interventions designed to improve utilization management issues
- Coordinates implementation of interventions
- Oversees auditing and oversight of CalAIM providers
- Collaborates with departmental leadership to oversee and maintain a cohesive team with a high level of productivity, accuracy and quality to achieve goals and objective
- Maintains updated policies and procedures, workflows, documentation, desktops, reports, etc.
- Fosters cross-departmental leadership in shared operational activities related to the CalAIM initiatives. (ex: Provider Relations, Utilization Management, Claims, etc.)
- Maintains knowledge of the CalAIM initiatives and shares updates with appropriate internal /external stakeholders when necessary

Manager of Utilization Management Operations

Responsible for the operational aspects of Utilization Management, including responsibility for providing daily oversight, leadership, support, and management of assigned staff. Ensures compliance with established criteria, regulations, standards, best practices and Health Plan benefits. The assigned activities include:

- Provides daily operations oversight and direction to the team Supervisor(s) and Data Coordinators
- Manages day to day functions including coordination of assignments, monitoring of call volume and adherence to Partnership workplace policy and is available to staff on-site or by telephone
- Assists in the refinement/improvement of the HS programs

- Provides performance feedback to the Data Coordinator staff and conducts staff trainings as needed.
- Monitors UM Data Coordinator activity for consistent application of desktop processes and procedures by UM Data Coordinator staff
- Provides leadership, direction, training, and support to the assigned staff
- Participates in staff trainings and on-site continuing education
- Conducts annual performance evaluations for assigned UM staff

Manager of Enhanced Health Services Operations

Responsible for the operational aspects of Enhanced Health Services, including responsibility for providing daily oversight, leadership, support, and management of assigned staff. Ensures compliance with established criteria, regulations, standards, best practices and Health Plan benefits. The assigned activities include:

- Provides daily operations oversight and direction to the team Supervisor(s), Program Manager and Project Coordinators
- Manages day-to-day functions including coordination of assignments, reporting and adherence to Partnership workplace policy and is available to staff on-site or by telephone
- Assists in the refinement/improvement of the CalAIM programs
- Provides performance feedback to the EHS staff and conducts staff trainings as needed
- Monitors staff activity for consistent application of desktop processes and procedures by EHS staff
- Provides leadership, direction, training, and support to the assigned staff
- Participates in staff trainings and on-site continuing education
- Conducts annual performance evaluations for assigned EHS staff

Senior Programmer Analyst

This position supports the design, development, and documentation of Partnership's core claims processing, TAR processing, and claims processing platforms. Provides technical support and problem resolution to UM Department end users.

- Maintains in-depth knowledge of various Partnership systems
- Tests, schedules, and implements new releases and upgrades of software
- Tests, schedules, and implements interface changes to systems, when needed
- Supports development of business requirements for various system implementations
- Uses sound technical judgment and makes appropriate systems decisions
- Assists in development and maintenance of policies and procedures to document new and changed elements of UM Operations

Inpatient/Outpatient/LTSS Nurse Supervisor UM - RN

This position is responsible for the daily mentorship and oversight of the staff assigned to inpatient, outpatient or LTSS services. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Works collaboratively with all levels of leadership within the department to efficiently coordinate workflow and individual staff assignments
- Provides day to day supervision to the assigned team, overseeing daily operations of the inpatient, outpatient or LTSS review process
- Participates in staff trainings and on-site continuing education. With UM Leadership, conducts annual performance evaluations for assigned UM staff
- Audits medical records as appropriate and monitors for consistent application of UM Criteria by UM staff, for each level and type of UM decision.
- This position, in addition to his/her own case load, may be assigned cases in the area of oversight as deemed necessary to provide coverage

Clinical Supervisor of Enhanced Health Services - RN

Provides daily supervision and program support to designated staff. Assists departmental leadership in developing and maintaining a cohesive team with a high level of productivity, accuracy and quality to achieve goals and objectives

- Provides daily leadership, direction, resources, training, evaluation, coverage, and program support to assigned staff
- Performs supervisory functions such as timecard management, directing work activities, conducting annual reviews and training to staff
- Maintains active participation with inbound and outbound provider reporting and other related duties, adjusting assignments as necessary to meet business needs and/or regulations
- Facilitates meetings with Partnership providers and/or external community partners as necessary
- Participates in oversight and audit of CalAIM providers
- Supports organizational collaboration and communication regarding CalAIM initiatives through active collaboration

Inpatient/Outpatient Nurse Lead UM - RN/ LVN
This position is responsible for assisting with oversight of daily operations of the inpatient or outpatient review process (as assigned). This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Provides direction and support, to staff concerning daily assignments.
- Participates in interview process and provides training in inpatient or outpatient review for new hires.
- Evaluates appropriateness of care through interpretation of benefits as outlined in Title 22, Medi-Cal Provider Manual using Partnership policies and procedures, and InterQual® criteria.
- Documents and maintains patient-specific records in the data collection software system.
- Assists in the refinement/improvement of the Health Services programs. Participates in continuous process improvement endeavors.
- Works with other Partnership departments to resolve issues relating to authorization of medical services.
- Participates in Inter-rater Reliability studies, reviewing medical records as assigned.
- Communicates regularly with the UM Team Manager and works collaboratively to resolve issues.

Nurse Auditor - RN
Under the direction of the UM Supervisor or higher, the Training & Education Nurse Auditor (RN) conducts audits of assigned areas, assists in department audit initiatives and performs audits in accordance with the department audit plan. As an integral member of the Training and Education Team, this position helps the audit function keep pace with the audit needs of the UM Department.

Nurse Coordinator/ UM/EHS II - RN/ LVN
Work collaboratively with all levels of UM leadership and other Partnership staff to develop, implement, and evaluate health outcomes, provider performance and other performance indicators pertinent to quality of care. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Assist in training and orientation of new staff to the department upon request
- Review and authorization of DME, Ancillary and Medical TARs based on established guidelines
- Review and authorization of Long Term Care TARs based on established guidelines
- Review and authorization of inpatient Hospital TARs based on established guidelines
- Review and authorization of Enhanced Care Management (ECM) and Community Supports TARs based on established guidelines
- Reviews residential placement authorization requests for substance use disorder (SUD) treatment services according to the specific terms of the contract with the provider and in accordance with the medical necessity requirements for Medi-Cal eligible beneficiaries. Licensed staff who operate in the capacity of behavioral health authorizations (for Substance Use Disorder (SUD) treatment services as outlined in the Regional Drug Medi-Cal Model) are required to complete specialized ASAM[1] training annually.
- Retrospective review of services to determine medical necessity

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

- Refer cases to the Chief Medical Officer for requests that may not appear to meet evidence- based medical necessity criteria
- Determines if requested services are part of the Member's benefit package
- Work collaboratively with the Care Coordination, Population Health, Pharmacy and Quality Improvement staff on UM issues

Nurse Coordinator/ UM/EHS I - RN/ LVN

Work collaboratively with all levels of UM leadership and other Partnership staff to develop, implement, and evaluate health outcomes, provider performance and other performance indicators pertinent to quality of care. This position has the authority to make decisions on coverage not relating to medical necessity. Activities assigned include:

- Review and authorization of DME, Ancillary and Medical TARs based on established guidelines.
- Review and authorization of Long Term Care TARs based on established guidelines.
- Review and authorization of inpatient Hospital TARs based on established guidelines.
- Review and authorization of Enhanced Care Management (ECM) and Community Supports TARs based on established guidelines
- Reviews residential placement authorization requests for SUD treatment services according to the specific terms of the contract with the provider and in accordance with the medical necessity requirements for Medi-Cal eligible beneficiaries. Licensed staff who operate in the capacity of behavioral health authorizations (for Substance Use Disorder (SUD) treatment services as outlined in the Regional Drug Medi-Cal Model) are required to complete specialized ASAM[1] training annually.
- Retrospective review of services to determine medical necessity
- Refer cases to the Chief Medical Officer for requests that may not meet medical necessity criteria
- Determine if requested services are part of the Member's benefit plan
- Work collaboratively with the Care Coordination, Population Health, Pharmacy, and Quality Improvement staff on UM issues

Data Coordinator/ Supervisor UM – Administrative

Works closely with UM Leadership to establish consistent evaluation of Data Coordinators' work performance. Responsible for oversight of Data Coordinators.

- Monitors day-to-day functions including coordination of assignments, monitoring of call volume and adherence to Partnership workplace policy and is available to staff on-site or by telephone
- Assists in the refinement/improvement of the HS programs
- Provides performance feedback to the Data Coordinator staff and conducts staff trainings as needed
- Monitors UM Data Coordinator activity for consistent application of desktop processes and procedures by UM Data Coordinator staff
- Provides leadership, direction, training, and support to the assigned staff
- Participates in staff trainings and on-site continuing education
- Conducts annual performance evaluations for assigned UM staff

Policy Analyst - (Regulatory/Delegation)

This position is responsible for drafting, editing, reviewing, auditing, tracking, monitoring and maintaining utilization management policies and procedures for Partnership. Under the supervision of the Associate Director of Utilization Management Regulations, ensures compliance with governing rules, regulations, and/or accreditation standards.

- Prepares UM policies and/or related materials for appropriate committees' review and attends meetings of the Internal Quality Improvement Committee and Quality/Utilization Advisory Committee.
- Performs policy research to analyze current and/or new regulations by applicable Partnership regulators and/or accrediting agencies (ex: DHCS, DMHC, CMS, NCQA, etc.)
- Reviews both draft and final All Plan Letters (APLs) and/or regulatory changes and supports leaders with the research, planning, implementation and/or operational readiness submissions across the organization.

- Participates in audits with Partnership's regulatory and/or accreditation bodies by preparing policies, documents and/or reports as needed.
- Conducts analysis, collects information, and evaluates impact of regulatory and compliance issues to inform auditing and monitoring activities.
- Analyzes the impact of new programs/benefits and efficacy of existing processes, policies, procedures and trainings.

Program Manager II – (Regulatory/Delegation)
Under the direction of the Associate Director of UM Regulations, this position conducts business analysis and program analytics and participates in strategic planning and administrative oversight of the UM authorization platform
Assigned activities include:

- Responsible for day-to-day duties associated with oversight of UM delegated entities
- Responsible for successful implementation of new activities and processes with delegated entities
- Ensures efficient and appropriate collaboration between the Utilization Management staff and UM delegated entities
- Provides oversight of the UM authorization platform

Program Manager I – (Regulatory/Delegation)
Under the direction of the Associate Director of UM Regulations, assigned activities include:

- Responsible for day-to=day duties associated with oversight of UM delegated entities
- Responsible for successful implementation of new activities and processes with delegated entities
- Identifies and resolves issues and concerns with UM delegation to ensure risk is mitigated in a timely manner and recommends solutions to Leadership for final decision, as necessary
- Responsible for collecting and tracking required document submissions from delegated entities
- Coordinates and participates in both desktop and onsite audits of delegated entities
- Ensures efficient and appropriate collaboration between the Utilization Management staff and UM delegated entities

Program Manager I – (EHS)
Under the direction of the Manager of Enhanced Health Services, develops, implements, improves, and manages assigned programs related to CalAIM. Participates in the design, implementation, and/or expansion of strategic programs and departmental initiatives. Supports the development and execution of program goals, outcome measures, and program reporting.

- Creates and delivers CalAIM program information and reports to both internal and external stakeholders
- Supports the development and execution of strategies to engage stakeholders.
- Responsible for program evaluation and continuous improvement activities
- Responsible for successful implementation of CalAIM activities.
- Reviews program data accuracy, completeness, and required submissions.

Program Manager I – (LTSS)
Under the direction of the Manager of Long Term Support Services (LTSS), supports operational aspects of Utilization Management related to LTSS including monitoring and reporting of the provision of LTSS benefits and services. Assigned activities include:

- Serves as the In-Home Supportive Services (IHSS) Specialist
- Serves as the Community Provider Advisory Council (CPAC) Coordinator
- Facilitates Point Click Care discharge reporting
- Monitors and tracks Letters of Agreement (LOAs)
- Coordinates with Health Analytics for Dashboard reporting
- Coordinates Critical Incident Review
- Creates specialized documents (Desktops, Info sharing with facilities and other departments, etc)
- Acts as a point of contact for the team for additional reporting needs

Program Coordinator II - (UM Regulations)
Under the direction of the Associate Director of UM Regulations, provides coordination and implementation support of defined tasks.

- Coordinates, facilitates, and leads program meetings
- Supports the successful management of program initiatives
- Customarily and regularly compiles, reviews and analyzes project data and results.
- Develops expertise in program focus areas and stays informed of key developments

Project Coordinator II - (EHS)
Under the direction of the Manager of Enhance Health Services, provides coordination and implementation support of defined tasks for CalAIM programs. Conducts business analysis to evaluate programs, exercises independent judgement in leading assigned projects, tracks and reports data to a higher complexity level, coordinates daily activities, communicates program status to stakeholders.

- Coordinates, facilitates, and leads both internal and external meetings for CalAIM Providers.
- Supports the successful implementation of CalAIM projects.
- Customarily and regularly compiles, reviews and analyzes project data and results.
- Develops expertise in program focus areas and stays informed of key developments and training/development opportunities within our network and across the healthcare industry, maintains accurate provider listing for CalAIM Providers.

Project Coordinator I - (EHS)
Under the direction of the Manager ofof Enhanced Health Services, provide coordination and implementation support of defined tasks for CalAIM program.

- Coordinates and facilitates both internal and external meetings for CalAIM Providers.
- Develops and publishes agendas, meeting minutes, and necessary documentation
- Attends project meetings, follows up on assigned tasks, and communicates the status of projects to the supervisor
- Manages, tracks, and processes CS or ECM referrals

Program Coordinator I - (Training & Education)
Under the direction of the UM Supervisor or higher, this position provides coordination and implementation support of defined tasks for the UM Training & Education team. Assigned responsibilities include:

- Attends program meetings, prepares agendas and minutes, and follows up with stakeholders on assigned action items
- Assists with planning, coordination, and execution of events, webinars, trainings, and user demos
- Coordinates with program leadership and internal units to support implementation of new programs/trainings and related processes

Health Services Analyst I
Performs routine and ad-hoc reporting and data management for the UM department for both internal and external users; assists in maintaining reporting systems within the department. Prepares, analyzes, reports, and manages data used for the UM department as well as plan-wide and regional decision making for evaluating performance in key quality measures and the effective use of health plan resources on a routine and ad hoc basis. Works collaboratively with departments company-wide to identify data needs, develop and maintain data queries and tools, and complete accurate reporting to support performance and process improvements.

Executive Assistant to the Chief Health Services Officer - Administrative
Provides administrative support to the Chief Health Services Officer. Manages appointment calendar, develops agendas, organizes meetings and executes minutes for designated meetings.

Health Services Administrative Assistant II – UM, EHS - Administrative
Provides administrative support to the Utilization Management Director or EHS Director and/or other UM or EHS Leadership. Manages appointment calendars, coordinates setup and executes minutes for designated meetings.

Health Services Administrative Assistant I – UM - Administrative

Provides administrative support to UM Leadership. Manages appointment calendars and works closely with the Information Technology Department to ensure appropriate electronic functioning for the Utilization Management Department.

Authorization Specialist/ UM Trainer – Administrative

Responsible for providing training on all appropriate software platforms for new hires. Creates and maintains current training materials for the UM department. In conjunction with UM leadership team, prepares and delivers retraining of identified topics as deemed necessary.

- Facilitates independent DME consultant evaluation visits to Members for specialty equipment needs as needed or directed by UM Leadership.
- Acts as a resource regarding UM department software programs and special projects upon request and is available to staff on-site or by telephone
- Coordinates with Member Services Call Center system to place Members into appropriate Direct Member status related to their care.

Data Coordinator/ UM Lead - Administrative

Under the direction of the Data Coordinator Supervisor and UM Leadership:

- Monitors Data Coordinator documentation for accuracy
- Ensures Data Coordinator staff have the resources required for completing TAR entry and using good judgment and is available to staff on-site or by telephone
- Enters both manual and electronic submitted data into Partnership systems for RAF and TAR authorizations
- Monitors UM Data Coordinator staff for consistent application of desktop processes and procedures
- Responsible for assisting with ongoing staff education in proper use of systems and Partnership UM Departmental policies and procedures
- Participates in staff trainings and on-site continuing education

Coordinator II - Administrative

Under the direction of applicable UM/ EHS leadership:

- Serves as a resource to other departments who have inquiries into the UM/ CalAIM process
- Responsible for the input of data and information concerning UM/ CalAIM Referrals and Authorizations
- Receives and responds to telephonic inquiries from providers regarding status of authorization requests and other questions or concerns
- Performs triage and transfers calls to appropriate professional staff when indicated
- Responsible for clerical processing of appeals (as applicable) in accordance with policy, procedures, timeframes and requirements of various regulatory bodies for all lines of business
- Acts as liaison to Claims Department in coordinating timely response to all claims inquiries
- Participates in special projects, tasks and assignments as directed

Coordinator I - Administrative

Under the direction of applicable UM/ EHS leadership - responsible for the input of data and information concerning UM/CalAIM Referrals and Authorizations.

- Maintains departmental documents
- Receives and responds to telephonic inquiries from providers regarding status of authorization requests and other questions or concerns
- Performs triage and transfers calls to appropriate professional staff when indicated
- Responsible for clerical processing of appeals (as applicable) in accordance with policy, procedures, timeframes and requirements of various regulatory bodies for all lines of business
- Acts as liaison to Claims Department in coordinating timely response to all claims inquiries
- Participates in special projects, tasks and assignments as directed

Behavioral Health Program Staff

Behavioral Health Clinical Director - MD/DO/PhD/ PsyD

The Partnership Behavioral Health Clinical Director is an MD, DO, clinical PhD, or PsyD who is actively involved in the behavioral health aspects of the UM program. This Director provides clinical oversight of Partnership's behavioral health activities including substance use services and the activities of Partnership's delegated managed behavioral health organization for the administration of certain mental health services. The Behavioral Health Clinical Director has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for behavioral health or substance use services. The assigned activities for this position include:

- Establishes policies and procedures for mental health services
- Oversees and monitors quality improvement activities
- Facilitates network adequacy
- Participates in the peer review process
- Evaluates behavioral health care and substance use disorder (SUD) treatment services requests
- Oversees and monitors utilization of behavioral health services
- Serves on Quality/Utilization Advisory Committee; Quality Improvement and Health Equity Committee (QIHEC); Pharmacy and Therapeutics Committee; Credentials Committee and Internal Quality Improvement Committee including the Substance Use Internal Quality Improvement Subcommittee.

Senior Director of Behavioral Health - MHA

This position is responsible for oversight and management of Partnership activities involving behavioral health (mental health and substance use) services and community projects which support access to and improvement of behavioral health.

- Responsible for the oversight activities involving the coordination of care for children and youth receiving child welfare services.
- Manages relationships with delegated entities and community stakeholders.
- Works with Partnership leadership, Member counties, providers and the community to develop the Plan's approach to behavioral health services to the Medi-Cal population and the related projects focused on the range of social and community factors that affect Members' behavioral health.
- Participates in network development, contracting and outreach efforts within the Partnership network.
- Monitors Member utilization and ensures coordination between Partnership's system of care for Non-Specialty Mental Health and the county Behavioral Health's system of care for Specialty Mental Health and Substance Use Services under Drug Medi-Cal

Senior Manager of Behavioral Health

Under the direction of the Senior Director of Behavioral Health, responsible for the management of a major division/service area referred to as the DMC-ODS Regional Model, which includes multiple work groups of significant depth and complexity. Responsibilities include overall management and administration of a large service area, including development of a division's objectives and design and implementation of supporting and expansion programs, processes, policies, and/or procedures to successfully achieve those objectives.

Sr. Manager of Behavioral Health Access

Under the direction of the Senior Director of Behavioral Health, responsible for directing and coordinating medically necessary behavioral health treatment services for members seeking behavioral health services. Oversees operations of Behavioral Health Call Center and staffing. Oversees staff to ensure the coordination of care for members seeking behavioral health services for both carved in and carved out services. Ensures regulatory compliance with call center performance requirements.

Sr. Manager of Child Welfare Program

Under the direction of the Senior Director of Behavioral Health, responsible for working directly with local county child welfare agencies, foster care agencies and providers who work directly with children and youth involved in the child welfare system, and former foster youth through age 25, in Partnership HealthPlan of California (Partnership) assigned counties. The goal of this position is to ensure child welfare involved youth

obtain the health services they are entitled to and that services are closely coordinated with other services. This position will assist in the design, implementation, and/or expansion of strategic programs and departmental initiatives in relation to this population and regulatory deliverables. Develops and delivers program goals, measures, and reports. The Liaison will be responsible for a range of systems to strengthen coordination and support for children and youth involved in child welfare. Facilitates communication with external stakeholders including network providers, county staff, CASA, foster care agencies, foster parents, birth families and other stakeholders as appropriate.

Manager of First 5 Commissions
Under the direction of the Sr. Manager of Child Welfare Programs and the Senior Director of Behavioral Health, responsible for working directly with local First Five Commissions and agencies and providers who work directly with children, in Partnership HealthPlan of California (Partnership) assigned counties. The goal of this position is to ensure youth obtain the health services they are entitled to and that services are closely coordinated with other services. This position will assist in the design, implementation, and/or expansion of strategic programs and departmental initiatives in relation to this population and regulatory deliverables. Develops and delivers program goals, measures, and reports. This position will be responsible for a range of systems to strengthen coordination and supports for children and youth and will facilitate communication with external stakeholders including: First Five Commissions, network providers, county staff, birth families and other stakeholders as appropriate.

Manager of Mental Health Programs
Under the direction of the Senior Director of Behavioral Health, responsible for the management of mental health services, which includes multiple work groups of significant depth and complexity. Responsibilities include overall management of this service area, including working with the Behavioral Health Administrator for the development of the service areas objectives and design and implementation of supporting and expansion programs, processes, policies, and/or procedures to successfully achieve those objectives.

County Child Welfare Liaison
Under the direction of the Sr. Manager of Child Welfare Program and the Senior Director of Behavioral Health, supports a range of social work services as a county child welfare liaison in collaboration with Partnership staff to meet the psycho-social and care coordination needs of members involved in the child welfare system. Responsible for the assessment and care coordination of the psychosocial needs of these members, families and/or caregivers to help promote positive coping skills, reduce the risk of premature institutionalization, assist individuals in maintaining independence in the community and increase stabilization of social determinants.

Pharmacy Program Staff

Pharmacy Services Director – Pharm.D.
This position is responsible for overseeing all HealthPlan activities related to medication benefit and pharmacy services and supervising the Partnership Pharmacy management team, Partnership Clinical Pharmacists, and support staff. The assigned activities for this position include but are not limited to:

- Medication coverage management
- Development of applicable policies and guidelines
- Serves on the Pharmacy and Therapeutics (P&T) Committee (serving as Chair when designated by the CMO), the Global Medi-Cal Drug Utilization Review (DUR) Board and the Pediatric Quality Committee (PQC)
- Drug utilization review
- Regularly attends the Quality Improvement and Health Equity Committee (QIHEC)
- Drug prior authorization for medications covered under the medical benefit
- Implementation of cost effective utilization management measures for medications covered under the medical benefit
- Participation in provider education initiatives such as academic detailing with plan physicians

- Medical education meetings
- Assisting with development of Clinical Practice Guidelines
- Other duties as assigned by the Chief Medical Officer

Clinical Pharmacist – Pharm.D., RPh
Work collaboratively with all levels of Pharmacy leadership to review medication Treatment Authorization Requests (TARs) to promote safe, appropriate, and cost-effective drug therapy. Pharmacists have the authority to make decisions based on medical necessity that result in the approval or denial of coverage of medications.

- Communicates and educates prescribers on TAR processes, TAR determination, and Partnership medication coverage policies
- Provides oversight to the pharmacy technician staff in the daily TAR review process
- Participates in P&T meetings and conduct drug utilization reviews to identify treatment gaps and optimize medication therapy outcomes based on national treatment guidelines and evidence-based medicine
- Participates in the development of technician drug review guidelines and creation of authorization criteria for medical benefit medications
- Participates and works with other departments on cross-departmental initiatives that require Clinical Pharmacy input/participation
- Support HEDIS and other clinical quality improvement work through provider academic detailing and Member engagement activities
- Ensures compliance with regulatory and quality standards/requirements including, but not limited to, the standards of the National Committee for Quality Assurance (NCQA) and the requirements for the California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS)
- Other duties as assigned by the Pharmacy Services Director

Pharmacy Technician – CPhT, RPhT
Work collaboratively with all levels of Pharmacy leadership to review medication Treatment Authorization Requests to promote safe, appropriate, and cost-effective drug therapy.

- Reviews and approves TARs based on established internal pharmacy technician review guidelines &/or Partnership drug TAR requirements (prior authorization criteria for use). If a TAR cannot be approved based on guidelines/criteria, the pharmacy technician will refer the TAR to the Clinical Pharmacist for an escalated review.
- Educates prescribers on TAR processes, TAR determination, and Partnership medication coverage policies.
- Supports HEDIS and other clinical quality improvement work through provider academic detailing and Member engagement activities.

Committees

Board of Commissioners
The Board of Commissioners on Medical Care (the Commission) promotes, supports, and has ultimate accountability, authority and responsibility for a comprehensive and integrated UM program. The Commission is ultimately accountable for the efficient management of healthcare resources and services provided to Members. The Commission has delegated direct supervision, coordination, and oversight of the UM program to the Q/UAC which reports to the PAC, the committee with overall responsibility for the program. Members of the Commission are appointed by the county Boards of Supervisors for each geographic service area and include representation from the community as follows: consumers, businesses, physicians, providers, hospitals, community clinics, HMOs, local government, and County Health Departments. The Commission meets six times a year.

The purpose of the Commission is to negotiate exclusive contracts with DHCS and to arrange for the provision of health care services to qualifying individuals, as well as other purposes set forth in the enabling ordinances established by the respective counties.

Community Advisory Committee (CAC)
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. The CAC is a liaison group between our Members and Partnership, advocating for Members by ensuring that the health plan is responsive to the health care and information needs of all Members. Additionally, the CAC provides Partnership Members with a forum to discuss common issues of interest and importance, while creating a supportive and informative environment. The CAC meets quarterly, reviews and makes recommendations regarding Member Services' quality improvement activities, provides feedback on quality and health equity initiatives and serves in the capacity of a focus group. Three CAC members are selected to serve on the Board of Commissioners to provide member input and report back to the CAC.

Pharmacy and Therapeutics Committee (P&T)
The P&T Committee is chaired by Partnership's Chief Medical Officer (CMO), or designee such as the Director of Pharmacy, and is comprised of Partnership's Pharmacy Director, Associate and Regional Medical Directors, Partnership staff and network practitioners including pharmacists, primary care physicians, behavioral health and other specialists. P&T makes decisions and recommendations on development and review of the physician administered drugs (PADs) provided under the medical drug benefit, medication policy and procedures, and drug approval criteria. P&T Committee also serves as Partnership's Drug Utilization Review (DUR) Board to review Partnership's DUR program and activities and make recommendations where necessary to improve Partnership's drug utilization. The P&T meets quarterly, providing regular activity reports and recommendations to the PAC, the approval authority for P&T related activities.

Physician Advisory Committee (PAC)
The PAC monitors and evaluates all Health Services activities and is directly accountable to the Board of Commissioners for the oversight of the UM program. The PAC meets at least ten (10) times a year and may not convene in the months of July and December, with the option to add additional meetings if needed. Voting membership includes external Primary Care Providers (PCPs), board certified high-volume specialists, behavioral health practitioners and non-physician clinicians. A voting provider member of the committee chairs the PAC. The Partnership Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Chief Medical Officer (CMO), Deputy CMO, Medical Director for Medicare Services, Medical Director for Quality, Regional Medical Director(s), Behavioral Health Clinical Director, Chief Health Services Officer and leadership from the following departments, Quality and Performance Improvement, Provider Relations, Care Coordination, Utilization Management, Pharmacy, and Network Services, attend the PAC meetings regularly. Other Partnership staff attend on an ad hoc basis to provide expertise on specific agenda items. The PAC oversees the activities of the Q/UAC and other quality-related committees and reports activities to the Board of Commissioners.

Quality/Utilization Advisory Committee (Q/UAC)
The Q/UAC is responsible to assure that quality, comprehensive health care and services are provided to Partnership Members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. Q/UAC voting membership includes consumer representative(s) and external clinicians who are contracted primary care providers (PCPs) and board-certified specialists in the areas of internal medicine, family medicine, pediatrics, OB/GYN, neonatology, behavioral health, and representatives from other high-volume specialties. These external providers represent hospitals, medical groups, and practice sites in geographic sections of Partnership's service area. The Partnership Chief Medical Officer (CMO) (chair of the committee), Behavioral Health Clinical Director, Director of Health Equity, Medical Director for Quality, Manager of Member Safety-Quality Investigations, Associate and Regional Medical Directors and leadership from the Health Services departments (*e.g. Quality and Performance Improvement, Utilization Management, Care Coordination, Pharmacy, Population Health, Health Equity, Enhanced Health Services*), Grievance and Appeals, and Provider Relations departments attend the Q/UAC meetings regularly. Other Partnership staff attend on an ad hoc basis to provide expertise on specific agenda items. The committee meets monthly at least ten (10) times per year, with the option to add additional meetings if needed. Q/UAC activities and recommendations are reported to the PAC and at least quarterly to the Commission. The Q/UAC provides

guidance and direction to the UM program by coordinating activities and by functioning as the expert panel when needed. Coordination includes but is not limited to:

- Annual oversight of the UM Program
- Annual evaluation of the UM program structure, scope, processes, and information used to determine benefit coverage and medical necessity.
- Annual identification of actions needed (based on evaluation)
- Annual review of the UM rates (as prescribed in the NCQA standards) for each of the following:
  - Non-Behavioral Health UM rates
  - Behavioral Health UM rates
  - Pharmacy UM rates
  - UM Appeals rates
  - Identification of actions to address opportunities identified
- Assuring individual Member needs are taken into consideration when determinations for care are rendered and in the development of medical policy and procedures.
- Analyzing summary data and making recommendations for action
- Reviewing action plans for quality improvements of UM activities and providing ongoing monitoring and evaluation
- Reviewing medical policy, protocol, criteria and clinical practice guidelines
- Approving and ensuring implementation of evidence-based guidelines and policies of medical practice including preventive, chronic care, and behavioral health initiatives
- Providing oversight of delegated activities

Quality Improvement and Health Equity Committee (QIHEC)

The Quality Improvement and Health Equity Committee (QIHEC) meets bimonthly for analyzing and evaluating the results of Health Equity related Quality Improvement activities. This includes annual review of the results of performance measures, utilization data, grievance and appeal data, consumer satisfaction surveys, and findings and activities of other Partnership specific committees. (e.g. Community Advisory Committee, , etc). This committee shall also be responsible for instituting actions to address health equity performance deficiencies, including policy recommendations, and ensuring appropriate measurement and follow-up of identified performance deficiencies.

The QIHEC provides recommendations to the Quality/Utilization Advisory Committee (Q/UAC) Committee. The Q/UAC provides recommendations to the Physician Advisory Committee (PAC).
Partnership Members of the QIHEC include (but are not limited to): CMO, Director of Health Equity, Director of Grievance and Appeals, COO, Director of Communications, Director of Health Analytics, Senior Director of Quality and Performance Improvement, Director(s) of Care Coordination, Director(s) of Utilization Management, Director(s) of Population Health, Senior Health Educator, Chief Health Services Officer (CHSO), Director of Pharmacy Services, Regional Medical Director(s), Associate Medical Director(s), Senior Provider Relations Representative Manager, and Senior Director of Member Services. In addition, a broad range of network providers (e.g. Hospitals, Clinics, County Partners, Subcontractors, Downstream Subcontractors, and Members are solicited to actively participate in the QIHEC.

Substance Use Services Internal Quality Improvement Subcommittee (SUIQI)

A committee comprised of appropriate Partnership and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for Partnership's administration of Substance Use Services on behalf of Regional Model counties. The SUIQI meets at least quarterly. Activities and progress are reported to the IQI. This also includes

- Review of Utilization Management retroactive and appeals review
- Review of inter-rater reliability for peer review and utilization management
- Review of quality of service, quality of facility, and access complaints and grievances
- Investigation of potential overuse, underuse, and misuse of services.
- Review of policies related to provision of Substance Use Services

Members of the committee include the Behavioral Health Clinical Director, the CMO, Senior Director of Behavioral Health, Senior Manager of Behavioral Health and representatives from the Provider Relations, Member Services, Claims, Compliance, Behavioral Health and Quality Improvement Departments.

UTILIZATION MANAGEMENT PROGRAM SCOPE

UM activities are developed, implemented and conducted by the Partnership Health Services Department under the direction of the Chief Medical Officer and the Chief Health Services Officer. The UM staff performs specific activities.

Specific functions include:

- Prospective, concurrent and retrospective utilization review for medical necessity, appropriateness of hospital admission, level of care and continued inpatient confinement on a frequency consistent with evidence-based criteria and Partnership guidelines, Partnership criteria/ medical policy and the Member's condition. This review is performed cooperatively with the facility care team which may consist of the attending physician(s) and any associated health care personnel who can provide information that will substantiate medical necessity and level of care.
- Discharge planning in collaboration with the facility care team
- Review inpatient and outpatient UM data to determine appropriateness of Member and provider utilization patterns
- Use of most current edition of InterQual® Criteria for medical authorization, and other Partnership UM guidelines and medical policy as developed and approved by the Quality / Utilization Advisory Committee (Q/UAC)
- Use of California Department of Health and Welfare Code of Regulations Title 22, Center for Medicare & Medicaid Services (CMS) Code of Federal Regulations (CFR) Title 42 and National and Local Coverage Determinations
- Review certification requests for skilled nursing care, home health care, durable medical equipment, ambulatory surgery, ambulatory diagnostic and treatment procedures such as physical, occupational and speech therapies.

The UM program incorporates the monitoring and evaluation for the subsequent services and reviews and updates policies and procedures as appropriate but at least annually.

- Acute hospital services
- Subacute care
- Ambulatory care
- Emergency and urgent care services
- Durable Medical Equipment and supplies
- Ancillary care services, including but not limited to home health care, skilled nursing care, subacute care, pharmacy, laboratory and radiology services
- Long-term care including Skilled Nursing Facility (SNF) Care and Rehabilitation Facility Care
- Residential Substance Use Disorder (SUD) treatment
- Behavioral Health Treatment (BHT) services
- Community Supports
- Enhanced Care Management
- Physician administered drugs (medical drug benefit)

PHARMACY PROGRAM SCOPE

The Pharmacy Department within Health Services is responsible for the utilization management of the medical drug benefit – those medications administered to a Member directly during a medical stay/visit at a clinic, office, or hospital, and billed to Partnership as part of a medical service claim; this includes drugs administered at time of service by physicians, dentists, podiatrists, nurse practitioners and physician assistants. Drugs and other prescription services provided to a Member by a pharmacy are not within the scope of Partnership's Pharmacy Program because the pharmacy benefit is carved-out to State Medi-Cal through the Medi-Cal Rx Program.

Out of Scope for Partnership Pharmacy Program:

- Pharmacy benefits and services pursuant to Executive Order N-01-19 and the Medi-Cal Rx program. The Medi-Cal pharmacy benefits and services administered by DHCS in the FFS delivery system is identified collectively as Medi-Cal Rx. This includes:
  - Covered Outpatient Drugs, as defined by SSA 1927(k)(2): prescription drugs which are not provided as part of *medical* service and thus are under the scope of the Pharmacy Benefit.
  - Self-administered medications provided to a Member to take/inject/inhale/apply/insert (or otherwise administer) at home.
  - Medication and supply services provided to Members at long-term care and skilled nursing facilities.
  - Medications administered by an infusion pharmacy or home health agency in a pharmacy infusion suite or in the Member's home
- Medications and services statutorily defined as a non-Medi-Cal benefit
- Medications provided in a medical setting which are carved out of the Managed Care Plan (MCP) capitation agreement: antivirals for HIV/AIDs, drugs and blood factor products for Hemophilia, drug and alcohol substance use disorder treatment (prescribed outside a narcotic treatment program), antipsychotics, and certain antidepressants (MAOI).

In Scope for Partnership Pharmacy Program:

- Utilization management of drugs administered in a medical setting and billed by the medical provider under the medical benefit, which includes:
  - Drugs other than Covered Outpatient Drugs. The SSA 1927(k)(2) definition of a Covered Outpatient Drug does not include any drug, biological product, or insulin provided as part of, or as incident to, the provision of and billing for medical or institutional services [SSA 1927(k)(3)]
  - Development of coverage criteria for injectable drugs requiring prior authorization based on current nationally accepted treatment guidelines, current medical literature, and input from specialists. These criteria may be drug-specific or class-specific.
  - Application of billing limits, restrictions, or requirements based on FDA approved indications and dosing &/or State Medi-Cal billing requirements. Such utilization management examples include maximum daily dose, allowed dosing frequency, age limits, place of service (e.g. dialysis centers) and current ICD (diagnosis) requirements.
  - The medical provider submits prior authorization requests directly to the pharmacy department. See policy MCRP4068 *Medical Benefit Medication TAR Policy* for further details.
  - Pre-service, Concurrent, and Post-Service (Retrospective) pharmaceutical utilization reviews of medical necessity using established prior authorization criteria requirements set forth by Partnership Pharmacy & Therapeutics (P&T) Committee, or as required by State Policy (All Plan Letters), or in accordance with Partnership case-by-case review guideline (below) when Partnership criteria are not yet established. Timeliness standards mirror those for UM Program Timeliness (see page 26).
  - Case-by-case review shall consider:
    - The Member's individual medical needs (allergies, disease history, treatment history, concurrent medications, concurrent disease states, contraindications) and assessment of access and local delivery system
    - Prescriber's scope of practice/areas of specialization
    - The FDA approved package labeling for indication(s), maximum safe & effective dosing, appropriate age group, recommended screenings and monitoring,
    - Prescribed drug's recommended place in therapy according to indication &/or nationally recognized treatment guidelines
    - Availability & effectiveness of preferred treatments for the same indication

    - Industry-standard clinical resources including (but not limited to): Lexi-Drug, Elsevier/Gold Standard Clinical Pharmacology, National Comprehensive Cancer Network (NCCN), UpToDate, IPD Analytics, and Facts & Comparisons
    - Trials of preferred alternatives: There is no set number of preferred medications that must be tried before a non-preferred medication can be approved. Trials of preferred alternatives is unique to each drug and may depend on factors including but not limited to available treatment alternatives, pharmacologic and therapeutic similarities between different treatments, indication, and Member's reason for failure with previous treatments. The number of trials required will be based on the clinical judgement of the physician or clinical pharmacist reviewer.
- Retrospective Drug Utilization Review (DUR) (post-claim analysis, educational programs)
    - Improve medication therapy outcome and reduce and prevent inappropriate use, fraud, or abuse.
- AB 1114 Pharmacist Services pursuant to APL 25-013 "Medi-Cal Rx Pharmacy Benefits and Cell and Gene Therapy Coverage" (09/18/2025)
- Disease/Medication Management Programs
    - Improve medication adherence, address therapeutic gaps, and optimize medication therapy outcome.
- Support of Care Coordination and Case Management
    - Support Members with complex medication regimen, multiple health conditions, behavioral and substance use disorder.
- Support of Quality Improvement (e.g. HEDIS, outcomes measures)
    - Performance improvement in medication related quality measures

Mental Health

Members may self-refer for mental health services to mental health providers using Partnership's toll-free Behavioral Health referral number (855) 765-9703 or by contacting the preferred behavioral health provider directly. Members do not need a referral or prior authorization to receive mental health services.

In an effort to coordinate the Member's overall health care, mental health providers are instructed to ask Members to sign a release of information so that the mental health provider can contact the Member's PCP or other providers. However, the release of information is not a condition for the approval or provision of services.

Mental health services for Members with Medi-Cal as their primary insurance are provided as follows:

- Members determined to have Non-Specialty Mental Health Services (NSMHS) needs that require mild to moderate mental health treatment are served by Partnership's behavioral healthcare department which can be reached by calling (855) 765-9703.
- Members determined to require Specialty Mental Health Services (SMHS) for moderate to severe mental health conditions are referred to the County Behavioral Health Plan (BHP) in the Member's county of residence. The administration of such referrals is addressed in the respective Memorandum of Understanding (MOU) with each respective County Behavioral Health Plan, consistent with California statutes and regulations.
- DHCS requires Managed Care Plans (MCPs) and BHPs to use specific Screening and Transition of Care Tools for Members under age 21 (youth) and for Members age 21 and over (adults) to determine the appropriate mental health delivery system referral for Members who are not currently receiving mental health services when they contact the MCP or BHP seeking mental health services. These tools can be found on the DHCS website on this page: https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-Medi-Cal-Mental-Health-Services.aspx

County Behavioral Health Plans provide crisis assessments and authorizations for care. Immediate access to the crisis service remains an option throughout all phases of treatment by any provider. Each County operates crisis services to address clients in crisis; crisis services also act as a backup after hours and on weekends as well as at other times of provider unavailability. Members may call the County crisis line directly, without a referral. Members eligible for mental health services from Partnership will be re-directed to appropriate County crisis services as needed.

A certain level of mental health services is appropriately dealt with in a primary care practice, including screening and referrals to services. Primary Care Providers may contact each county's Behavioral Health Plan or Partnership, as applicable, for telephone consultation. For detailed referral and consultation procedures, PCPs can refer to Partnership policy MPBP8011 *Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines*.

Partnership is responsible for the delivery of non-specialty mental health services for children under age 21 and outpatient mental health services for adult beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM). Outpatient mental health services are delivered as specified in policy MPBP8003 *Mental Health Services* whether they are provided by PCPs within their scope of practice or through Partnership's provider network. Partnership continues to be responsible for the arrangement and payment of all medically necessary, Medi-Cal-covered physical health care services, not otherwise excluded by contract, for Partnership beneficiaries who require specialty mental health services.

In compliance with Mental Health Parity requirements on October 1, 2017, as required by Title 42, CFR Section 438.930, Partnership ensures direct access to an initial mental health assessment by a licensed mental health provider within the Partnership provider network. No referral from a PCP or prior authorization is required for an initial mental health assessment to be performed by a network mental health provider.

Partnership meets the general parity requirement (Title 42, CFR, §438.910(b)) which stipulates that treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. Neither a referral from the PCP, nor prior authorization, is required for a beneficiary to seek any mental health service, including the initial mental health assessment from a network mental health provider.

If a dispute occurs between the local County Behavioral Health plan and Partnership HealthPlan of California, both parties will participate in a dispute resolution process as defined in Partnership policy MPBP8005 Dispute Resolution Between Partnership and BHPs in Delivery of Behavioral Health Services. This is consistent with the dispute resolution process outlined by State regulations and the individual County/Partnership Memoranda of Understanding.

Triage and Referral for Mental Health

Partnership monitors triage and referral protocols to ensure they are appropriately implemented, monitored and managed. Protocols utilized are based on sound clinical evidence and accepted industry practice. They must define the level of urgency and appropriateness of the care setting.

Triage and referrals are performed by the Behavioral Health Access Line with oversight by Partnership's Senior Director of Behavioral Health and Behavioral Health Clinical Director. Partnership works collaboratively with the respective County Behavioral Health Plans to coordinate and ensure Members receive care at the appropriate level in a timely manner.

Substance Use Disorder Treatment Services/ Wellness & Recovery Program

Partnership works to ensure that Members receive effective and appropriate behavioral health care services for both mental health and substance use disorders. Partnership provides Substance Use Disorder (SUD) treatment services as outlined in the Regional Drug Medi-Cal Model (Regional Model). SUD services are administered either by Partnership or through individual counties not participating in the Regional Model.

The range of services in the Wellness & Recovery Program include:

- Outpatient treatment (licensed professional or certified counselor, up to nine hours per week for adults)
- Intensive outpatient treatment for individuals with greater treatment needs (licensed professional or certified counselor, structured programming, 9-19 hours per week for adults)
- Detoxification services (withdrawal management)
- Residential treatment (Prior authorization is required as per policy MPUP3144 *Residential Substance Use Disorder Treatment Authorization*)
- Medication assisted treatment (MAT) (methadone, buprenorphine, disulfiram, and naloxone). *Partnership is financially responsible for the dispensing of these medications when services occur in a contracted Narcotic Treatment Program (NTP)/ Opioid Treatment Program (OTP) facility. When MAT is prescribed outside of a NTP/OTP (e.g. dispensed through a pharmacy) the medications will be authorized through the state Medi-Cal Rx program.*
- Care Coordination
- Recovery services (aftercare)

Behavioral Health Treatment (BHT) for Members Under 21 Years of Age

Partnership has provided benefits for Behavioral Health Therapy for children diagnosed with Autism Spectrum Disorder (ASD) since September 2014. Effective July 1, 2018, Partnership expanded its benefit coverage to include Behavioral Health Treatment (BHT) for eligible Medi-Cal Members under the age of 21 as required by the Early and Periodic Screening and Diagnostic Treatment (EPSDT) mandate.

Treatment services may include Applied Behavioral Analysis (ABA) and other services known as 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 include a variety of behavioral interventions that have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence that are designed to be delivered primarily in the home and in other community settings.

Partnership will provide medically necessary BHT services covered under Medicaid (Medi-Cal) for all Members who meet the eligibility criteria for services as stated in 1905® of the Social Security Administration (SSA) and outlined in DHCS All Plan Letter (APL) 23-010 *Revised*.

- Additional detailed information regarding the BHT benefit can be found in the following Partnership Policies and Procedures:
  - MCUP3126 *Behavioral Health Treatment (BHT) for Members Under the Age of 21*
  - MPCP2014 *Continuity of Care*

Quality Improvement Collaboration

The UM team works collaboratively with the Quality Improvement (QI) Department to enhance the care provided to our Members through venues such as the Internal Quality Improvement Committee (IQI), the Quality/ Utilization Advisory Committee (Q/UAC) and daily UM activities.

In the committee environment, the UM team takes an analytical, evaluative and strategic look at predetermined metrics to evaluate and offer recommendations which further enhance the UM program. Data is reviewed and discussed at least bi-annually during the IQI and Q/UAC meetings. The Q/UAC provides guidance and direction to the UM program by coordinating activities and by functioning as the expert panel when needed. Collaboration includes but is not limited to:

- Reviewing, making recommendations to, and approving the *UM Program Description* annually
- Assuring individual Member needs are taken into consideration when determinations for care are rendered
- Analyzing summary data and making recommendations for action
- Reviewing the recommendations of Process Implementation Teams to develop UM improvement action plans, ongoing monitoring, and evaluation
- Recommending medical policy, protocol, and clinical practice guidelines based on provider and Member experience information.

During daily activities, the UM team supports QI efforts in the identification of potential quality of care issues, reporting adverse occurrences identified while conducting UM case review, improvement of Healthcare Effectiveness Data and Information Set (HEDIS®) scoring by referrals to care coordination, and care coordination efforts to ensure Members are seen by the appropriate provider for their condition.

UTILIZATION MANAGEMENT PROCESS

Partnership applies written, objective, evidence-based criteria (InterQual® and pharmaceutical criteria) and considers the individual Member's circumstance and community resources when making medical appropriateness determinations for behavioral health and physical health care services.

Appropriately licensed professionals supervise all medical necessity decisions as described in the UM Program Staff section starting on page four (4). 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 UM decision making is based only on appropriateness of care and service.

Furthermore, Partnership does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service. 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.

Working with practitioners and providers of care, the following factors are taken into consideration when applying guidelines to a particular case in review:

- Input from the treating practitioner
- Age of Member
- Comorbidities in existence
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment
- Consideration of the local delivery system, availability of services and their ability to meet the Member's specific health care needs to include but not be limited to:

- Availability of inpatient, outpatient, transitional and residential treatment (SUD) facilities
    - Availability of outpatient services
    - Availability of highly specialized services, such as transplant facilities or cancer centers
    - Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge
    - Local hospitals' ability to provide all recommended services
- Benefit coverage

Referrals and requests for prior authorization of services are to be submitted by the provider of service to the Partnership UM department by fax or through Partnership's Online Services portal, which is a Secure Electronic Internet system. The following information must be provided on all requests.

- Member demographic information
- Provider demographic information
- Requested service/procedure to include specific CPT/HCPCS code(s)
- Member diagnosis (Using current ICD Code sets)
- Clinical indications necessitating service or referral
- Pertinent medical history, treatment or clinical data
- Location of service to be provided
- Requested length of stay for all inpatient requests
- Proposed date of procedure for all outpatient surgical requests

Pertinent data and information is required to enable a thorough assessment of medical necessity. If information is missing or incomplete, the requestor will be notified and given an opportunity to submit additional information.

Addition of Benefits and Modifications of TAR Requirements

The process for adding a new Partnership benefit and specifying TAR requirements, as well as the process for adding or removing TAR requirements for existing benefits, both begin when a request is submitted by a Provider, Member, or Staff. The following information should be included:

- Justification for the new benefit and/or change in TAR requirements
- Identification of Member population that would benefit
- Relevant clinical information
- TAR requirements (e.g. Will a TAR be required? Will TAR requirements be removed?)

The Chief Medical Officer (CMO) or Physician Designee reviews the request, with input from the Chief Health Services Officer. Feedback may also be sought from relevant specialists, physician committees, or advisory committees to determine whether new benefits and/or TAR requirements should be added, and under what criteria, or if existing requirements should be removed.

Operational review is conducted through the Benefit Review and Evaluation Workgroup (BREW), which includes leaders from clinical, operational, financial, and regulatory areas. BREW examines the medical, financial, and operational implications and presents findings to the Executive Committee. The Executive Committee may consult the Physician Advisory Committee (PAC), approve minor changes such as single CPT codes, or recommend larger benefit changes to the Board for approval. They also oversee necessary IT, claims, and financial adjustments, including potential recommendations to state regulators. This structured process ensures medical necessity, operational feasibility, and financial sustainability are carefully considered before new benefits are adopted and TAR requirements are applied.

Elective Admission Precertification

The UM department evaluates every proposed treatment plan, and determines benefit eligibility, suitability of location and level of care prior to the approval of service delivery for select diagnoses and procedures.

Utilizing written criteria such as InterQual®, Medi-Cal criteria and Partnership medical policy approved by the Q/UAC, licensed and professional UM staff review and approve completed Treatment Authorization Requests (TARs).

Only the Chief Medical Officer or physician designee may make a medical necessity determination and have the authority to deny a service request based on lack of medical necessity. Partnership offers the practitioner the opportunity to discuss any medical necessity denial determination with the physician reviewer rendering the decision.

Referral Management

Referrals are generated by the primary care provider and submitted to Partnership's Online Services (OLS) portal (or by fax or mail). Partnership monitors and analyzes requests to identify trends and assist in follow-up care. Requests for out-of-network referrals are reviewed to determine if the service is available and can be provided within Partnership's network. Out-of-Network requests are also used to evaluate provider access and to determine if the local network requires enhancements to meet Member needs.

Continued Stay/Concurrent Review

Acute care hospitalization reviews are performed by licensed professionals to ensure medical necessity of continued stay, the appropriateness of level of care, and care duration. This review is conducted either on site, by accessing the facility electronic medical record through a secure portal, or telephonically using written Partnership medical policy, InterQual®, and/or Medi-Cal guidelines.

Requests for authorization are reviewed within 24 hours of notification of admission and concurrently throughout the stay. The UM team facilitates discharge planning in collaboration with the facility care team and makes referrals to Partnership case management and social services as appropriate.

Consideration of available services in the local service area or delivery system and the ability to meet the Member's specific health care needs are evaluated as part of application of criteria and the development of an ongoing plan of care and discharge plan.

Only the Chief Medical Officer or physician designee has the authority to deny a request for service based on lack of medical necessity. Partnership offers the practitioner with clinical expertise in the area being reviewed the opportunity to discuss the application of criteria in determining medical necessity or any determination based on lack of clinical justification with the physician reviewer.

In addition to individual conversations with practitioners on specific case reviews, Partnership conducts several committees for the purpose of hearing and incorporating practitioner input in the development of medical policy. Partnership, through the Physician Advisory Committee (PAC), the Quality/ Utilization Advisory Committee, and the Pharmacy and Therapeutics Committee (P&T), provides practitioners with clinical expertise in several areas the opportunity to advise or comment on the development and/or adaptation of UM criteria and provide feedback or instruction on the application of those criteria. Within the previously stated committees, Partnership evaluates UM criteria and procedures against current clinical and medical evidence and updates them accordingly.

Skilled Nursing/Sub acute/ Long-Term Acute/Rehabilitation Facility Review

Review of all Skilled Nursing and Rehabilitation Facility confinements are performed by licensed professionals to ensure medical necessity of continued stay and the appropriateness of level and duration of care. This review is conducted telephonically using written Partnership medical policy, Title 22 criteria, and/or InterQual® criteria. Requests for authorization are reviewed within 24 hours of notification of admission. The UM team facilitates discharge planning in collaboration with the facility care team and makes referrals to Partnership case management and social services as appropriate.

Consideration of available services in the local service area or delivery system, and the ability to meet the Member's specific health care needs are evaluated as part of applying criteria and the development of an ongoing plan of care and discharge plan.

Discharge Planning
Discharge planning is a critical component of the utilization management process and begins upon admission with an assessment of the patient's potential discharge needs. It includes preparation of the family and the patient for continuing care needs and initiation of arrangements for services or placement needed after acute care discharge.

Partnership Nurse Coordinators work with hospital discharge planners, case managers, admitting/attending physicians and ancillary service providers to assist in making necessary arrangements for post-discharge needs.

Post-Service Retrospective Review
Post-service retrospective reviews may occur when a Member is retroactively granted Medi-Cal benefits by the State of California, when a provider does not realize an authorization is required prior to rendering a service, when the rendered service code billed does not match the code authorized, or the service may have been rendered after the expiration of the authorization. TARs must be received by Partnership within 15 business days of the date of service or within 60 calendar days of either a denial from the primary insurance carrier or retrospective eligibility. (TARs submitted beyond these timeframes are considered late but will still be reviewed for medical necessity.)

All retrospective reviews are completed within 30 calendar days of receipt of request. 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.

Services requiring an authorization can be retrospectively reviewed for medical necessity, appropriateness of setting, and length of stay up to one year after services are rendered and may result in an adverse determination.

Emergency Room Visits
Emergency room visits where a prudent layperson, acting reasonably, would believe an emergency condition exists, DO NOT require prior authorization.

Timeliness of UM and Pharmacy Decisions

Partnership makes UM and Pharmacy decisions in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of care. Partnership measures the timeliness of decisions from the date when the organization receives the request from the Member or PCP, even if the Partnership does not have all the information necessary to make a decision. Partnership documents the date when the request is received and the date a decision is rendered in the UM documentation system.

Partnership has communicated to both providers and Members the practice of processing non-urgent requests during the next business day if the request is received after business hours.

Partnership Utilization Management abides by the following timeliness guidelines when processing health services requests.

Urgent Requests
A request for medical care or services where application of the time frame for making routine or non-life threatening care determinations could jeopardize the live, health or safety of the Member or others due to the Member’s psychological state or, in the opinion of the practitioner with knowledge of the Member’s medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment requested.

Concurrent Review 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 the organization did not previously approve the earlier care.

Pre-Service Request
A request for medical care or services that Partnership must approve in advance, in whole or in part.

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.

Post-Service Request / Retrospective Review
A request for medical care or services that have been received.

Non-Behavioral Healthcare Decisions and Behavioral Healthcare Decisions

Type of Request	Decision Time Frame	Notification[1] Time Frame	Extended Time Frame
Urgent concurrent review	72 hours of receipt of request	72 hours of receipt of request	May be extended one time up to 14 calendar days from receipt of request
Urgent pre-service	72 hours of receipt of request	72 hours of receipt of request	May be extended one time up to 14 calendar days from receipt of request
Non-urgent pre-service	7 calendar days of receipt of request	24 hours of determination date[1]	May be extended one time up to 14 calendar days from receipt of request
Post-service	30 calendar days of receipt of request	30 calendar days of receipt of request	N/A

[1] Notification: Give electronic or written notification of decision to practitioner (and Member when required).
Per DHCS requirement, written notification must be mailed to a Member within two (2) business days of the decision.

Pharmacy Decisions

Type of Request	Decision Time Frame	Notification Time Frame	Extended Time Frame
Urgent concurrent review	24 hours of receipt of request	24 hours of receipt of request[3]	May be extended one time up to 14 calendar days from receipt of request[4]
Urgent pre-service	24 hours of receipt of request	24 hours of receipt of request[3]	May be extended one time up to 14 calendar days from receipt of request[4]
Non-urgent pre-service	24 hours of receipt of request	24 hours of receipt of request[3]	May be extended one time up to 14 calendar days from receipt of request[4]
Post-service	30 calendar days of receipt of request	30 calendar days of receipt of request	N/A

[3] Notification Time Frame: Per DHCS regulations
[4] Extended Time Frame: Per DHCS regulations

Review Criteria
Current InterQual® criteria sets are used as the main review guidelines. Additional criteria are selected or developed using other resources as necessary to help in determining review decisions which include, but are

not limited to, Medi-Cal (State of California) guidelines and State policy letters (see policy MPUP3139 *Criteria and Guidelines for Utilization Management*). InterQual® criteria are produced using a rigorous development process based on evidence-based medicine and reviewed at least annually, but as frequently as quarterly, by a panel of board-certified specialists. All UM policies are based on InterQual® criteria and are reviewed annually by the Quality/Utilization Committee (Q/UAC) and the Physician Advisory Committee (PAC) which also include board-certified specialists who are practicing network physicians. All Pharmacy policies are reviewed annually by the Pharmacy and Therapeutics (P&T) Committee and PAC. Refer to pharmacy policies MCRP4068 *Medical Benefit Medication TAR Policy* and MPRP4001 *P&T Committee* for further details regarding pharmaceutical criteria.

In the absence of applicable criteria, the Partnership UM medical staff refers the case for review to a licensed, board-certified practitioner in the same or similar specialty as the requested service. The reviewing practitioners base their determinations on their training, experience, the current standards of practice in the community, published peer-reviewed literature, the needs of the individual patients (age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable), and characteristics of the local delivery system. Board-certified consultants are available through our providers on our Quality/Utilization Advisory Committee (Q/UAC). Partnership also contracts with a third-party independent medical review organization which provides objective, unbiased medical determinations to support effective decision making based only on medical evidence. (See policy MPUP3138 *External Independent Medical Review*.)

Criteria are selected, reviewed, updated or modified using feedback from the Q/UAC and PAC as well as Member feedback identified in Member survey results and the Community Advisory Committee (CAC), State policy letters, State Memorandums of Understanding and/or medical literature, among other sources. In collaboration with actively practicing practitioners, criteria are evaluated on at least an annual basis. Relevant clinical information is obtained when making a determination based on medical appropriateness and the treating practitioner is consulted as appropriate. All information obtained to support decision-making is documented in the utilization management documentation system.

Decisions are based on information derived from the following sources:

- Clinical records
- Medical care personnel
- Facility utilization management staff
- Attending physician (attending physician can be the primary care physician, hospitalist or the specialist physician (or all three as necessary)
- Board-certified specialists are consulted when medically necessary

When applying criteria to a treatment request, reviewers consider the needs of the individual patient (age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable) as well as the availability of services in the local delivery system and their ability to meet the Member's specific health care needs.

Inter-Rater Reliability (IRR)

Partnership assesses the consistency with which physician and non-physician reviewers apply UM criteria in decision making and evaluates Inter-Rater Reliability. The Inter-Rater Reliability mechanism uses live cases to ensure medical management criteria are appropriately and consistently applied in making UM determinations. The methodology employed is designed to annually assess 50 cases or 5% of reviewer case load, whichever is less, over the course of a year period.

The following types of reviews/reviewers are audited:

- Nurse Coordinator Review of Inpatient Services
- Nurse Coordinator Review of Outpatient Services
- Nurse Coordinator Review of Long Term Care Services
- Behavioral Health (BH) Nurse Coordinator Review of Residential Substance Use Disorder Treatment Authorizations

- Physician Review of Medical Necessity Authorizations
- Pharmacist and Pharmacy Technician Review of Pharmacy TARs

A performance target of 90% accuracy is set for inter-rater reliability. An audit summary is reported at least annually or more often as needed to the Internal Quality Improvement (IQI) Committee. If a reviewer falls below the targeted threshold, a corrective action plan is initiated and monitored and results are presented to the Quality/Utilization Advisory Committee (Q/UAC) for review and discussion. Please refer to policy MPUP3026 *Inter-Rater Reliability Policy* for a full description of the IRR process.

Availability of Criteria

All criteria used to review authorization request are available upon request. In the case of an adverse determination, the criteria used are made part of the determination file. Access to and copies of specific criteria utilized in the determination are also available to any requesting practitioner by mail, fax, email, or on our website: http://www.partnershiphp.org. To obtain a copy of the UM criteria, practitioners may call the Partnership UM Department at (800) 863-4155.

Members may request criteria used in making an authorization determination by calling the Member Services department to request a copy of the criteria. The UM team will work with Member Services to provide the criteria used in the review decision.

Partnership's Provider Relations Department notifies providers in writing and electronically through the New Provider Credentialing Packet and the provider's contract that UM criteria is available online at http://www.partnershiphp.org in the Provider Manual section. Providers are also notified quarterly through electronic mail and fax via the Quarterly Provider Newsletter about the on-line availability of UM criteria and policies at http://www.partnershiphp.org in the Medi-Cal Provider Manual section.

Partnership's UM Program plans include development and implementation of its CMS Final Rule Interoperability plan during CY 2026. This plan will include steps for the implementation of practitioner access to criteria electronically at point of service. Implementation is planned for January 2027.

Communication Services

Partnership provides access to UM staff for Members and practitioners seeking information about the UM process and the authorization of care in the following ways:

- 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 HealthPlan is in operation (Monday - Friday 8 a.m. - 5 p.m.).
- For after-hours communication regarding UM issues, telephonic voicemail service is available. Members and practitioners may leave a message which is communicated to the appropriate person on the next business day. Calls received after normal business hours are returned on the next business day, hence, calls received after midnight on Monday - Friday are returned on the same business day.
- After normal business hours, Members may contact the advice nurse line at (866) 778-8873 for assistance with clinical concerns.
- Practitioners, both in-network and out-of-network, may contact UM staff directly either through secure email or voicemail. Each voicemail box is confidential and will accept messages after normal business hours. Communications received after normal business hours are returned on the next business day, hence communications received after midnight on Monday - Friday are responded to on the same business day.
    - Partnership has a dedicated after-hours phone number local (707) 430-4808 or toll free (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 staff are available 24 hours per day, 7 days per week to coordinate the transfer of a Member whose emergency medical condition is stabilized.

- Partnership 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 the Program Staff section of this document starting on page four (4) above.
- Partnership maintains a toll-free number (800) 863-4155 that is available to both Members and practitioners.
- Members can view information about Partnership's language assistance services and disability services in the Member Handbook which is made available to Members upon enrollment and is always viewable online at http://www.partnershiphp.org/Members/Medi-Cal/Documents/MCMemberHandbook.pdf Additionally, Partnership provides annual written notice to Members about our language assistance services and disability services (e.g. TTY for hearing impaired) in our Member Newsletter.

Linguistic services are provided by Partnership to monolingual, non-English speaking or limited English proficiency (LEP) Medi-Cal beneficiaries as well as eligible Members with disabilities for population groups as determined by contract. These services include the following:

No Cost Linguistic Services:

- 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
- Written information and materials (to include notice of action, grievance acknowledgement and resolution letters) are fully translated by qualified translators into threshold languages for Partnership Members according to regulatory timeframes, and into other languages or accessible formats upon request. Alternative material formats available to Members include audio format, Braille, large-size print format, and accessible electronic format for Members with hearing and/or visual disabilities. Auxiliary aids are also available upon request. Please refer to MPND9002 Cultural and Linguistic Program Description for more information. 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.
- Use of California Relay Services for hearing impaired [TTY/TDD: (800) 735-2929 or 711]

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. (See policy MPND9002 *Cultural and Linguistic Program Description*)

Denial Determinations

Denial determinations may occur at any time in the course of the review process. Only the Chief Medical Officer, or a physician designee acting through the designated authority of the Chief Medical Officer, has the authority to render a denial determination based on medical necessity which is defined as "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."

A denial determination may occur during continued stay/concurrent review in which case notification and/or discussion with the treating practitioner and the Health Plan physician adviser/Chief Medical Officer or physician designee is offered.

Denial determinations may occur at different times and for various reasons including but not limited to:

- At the time of prior authorization; when the requested service is not medically indicated or not a covered benefit.

- When timely notification was not received from a facility for an inpatient stay to foster transfer of a medically stable patient
- When an inpatient facility fails to notify the Health Plan of admission within one business day of the admission or appropriate clinical information is not received
- When out-of-network services are not clinically appropriate
- Or after services are rendered at claims review when the services were not authorized, or are medically unnecessary

A denial may also occur for inappropriate levels of care or inappropriate care. Notwithstanding previous authorization, payment for services may be denied if it is found that information previously given in support of the authorization was inaccurate.

Partnership offers the practitioner the opportunity to discuss any denial or potential denial determination based on lack of medical necessity with the Health Plan Chief Medical Officer, or a physician designee.

The denial notification states the reason for the denial in terms specific to the Member's condition or service request and in language that is easy to understand and references the criterion used in making the determination so the Member and provider have a clear understanding of the Health Plan's rationale and enough information to file an appeal.

Partnership HealthPlan of California is aware of the need to be concerned about under-utilization of care and services for our Members. Partnership monitors over and under-utilization through the Over/Under Utilization Workgroup which reviews annual utilization patterns. Decisions made by Partnership's Utilization Reviewers are solely based on the appropriateness of the care or service.

The Health Plan does not compensate any individual involved in the utilization process to deny care or services for our Members nor do we encourage or offer incentives for denials.

Process for a Member or a Provider on Behalf of a Member to Appeal an Adverse Benefit Determination

Members and providers are provided fair and solution-oriented means to address perceived problems in exercising rights as a Medi-Cal beneficiary or provider, in accordance with requirements of Partnership's contract with the Department of Health Care Services (DHCS). This process is entirely separate from that of State Fair Hearings, to which Members retain their access. The Member or their authorized representative may submit a request for appeal verbally or in writing. The Member or the authorized representative may submit additional information for review and may request copies of all documents considered as part of the review. The time for resolution begins when the request is received, even if the information provided is incomplete. Partnership makes appropriate attempts to obtain any needed information for review within the required timelines, in order to make an informed decision within required timeframes based on clinical urgency and according to our policies and procedures. Please refer to Partnership policy MCUP3037 *Appeals of Utilization Management/ Pharmacy Decisions* for a full description of the process.

Data Sources

Utilization Management supports the effective, efficient, and appropriate utilization of Member benefits through ongoing review, evaluation and monitoring of the Member's personal health information in making medical necessity determinations.

Data sources may include, but are not limited to:

- Medical records, from outpatient provider offices and hospital records (including accessing hospital Electronic Medical Records (EMR); for current and historical data
- Member handbook/Evidence of Coverage

- Consultations with treating physicians
- Network adequacy information
- Local delivery system capacity information
- Specialist referrals
- Recent Physical exam results
- Diagnostic testing results
- Treatment plans and progress notes
- Operative and pathological reports
- Rehabilitation evaluations
- Patient characteristics and information
- Patient psychosocial history
- Information from family / social support network
- Prospective/concurrent/retrospective utilization management activities
- Claim/encounter (administrative) data

Data Collection, Analysis, and Reporting

Data collection activities for analysis and reporting are coordinated by the UM department. At the data gathering/performance measurement phase, participants in the process include programmers and analysts in the Finance and Health Services departments, staff nurses, and any other personnel required for the collection and validation of data. All data collection activities are documented and reported to the Q/UAC twice a year and more often if requested. Data collection activities may include, but are not limited to:

- Member satisfaction surveys
- Provider satisfaction surveys
- Readmission statistics
- Potential quality incident data
- Member appeal data
- Provider appeal data
- Internally developed databases
- Pharmacy utilization data
- Other administrative or clinical data
- Member utilization data
- Provider prescribing data

EVALUATION OF NEW MEDICAL TECHNOLOGY

Partnership evaluates the inclusion of new medical technologies and the new application of existing technologies in its benefit packages. While the basic benefits are set by the State of California Department of Health Care Services (DHCS) and outlined in Title 22 of the Health and Welfare Code, Partnership has the option of adding to this basic package of benefits for its Members.

Partnership's Policy MPUP3042 *Technology Assessment* outlines the steps taken during the determination process. The Partnership Physician Advisory Committee will review all cases and make a final recommendation to the Board of Commissioners as to new benefits. The Commission is the only entity that can add benefits.
Once a new benefit is added, the information is disseminated to all Primary Care Providers and appropriate specialists in the form of a mail notification of benefit addition, and to all Members in the next Member newsletter.

New technologies are handled on a case-by-case basis which includes obtaining information regarding the safety, efficacy and indications that support the use of the intervention. There must be evidence that the proposed intervention will add to improved outcomes as compared to what is currently available. The service provider must have a record of safety and success with the intervention and cannot be part of a funded

research protocol. The Chief Medical Officer works closely with the requesting physician and specialists as needed in researching these cases.

DELEGATION

UM activities that are delegated to contract providers are reviewed and approved on an annual basis by the Quality/Utilization Advisory Committee (Q/UAC). A delegation agreement, including a detailed list of activities delegated and reporting requirements is signed by both the delegate and Partnership.

- Providers to whom UM activities have been delegated are responsible for reporting results and analyses to Partnership on a quarterly or annual basis. Reports are summarized for review and evaluation by Partnership's Delegation Oversight Review Sub-Committee (DORS) and Q/UAC.
- Audits are conducted no less than annually and evaluation includes a review of both the processes applied in carrying out delegated UM activities, and the outcome achieved in accordance with the respective policy(s) and agreement governing the delegated responsibility.
- The Q/UAC reviews evaluations and make recommendations regarding opportunities for improvement and continuation of delegated functions.

A pre-delegation evaluation is conducted when delegation of functions to providers is being considered.

Protected Health Information (PHI)

The Privacy Rule, described in 45 CFR Parts 160 and 165, applies to covered entities. The Privacy Rule allows covered providers, entities, and health plans to disclose PHI in order to carry out their health care functions.

Partnership HealthPlan of California is fully compliant with the general rules, regulations and implementation specified in The Privacy Rule. Partnership also provides reasonable administrative, technical, and physical safeguards to ensure PHI confidentiality, integrity and availability and to prevent unauthorized or inappropriate access, use or disclosure of PHI.

The Partnership Director of Regulatory Affairs and Program Development also serves as the Partnership Privacy Officer. Partnership has implemented a comprehensive program that includes "Notice of Privacy Practices" (NPP) sent to all Members, as well as implementation of a confidential toll-free complaint line available to Members, providers and Partnership staff. For non-covered entities, Partnership requires Business Associate Agreements (BAA). Additionally, there is training on an annual basis for the Partnership workforce and Partnership providers/networks, and Partnership maintains policies and procedures around documentation of complaints of violations or suspected privacy incidents.

STATEMENT OF CONFIDENTIALITY

Confidentiality of provider and Member information is ensured at all times in the performance of UM activities through enforcement of the following:

- Members of the Q/UAC and PAC are required to sign a confidentiality statement that will be maintained and securely stored in the QI files.
- UM documents are restricted solely to authorized Health Services Department staff, members of the PAC, Q/UAC, and Credentials Committee, and reporting bodies as specifically authorized by the Q/UAC.
- Confidential documents may include, but are not limited to, Q/UAC and Credentials Committee meeting minutes and agendas, QI and Peer Review reports and findings, UM reports, or any correspondence or memos relating to confidential issues where the name of a provider or Member are included.
- Confidential documents are stored in locked file cabinets with access limited to authorized persons only, or they are electronically archived and stored on protected drives.

- Confidential paper documents are destroyed by shredding.
- Partnership has designated a Privacy Officer responsible to oversee compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other state and federal privacy laws.
- Partnership maintains administrative structure, reporting procedures, due diligence procedures, training programs and other methods to ensure effective compliance in use and disclosure of Members' Protected Health Information (PHI).

NON-DISCRIMINATION STATEMENT

Partnership complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin (including limited English proficiency (LEP) and primary language), age, disability, or sex (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes).

Partnership will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily are exclusively available. Also, Partnership will not otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.

Partnership provides free aids and services to people with disabilities to communicate with us, such as:

- Qualified sign language interpreters or Video Remote Interpreters (VRI)
- Written information in other formats (large print, audio, Braille, accessible electronic formats, other formats)

Partnership provides free language services to people whose primary language is not English or those with limited English proficiency (LEP). These services include the following:

- Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact
- Information written in other languages
- Use of California Relay Services for hearing impaired

STATEMENT OF CONFLICT OF INTEREST

Any individual who has been personally involved in the care and/or service provided to a patient, an event or finding undergoing quality evaluation may not vote or render a decision regarding the appropriateness of such care. All members of the Q/UAC are required to review and sign a conflict of interest statement, agreeing to abide by its terms.

PROVIDER AND MEMBER SATISFACTION

Partnership conducts satisfaction surveys with both Members and providers. Included in the evaluation are questions that deal with both Member and provider satisfaction with the UM program. The responses to the survey are reviewed by staff from Health Services, Member Services, and Provider Services. Thresholds are set and responses that fall below are considered for corrective action by the HealthPlan. The results, as well as plans for corrective action, are developed in conjunction with the Q/UAC. Corrective actions that were in place are evaluated at the time the follow-up annual survey is done unless the committee feels an expedited time frame needs to be implemented.

Annual Program Evaluation

The Utilization Management program undergoes a written evaluation of its overall effectiveness annually by the Q/UAC, which is reviewed and approved by the PAC.

At a minimum the evaluation considers UM department activities and outcomes, the review of Key Performance Indicator metrics such as Productivity, Timeliness, Bed-days, readmission rates and denial rates along with resource effectiveness and barriers to performance.

Preparation for the Annual Program Evaluation involves participation by all Utilization Management, Pharmacy and Behavioral Health leadership including but not limited to:

- Chief Health Services Officer
- Senior Director of Care Management
- Senior Director of Behavioral Health
- Director, Pharmacy Services
- Director of Enhanced Health Services
- Directors of UM
- Associate Directors of UM
- UM Managers

Elements of the program evaluation include an objective assessment of meeting targeted goals to ensure appropriate, efficient utilization of resources/services for Partnership Members across the continuum of care in compliance with requirements of state/federal and regulatory entities.

- Annual UM Program Description update
- Annual review and evaluation of UM processes (meeting goals and identifying opportunities for process improvements)
- Timely review and update of UM policies and procedures
- Obtain approval of UM policies and procedures at Q/UAC

Inter-Rater Reliability (IRR) scoring and TAR timeliness are compared with regulatory compliance standards and internal benchmarks.

To determine if the UM program remains current and appropriate, the organization annually evaluates:

- The program structure
- The program scope, processes, and information sources used in the determination of benefit coverage and medical necessity
- The level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program
- Consideration of Member and practitioner experience data when evaluating the UM program

The organization updates the UM program and its description annually based on the evaluation.

To ensure the provision of healthcare services at the appropriate level of care the evaluation considers:

- Inpatient bed day rate
- Inpatient average length of stay
- SNF admit rate
- SNF average length of stay
- Readmission rate
- Denial rate
- Timely completion of notifications of denial of care
- Timely completion of notifications of authorization of care
- Rate of referrals to Care Coordination
- Effectively integrating feedback - the program reflects on Member/Provider satisfaction results concerning the UM program looking at:
    - Daily Work Flow Monitoring
    - Call Abandonment rates

- Call Volume
- Average caller wait time

An assessment of Department resources is determined by looking at the impact of staffing changes, learning curves and system limitations which impede work effectiveness. There is a review of Inter-Rater Reliability scoring in relation to staff training/re-education, acclimation to new technology such as documentation software/ hardware based on evaluating user acceptance, and the assessment of appropriate staffing ratio to ensure adherence to regulatory and internal performance standards.

A summary of the program evaluation, including a description of the program, is provided to Members or practitioners upon request.

REFERENCES:

- Department of Health Care Services (DHCS) standards
- National Committee for Quality Assurance (NCQA) Guidelines UM Standards
- Covered Outpatient Drugs, SSA 1927(k)(2), SSA 1927(k)(3)
- California State Department of Health Care Services (DHCS) Medi-Cal Rx Resources and Reference Materials:
- https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/Medi-CalRX.aspx
- State Medi-Cal Managed Care Plans: https://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx

Original Date: QI/UM Program 04/22/1994 effective 05/01/1994**Revision Date(s): 08/16/95**
Revision Date(s): UM Program Description - 04/17/97; Board Approval January 28, 1998; 06/10/98; 01/20/99; 05/2000; 05/01/01; (UD100301) 03/20/02; 08/20/03; 10/20/04; 10/13/05; 06/21/06; (MPUD3001) 04/16/08; 08/03/10; 11/19/14; 02/17/16; 04/19/17; *06/13/18; 04/10/19, 06/12/19 *(Amended)*, 11/13/19 *(Amended);* 04/08/20; 06/10/20 (*Amended*); 04/14/21; 01/12/22; 05/11/22; 05/10/23; 05/08/24; 05/14/25; 10/08/25; 03/11/26; 05/13/26

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

UM PROGRAM DESCRIPTION APPROVAL

	04/15/2026

Robert Moore, MD, MPH, MBA *Date Approved*
Quality/Utilization Advisory Committee Chairperson

	05/13/2026

Angela Brennan, DO *Date Approved*
Physician Advisory Committee Chairperson

	06/24/2026

Dean Germano *Date Approved*
Board of Commissioners Chairperson

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
April 24, 2026

Agenda Item Number:
3.4

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Approved by:
Physician Advisory Committee and Partnership Staff

Topic Description:
Due to a new federal regulation that went into effect at the end of 2025, the Hospital Quality Incentive Program must transition to a calendar year program by January 2027. Therefore, the proposed changes below pertain to the proposed abbreviated six-month bridge measurement set covering the period of July 1, 2026, through December 31, 2026. There are no new measures proposed for this set, but several are proposed for removal for this six-month period. (see attached summary).

Reason for Resolution:
To approve the Hospital Quality Improvement Program (HQIP). six-month bridge measurement set covering the period of July 1, 2026, through December 31, 2026.

Financial Impact:
The impact to the HealthPlan is included in the budget assumptions.

Requested Action of the Board:
Based on the recommendation of the Physician Advisory Committee and Partnership staff, the Board is asked to approve the Hospital Quality Improvement Program (HQIP). six-month bridge measurement set covering the period of July 1, 2026, through December 31, 2026.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 24, 2026

Agenda Item Number:
3.4

Resolution Number:
26-

IN THE MATTER OF: APPROVING PROPOSED HOSPITAL QUALITY INCENTIVE PROGRAM(HQIP) SIX-MONTH BRIDGE MEASUREMENT SET

Recital: Whereas,

A. The Board has responsibility to review and approve policies, programs, and benefits.

B. The Board has fiduciary responsibility for the operation of the organization.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the Hospital Quality Improvement Program (HQIP). six-month bridge measurement set covering the period of July 1, 2026, through December 31, 2026.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 24th day of June 2026 by motion of Commissioner Starr seconded by Commissioner Germano and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

____
Dean Germano, Chair

____
Date

ATTEST:

BY: ______________________________
Ashlyn Scott, Clerk

HQIP Six-Month Measure Proposal

HQIP 2026 Six-Month Bridge Measurement Set (July 1 – December 31, 2026)

Providers have the potential to earn a total of 100 points in six domains 1) Readmissions; 2) Advanced Care Planning; 3) Clinical Quality; 4) Patient Safety; 5) Operations/Efficiency; 6) Patient Experience. Individual measure values will be assigned for the final and approved measurement set.

Key: Proposed for extension || Proposed for removal or postponement

2025-26 Measures	2026 Six-Month Bridge Set Recommendations
Risk Adjusted Domain	**Risk Adjusted Domain**
1. Risk Adjusted Readmissions (RAR)	1. Risk Adjusted Readmissions (RAR)
2. 7-Day Follow-up Clinical Visit (RAR)	2. 7-Day Follow-up Clinical Visit (RAR)
Palliative Care Domain	**Palliative Care Domain**
3. Palliative Care Capacity	3. Palliative Care Capacity
Clinical Domain	**Clinical Domain**
4. Elective Delivery Before 39 Weeks	4. Elective Delivery Before 39 Weeks
5. Exclusive Breast Milk Feeding Rate	5. Exclusive Breast Milk Feeding Rate
6. Nulliparous, Term, Singleton Vertex (NTSV) Cesarean Rate	6. Nulliparous, Term, Singleton Vertex (NTSV) Cesarean Rate
7. Vaginal Birth After Cesarean (VBAC)	7. Vaginal Birth After Cesarean (VBAC)
8. Expanding Delivery Privileges	**8. Expanding Delivery Privileges**
9. Doula Support	**9. Doula Support**
10. Increasing Mammography Capacity	10. Increasing Mammography Capacity
11. Vaccines For Children Enrollment	11. **Vaccines For Children Enrollment**
Patient Safety Domain	**Patient Safety Domain**
12. CHPSO Patient Safety Organization Participation	12. Patient Safety Organization Participation
13. Substance Use Disorder Referral, Medication Assisted Treatment (MAT)	13. Substance Use Disorder Referral, Medication Assisted Treatment (MAT)
Operations / Efficiency Domain	**Operations / Efficiency Domain**
14. QI Capacity	**QI Capacity**
15. Hospital Quality Improvement Platform	14. Hospital Quality Improvement Platform
Patient Experience Domain	**Patient Experience Domain**
16. Cal Hospital Compare-Patient Experience	**Cal Hospital Compare-Patient Experience**
17. Health Equity	**Health Equity**

HQIP Six-Month Measure Proposal

Programmatic Changes:

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

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

A. Revisions to Existing Measures:

1. **Measure 8: Expanding Delivery Privileges:**
   It is proposed that this measure **remains** in the six-month set at the Phase Two level and move to Phase 3 in the 2027 measurement year. While many hospitals have expanded privileges during the 2025-26 measurement year, this six-month extension will give those hospitals that did not expand this year to expand privileges before moving to Phase 3, which will require contracting and hiring of the providers.

Specifications

In this second phase of measure implementation, hospitals are now required to work toward actively recruiting, granting privileges, and demonstrating evidence of family physicians' and nurse midwives' clinical activity.

Measure Requirements

This multi-phase measure began with ***Phase One*** in the 2024-25 measurement year, which asked hospitals to develop by-laws and/or policy and procedure to expand delivery privileges to midwives and family physicians. With ***Phase One*** completed in 2024-25, this measure moved into ***Phase Two*** for the 2025-26 HQIP Measurement Year starting July 1, 2025.

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

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

2. Measure 9: Doula Support

It is proposed to extend the deadline for the Doula Support measure to December 31, 2026, with the same measure specifications as last year. The plan will be to move into Phase 2 of the measure during the 2027 measurement year at which time hospitals will need to demonstrate recruitment or use of doulas in the hospitals.

Specifications

This measure will be implemented over multiple years, with **Phase One** starting with the 2025-26 measurement year. In future years, hospitals will be required to work toward actively recruiting and allowing doulas to provide support during labor and delivery.

Measure Requirements

Hospitals will develop policy and/or procedures that allow doulas to support birthing parents in the hospital during labor and delivery.

In future years, we anticipate a second phase of this measure to include evidence that doulas are being utilized in labor and delivery

Hospitals with existing bylaws and/or written policies that allow doulas to provide support during labor and delivery will get full points for the measure.

3. Measure 11: Vaccines For Children (VFC) Enrollment

It is proposed to extend the Vaccines For Children (VFC Enrollment) measure through this period, which will allow additional time for hospitals to enroll in the program. The plan is for this measure to be removed in 2027.

Measure Specification:

HQIP birthing hospitals can save cost and positive impact their newborn population by enrolling in the 'no cost" Vaccination For Children program through CDPH. Partnership's HQIP birthing hospitals will be eligible to receive points by successfully enrolling in the CDPH's VFC program by the end of the measurement year.

Exclusions

Very Small sized hospitals with less than 25 Licensed General Acute beds are excluded from participation in this measure. This measure will not be applicable to hospitals who already enrolled during the 2025-26 measurement period.

HQIP Six-Month Measure Proposal

B. Removal of Existing Measures for 2025-26

1. **Quality Improvement Capacity:**
   This measure is designed to provide a free full day Hospital Quality Symposium each measurement year for our participating hospitals. At which, hospital quality and executive staff can stay up to date on quality topics at large and at Partnership. It is proposed to remove this measure from the six-month bridge set because hospitals have already attended Partnership's Hospital Quality Symposium for the 2025-26 measurement year, and it would be redundant to host another event. The plan is for this measure to be part of the full 2027 calendar year HQIP.

2. **California Hospital Compare:**
   This measure is intended to encourage hospitals to provide excellent patient experience and Partnership's scoring of the measure relies upon California Hospital Compare's scores, which are updated annually. It is proposed to remove this measure for this six-month bridge set as the scores for the 2025-26 measurement year would have just been delivered meaning there would be no new information to score the hospitals. The plan is to return this measure to the full 2027 calendar year HQIP.

3. **Health Equity:**
   It is proposed to remove the Health Equity measure from the six-month bridge set because the hospitals would have just submitted their annual report to Partnership in August of 2026. It is also recommended to remove this measure because CMS removed its requirement for a Commitment to Health Equity Attestation, which is what this measure was based upon. The plan is to develop a new Health Equity measure for the full 2027 calendar year HQIP.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 24, 2026

Agenda Item Number:
3.5

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Approved by:
Physician Advisory Committee and Partnership Staff

Topic Description:
In order to provide high quality health services, the Board is asked to review the 2027 Palliative Care Quality Improvement Program measurement set (see attached summary).

Reason for Resolution:
To optimize the Palliative Care QIP to improve quality of care.

Financial Impact:
The impact to the HealthPlan is included in the budget assumptions.

Requested Action of the Board:
Based on the recommendation of Partnership staff and PAC, the Board is asked to approve the 2027 Palliative Care Quality Improvement Program measurement set.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 24, 2026

Agenda Item Number:
3.5

Resolution Number:
26-

IN THE MATTER OF: APPROVING THE 2027 PALLIATIVE CARE QUALITY IMPROVEMENT PROGRAM (PQIP) MEASUREMENT SET

Recital: Whereas,

A. The Board has responsibility to review and approve HealthPlan policies, programs, and benefits.

B. The Board has fiduciary responsibility for the operation of the organization.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the 2027 Palliative Care Quality Improvement Program measurement set.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 24th day of June 2026 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

____
Dean Germano, Chair

____
Date

ATTEST:

BY: ______________________________
Ashlyn Scott, Clerk

Palliative Care Quality Incentive Program
Summary of Proposed 2027 Measures

Key:

New Measure **|** Change to Measure Design **|** ~~Measure removed~~

2026 Measures	2027 Recommendations
Utilization	
1. Avoiding Hospitalization & Emergency Room Visits • $240 PMPM if no inpatient or ED use per calendar month	**1. Avoiding Hospitalization & Emergency Room Visits** • $240 PMPM if no inpatient or ED use per calendar month *CHANGE:* *No recommended changes*
Quality	
2. Completion of POLST • $120 PMPM once a signed POLST is completed **3. Completion of a Standardized Patient Symptom Assessment** • $120 PMPM if two (2) standardized patient symptom assessments are completed, with all essential data elements included. Thresholds: • ≥ 70% of data elements entered on assessments = Full points ($120 PMPM) • 50-69% of data elements entered on assessments = Partial points ($60 PMPM)	**2. Completion of POLST** • $120 PMPM once a signed POLST is completed **3. Completion of a Standardized Patient Symptom Assessment** • $120 PMPM if two (2) standardized patient symptom assessments are completed, with all essential data elements included. Thresholds: • ≥ 70% of data elements entered on assessments = Full points ($120 PMPM) • 50-69% of data elements entered on assessments = Partial points ($60 PMPM) *CHANGE:* *No recommended changes*

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 24, 2026

Agenda Item Number:
3.6

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Approved by:
Physician Advisory Committee and Partnership Staff

Topic Description:
In order to provide high quality and timely prenatal and postpartum care to Partnership members, the Physician Advisory Committee and Partnership staff are proposing changes to the 2027 Perinatal Quality Improvement Program (PQIP) measurement set (see attached summary).

Reason for Resolution:
To optimize the Perinatal QIP to improve quality of care.

Financial Impact:
The impact to the HealthPlan is included in the budget assumptions.

Requested Action of the Board:
Based on the recommendation of the Physician Advisory Committee and Partnership staff, the Board is asked to approve proposed changes to the 2027 Perinatal Quality Improvement Program measurement set.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 24, 2026

Agenda Item Number:
3.6

Resolution Number:
26-

IN THE MATTER OF: APPROVING PROPOSED CHANGES TO THE 2027 PERINATAL QUALITY IMPROVEMENT PROGRAM (PQIP) MEASUREMENT SET

Recital: Whereas,

A. The Board has responsibility to review and approve policies, programs, and benefits.

B. The Board has fiduciary responsibility for the operation of the organization.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve proposed changes to the Perinatal Quality Improvement Program (PCPQIP) measurement set.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 24th day of June 2026 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

____
Dean Germano, Chair

____
Date

ATTEST:

BY: ______________________________
Ashlyn Scott, Clerk

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

Proposed 2027
Perinatal Quality Improvement Program (PQIP)
Measurement Set

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

(A) Gateway Measure – Measure 1

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

(B) Clinical Measures – Measures 2-6

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

Key:
New Proposed Measures || Change to Measure Design

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

PROPOSED CHANGES FOR THE PQIP 2027 MEASURE SET

Programmatic Changes:

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

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

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

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

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

Measure Requirements

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

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

B. CLINICAL MEASURES

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

Measure Summary:

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

Proposal:

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

Reporting (Applies to Measures 3 & 4)

Monthly DataLink Extractions

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

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

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

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

Measure Summary:

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

Proposal:

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

III. Measure 6: Timely Comprehensive Assessments

Measure summary

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

Proposal

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

Measure Target Specifications

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

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

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date: June 24, 2026

Agenda Item Number: 3.7

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
Quality / Utilization Advisory Committee & Physician Advisory Committee

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Topic Description:
Each year, Partnership conducts an overall assessment of the health environment, community needs, and the factors that influence the well-being of the member population. This assessment is required by the National Committee for Quality Assurance (NCQA) Health Plan Accreditation Standards for an annual Population Needs Assessment (PNA). The results of this assessment are used to develop this PNA report, which informs Partnership's Population Health Management Strategy and the corresponding Population Health Management workplan; this assessment may also inform the Cultural & Linguistics (C&L) Program description and its C&L work plan as needed.

Reason for Resolution:
To allow the full Board the opportunity to review and approve Partnership's Population Needs Assessment when there are edits and on an annual basis.

Financial Impact:
There is no measurable financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of the Quality / Utilization Advisory Committee and the Physician Advisory Committee, the full Board is asked to approve Partnership's Population Needs Assessment.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 24, 2026

Agenda Item Number:
3.7

Resolution Number:
26-

IN THE MATTER OF: APPROVING THE POPULATION NEEDS ASSESSMENT

Recital: Whereas,

A. The Board has the authority and responsibility for ensuring Partnership has a cohesive planfor population health management.

B. The Board has ultimate responsibility for approving Partnership's Population Needs Assessment.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve Partnership's Population Needs Assessment.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 24th day of June 2026 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

____
Dean Germano, Chair

____
Date

ATTEST:

BY: ______________________________
Ashlyn Scott, Clerk

Population Needs Assessment

May 2026

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I. Population Needs Assessment Overview

Partnership HealthPlan of California is a not-for-profit Medi-Cal managed care plan (MCP) serving 24 counties in Northern California. As of December 2025, the plan has approximately 893,608 members.[1] Partnership is one of six County Organized Health System (COHS) managed care plans in California, endorsed by its counties' Boards of Supervisors.

Most Medi-Cal beneficiaries, including Seniors and Persons with Disabilities (SPDs), California Children's Services (CCS) beneficiaries, and those in skilled nursing facilities are automatically assigned to Partnership. 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 enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook. In addition, other dual-eligible Medicare-Medicaid members, who are not Partnership Advantage Members, will be assigned to Partnership as a secondary line of coverage. In 2025, Partnership provided primary and specialty health services through a contracted network of community providers, medical groups, Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Indian Health Centers, local hospitals (acute and other), skilled nursing facilities, pharmacies, and ancillary providers.[2]

Each year, Partnership conducts an overall assessment of the health environment, community needs, and the factors that influence the well-being of the member population. This assessment is required by the National Committee for Quality Assurance (NCQA) Health Plan Accreditation Standards for an annual Population Needs Assessment (PNA). The results of this assessment are used to develop this PNA report, which informs Partnership's Population Health Management Strategy and the corresponding Population Health Management workplan; this assessment may also inform the Cultural & Linguistics (C&L) Program description and its C&L work plan as needed. To develop the 2026 PNA, Partnership integrates and analyzes various data sources, including:

- Partnership Member Enrollment data

[1] Partnership Membership Dashboard, 2025
[2] Partnership Quality and Performance Improvement Program Description, 2025

- Local Community Needs Assessments
- County Health Rankings and Roadmaps
- Small Area Income and Poverty Estimates (SAIPE)
- U.S. Census Bureau data
- Published articles and reports from the CDC and other reputable sources
- Partnership Integrated Claims and Encounter data
- Healthcare Effectiveness Data and Information Set (HEDIS®) results
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data
- HEDIS Disparities Analysis Summary Dashboard
- Timely Access data
- Partnership Grievance and Appeals data
- Internal Human Resources reports
- Other sources as relevant

Member enrollment data is further segmented by age, gender, race/ethnicity, primary language, geographic distribution, and other factors, to identify gaps in services and health disparities.

Population Health staff completed the analysis and made the decisions included in the report, with cross-departmental input and approval as needed. The writing staff consists of the positions listed in the table below:

Position Title	Department
Manager	Population Health
Community Health Needs Liaisons	Population Health

A. Summary of Key Findings

Partnership's membership remained relatively stable in 2025. At the close of 2025, Partnership served approximately 893,608 members throughout 24 counties. The 2026 Population Needs Assessment draws from a broad range of data sources to identify member needs along with the overall community conditions where members live.

1. 2025 Summary of Findings

Local community needs assessments identified a variety of priority areas of need that can be grouped by Healthy People 2030 domains of Social Determinants of Health (SDoH),[3] including:

- Economic stability: high poverty rates, economic instability, food insecurity and disparities in access to social services
- Healthcare access and quality: provider shortages, insufficient access to healthcare, mental health, substance use disorder and prenatal care services
- Neighborhood and built environment: geographic isolation, lack of affordable housing, safe neighborhoods, higher rates of violence, unintentional injury, fire threat, and challenges with transportation
- Education access and quality: Low education attainment and limited internet access
- Social and community context: higher rates of adverse childhood experiences (ACEs), need for fostering community connections, trusted leaders and institutions, and healthcare system navigation

A review of the data sources highlights significant concerns related to access to care, behavioral health, and other social determinants of health. Across multiple counties, challenges such as a shortage of healthcare providers, transportation barriers, and economic instability are prevalent. Behavioral health, including mental health and substance use disorders, is consistently identified as a primary concern. Additionally, social determinants like income inequality, housing insecurity, and food deserts disproportionately affect marginalized communities, exacerbating health disparities. These factors contribute to a landscape where members face compounding obstacles to achieving optimal health.

Disparities in health outcomes are particularly pronounced among racial minorities, LGBTQ+ individuals, and Indigenous populations. Maternal and child health disparities, coupled with high rates of adverse childhood experiences (ACEs), further emphasize the need for targeted interventions. The availability of healthcare providers remains a significant concern across all counties, particularly in rural and frontier regions, where the number of available providers in areas like primary care, dental care, and mental/behavioral health is insufficient to meet demand and appears to be declining.

[3] Social Determinants of Health, Healthy People 2030

Transportation challenges further complicate access to care, especially in remote areas where long distances must be traveled to access healthcare services. Many individuals lack reliable transportation options and geographical isolation exacerbates the difficulty in attending provider visits. Housing issues also remain a constant challenge, with a lack of affordable and quality housing preventing many individuals from securing stable living situations. This issue has remained persistent during 2025, contributing to a continued homelessness crisis across many counties.

In 2025, there were 148 wildfires in Partnership's regions, likely contributing to loss of available housing, and possible adverse pulmonary and cardiovascular effects. Compounding these environmental factors are lifestyle choices like smoking. Adult smoking rates were equal to or higher than the state average in all of Partnership's counties, and some smokers start as early as elementary school.

Partnership utilizes claims and encounter data to approximate disease prevalence among its members. In 2025, hypertension, anxiety, depression, tobacco use, obesity and substance use were the 6 most prevalent conditions diagnosed among adults. The most common diagnoses for pediatric members were anxiety, trauma/stress, depression, obesity, asthma, and substance use. Telehealth utilization in general has increased for 2025. Partnership's southern region had the highest number of members accessing specialty mental health services. Breast cancer screening rates and cervical cancer rates in the northern counties also continue to underperform.

To determine if there are health disparities within the overall population served, Partnership reviewed the HEDIS Disparity Analysis Dashboard for Controlling Blood Pressure (CBP). The analysis found that the multiracial group had the poorest rates of blood pressure control for HbA1c in diabetes. Native Hawaiian and Other Pacific Islander, American Indian and Alaska Native, and Black or African American populations had significantly higher rates of poor control, performing below the MPL 50th percentile. In contrast, the Asian population had the lowest rate of poor control, performing above the 90th percentile, indicating better control of diabetes. For prenatal care visits, the Asian population had the highest rates of completion, while the Native Hawaiian and Other Pacific Islander population had the lowest. Native Hawaiian and Other Pacific Islanders had the highest rates of postpartum care (100%), while the American Indian and Alaska Native population had the lowest (69.44%). These findings highlight significant health disparities across various racial/ethnic groups, with certain populations experiencing lower levels of care and worse health outcomes compared to others.

2. 2025 Summary of Planned Actions

Partnership works closely with provider and community resources to ensure members have access to a wide range of services. This PNA revealed opportunities for action by addressing needs in the following areas: organizational structure, social and environmental needs, member health and wellness, access to care, health disparities, as well as Member Benefits/Services Education, Health Education, and Culture and Linguistics.

In the realm of organizational structure, in 2025, Partnership has continued to provide teams who work to build relationships with community partners and other stakeholders, including the recent mandate for Partnership to work collaboratively with the Local Health Jurisdictions in its service area on their Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP). These teams, alongside other population health staff, connect members to local resources and follow up to ensure their needs are met. They also represent Partnership at various community collaborative meetings and events to learn about the ongoing needs of communities.

The position of Director of Health Equity oversees internal staff equity, provider and non-provider contractor equity, member equity, and interventions designed to mitigate health disparities. In 2024, Health Equity branched off into its own department. In 2025, the department continued to grow. Additional staff were hired, including 1 Cultural and Linguistic Liaison, a Supervisor of Health Equity Training, and a Manager of Cultural Community. A second position for a Cultural and Linguistic Liaison was also created.

To address social and environmental concerns, Partnership has dedicated staff and resources to manage these concerns and to collaborate with other community agencies in addressing these challenges. One example is the State funds and initiatives like the CalAIM Incentive Payment Program which provides the means for managed care plans to offer grant funding to address housing concerns. Lastly, as part of DHCS's Incentive Payment Program (IPP), Partnership has awarded over $52 million to more than 100 CalAIM providers via grants to build capacity for programs such as Enhanced Care Management (ECM) and Community Supports (CS) services; both of these programs work to ensure the needs of the most vulnerable members are met.

Many of Partnership's counties have household incomes below the state average, and local Community Health Assessments revealed challenges around sufficient employment and income. In collaboration with community partners, Partnership is working to increase workforce opportunities including providing member scholarships to aid in education with a focus on health care, social work, and other related fields.

One of the ways Partnership continues to provide support for members living in fire-prone areas is through a Fire and Disaster Reporting email inbox for member- and provider-facing departments within Partnership. Partnership continued to use the Fire and Disaster Reporting email inbox for internal reporting, monitoring, and notifications around disasters in Partnership's service area throughout early 2025. The inbox is used as a tool to share information within Partnership HealthPlan in the event an environmental disaster threatens to affect members, providers, or the community. Partnership also posted member materials to Partnership's website comprised of a Disaster Preparedness booklet and Emergency Kit Pocket Card.

In the realm of member health and wellness, pediatric members with asthma who live in Partnership's Northern Region may have more difficulties controlling their asthma than those living in the Southern Region. Wildfires are more prevalent in Partnership's Northern Region than in the Southern Region, and this may contribute to the poorer asthma control. In alignment with CalAIM BPHM requirements, Partnership continued the new Asthma Emergency Department (ED) Visit Outreach Program Campaign to better support members with asthma in 2025. The Asthma Management campaign offers additional support to members who were recently seen in the ED for their asthma. To help manage other member chronic diseases, and in alignment with DHCS' Population Health Management requirements, Partnership will continue to support and refine its Basic Population Health Management programs centered on hypertension, diabetes, and depression.

Partnership continued conducting health education sessions around tobacco prevention in counties with high tobacco usage in 2025. Partnership also implemented an ADHD program to help address mental health conditions in children. Furthermore, as part of Partnerships' efforts to improve poor behavioral health outcomes and increase access among K-12 students, Partnership is actively participating in and supporting our school partners through implementation of the new Multi-Payer Fee Schedule which includes new and expanded behavioral health provider types. Partnership also continues to contract with Alinea Medical Imaging to bring mobile mammography imaging to rural communities and to health centers that do not have ready access to mammography services. With 72 mobile mammography days in 19 different Partnership counties and modest improvements in screening outcomes, Partnership intends to continue this collaboration in 2025. Other organizational efforts in the realm of member health and wellness include efforts to increase cervical cancer screenings and colon cancer screenings.

Finally, Partnership will continue to make significant investments into expanding services for maternal and child health. Partnership performs outreach to all members

with babies from ages 0-30 months and children ages 3 to 6 years, offering incentives to attend well-care visits and encouraging vaccinations. Additional outreach campaigns target pre-teen visits for vaccinations and wellness visits. Furthermore, Partnership has allocated staff, and time to collaborate with public health officers, and other necessary stakeholders which has resulted in plans to conduct school-based clinics, and other strategies to promote childhood wellness care. Partnership will continue to evaluate the impact of these activities through appropriate reports, monitoring efforts, and multi-disciplinary committees.

Efforts to improve access include Partnership's development of a multi-pronged approach to recruit and retain providers. For example, Partnership continued the Provider Recruitment Program in 2025, which focused on helping the contracted network recruit and retain high-quality health professions in Partnership counties; this program provided incentives, including sign-on bonuses. Partnership also has a Provider Retention Initiative (PRI) to recognize primary care clinicians, providers of perinatal services, and/or obstetrics/gynecology, and psychiatrists who are deeply invested in the safety net population, while helping to incentivize additional years of service. These Partnership efforts focus on strengthening recruitment of PCPs, behavioral health providers, mid-levels, and specialists in the areas where access is impacted most, as indicated by high HPSA scores or the "frontier" geographic designation.

Partnership is committed to inclusion and equality of opportunity for staff and members. Partnership hosts Health Equity Week for staff in April with emails, videos, and interactive activities to elevate diversity awareness. Partnership also offered staff training around cultural diversity, linguistics, and gender inclusion, which are all required on a regular basis. In 2026 and beyond, DEI trainings for Partnership will align with new DHCS regulatory requirements.

Partnership is committed to enhancing the member experience by actively reviewing and offering trainings and tools to contracted providers, with a focus on reducing unintended bias, discrimination, and health disparities. In 2025, Partnership's Cultural and Linguistic and Health Education Team reviewed and updated the comprehensive Cultural and Linguistic toolkit for providers. We also began offering providers regular DEI training to align with NCQA and DHCS quality standards. This training is supported by key staff in the Health Equity Department and will continue in 2026.

American Indian/Alaska Native populations face many health disparities. To help remedy known health disparities, Partnership will continue its strategy to strengthen relationships and collaborative efforts with tribal health providers within its service area, to decrease known health disparities between American Indian and non-American Indian members. Partnership has been an active participant in several such efforts. Partnership is also heavily involved in other activities geared towards addressing health disparities among other populations and are later described in this report.

To help support health education/culture and linguistics, Partnership shares member-facing videos on relevant topics to help educate members. In 2025, videos were created about colorectal cancer screenings and instructions on how to use the ColoGuard test. Each of Partnership's counties has a dedicated county resource page and the support of Partnership's Population Health Department in accessing those resources. These resources are continuously updated and improved upon, and Population Health staff monitor and follow up on resource needs of members. Partnership will also continue to collaborate with community groups and plans to offer educational sessions to members, particularly non-English-speaking ones, about available benefits like vision, mental health services, and preventative care services. Furthermore, Partnership Member Services staff are conducting in-person presentations called Member (or Community) Informative Sessions." Member Services staff provide an overview of Partnership's services and the resources that are available to members. While onsite, Member Services staff also provide in-the-moment support, helping members navigate their transition into Partnership. Partnership conducts these sessions primarily in English and Spanish. Finally, Partnership will continue to offer members an opportunity to submit grievances and appeals and will further its own organizational culture of diversity, equity and inclusion by offering regular staff and provider trainings.

II. Data Sources

A. Overview of Procedures, Resources, and Methodologies

Partnership collects, integrates, and assesses data from its member population to develop the PNA and various related activities. Partnership uses this data to determine the profile and needs of its member population, which may include, but is not limited to:

- Member demographics such as age, language (including limited English proficiency), race/ethnicity, and geographic location
- Local community needs assessments
- Social Determinants of Health (SDoH), drawn from County Health Rankings

- Service utilization, based on integrated claims and encounter data
- Health conditions and health-related behaviors, based on Partnership's HEDIS data
- Timely Access Data
- Key populations such as child and adolescent members, members with multiple chronic conditions, vulnerable populations, members with disabilities, and members with serious mental illness or serious emotional disturbance (SMI/SED), and or both, based on member demographics, and integrated claims and encounter data
- Member satisfaction or lack thereof, based on CAHPS data and member grievance data
- Partnership's Reducing Health Disparities Dashboard (i.e. 2025 Health Disparities data)

1. 2025 Partnership Member Enrollment Data

Partnership demographic data is based on the Medi-Cal enrollment data received as of December 2025. This data includes the total number of individuals enrolled in Medi-Cal and assigned to Partnership by eligibility group. Through daily and monthly releases, DHCS submits eligibility and enrollment data to Medi-Cal Managed Care Plans based on their contracted service areas. This data includes member-level characteristics such as race/ethnicity, date of birth, gender, language, alternate format selection and eligibility indicators for seniors and persons with disabilities, and membership data for review for enrollment in the California Children's Services Program.

2. Local Community Needs Assessments

The Community Needs Assessment section was compiled using the most recent versions of publicly available Community Health Assessment (CHA), Community Health Improvement Plans (CHIPs), or Local Community Health Needs Assessment (CHNA) reports from each of Partnership's 24-county service area. The reports were published in different years ranging from 2022-2029. Some of Partnership's counties have CHA reports in progress, set to be released in the near future. The reports used to summarize needs in each county are based on the most recent reports available.

3. 2025 County Health Rankings and Roadmaps

The County Health Ranking and Roadmaps program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health

Institute.[4] The 2025 Annual County Health Rankings uses the most currently available data to measure a range of vital health factors, including but not limited to air pollution, adult smoking, severe housing problems, physical inactivity, and food environment index (access to healthy foods). County Health Rankings also typically includes measures such as high school graduation rates, obesity, unemployment, income inequality, teen births, and more. The rankings are modeled after a view of population health that highlights the many factors that influence one's health. If these factors improve, communities thrive and reduce health disparities for subpopulations. The rankings are determined by:

- Health Outcomes: The overall ranking in health outcomes measures the general health of county residents. They reflect the physical and mental well-being of residents within a community through measures representing length of life and quality of life.
- Health Factors: The overall ranking in health factors represents many things that influence quality of life and how long we live. Health factors represent circumstances or behaviors that can be modified to improve the length and quality of life for residents. They are predictors of how healthy our communities can be in the future.

4. 2025 Partnership Integrated Claims and Encounter Data

Partnership's Health Analytics team manages an integrated data set, including medical, behavioral, laboratory results, and services directly reimbursed by the state (e.g., pharmacy claims). The 2025 data set is gathered from information submitted by health care providers such as doctors, hospitals, and ancillary services. The data set documents both the diagnosed clinical conditions, and the services and items received by beneficiaries to treat these diagnosed conditions. Data is presented in a series of Tableau dashboards showing prevalence of disease, benefit utilization, referral practices, and other utilization benchmarks. Partnership's paid claims, laboratory results, and encounter data are integrated with state-provided data, such as California Immunization Registry (CAIR) data, state pharmacy claims, and claims from our delegated managed behavioral healthcare organization (Carelon Behavioral Health).

5. 2025 Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS is a measurement tool maintained by the National Committee for Quality Assurance (NCQA). HEDIS is used to evaluate clinical quality in a standardized way. The California Department of Healthcare Services (DHCS) and NCQA selects a subset

[4] Robert Wood Johnson Foundation, About Us, 2024

of measures for Medi-Cal plans to report on annually as required for State and NCQA Accreditation reporting. NCQA and DHCS use annual HEDIS performance reporting to evaluate the delivery of quality care and services to its members. For Measurement Year 2025 (MY2025) Partnership will be required to report the HEDIS measures at the plan-wide level to include all (24) counties. The DHCS required reporting measures is referred to as the Managed Care Accountability Set (MCAS); the methodology for each HEDIS measure is described in the annual NCQA HEDIS Technical Specifications corresponding to the measurement year.

Using the NCQA Quality Compass benchmarks and thresholds, DHCS sets targets for minimum and high performance. The DHCS-specified minimum performance level (MPL) is set at the 50th percentile based on the National Medicaid benchmarks and varies by each measure.

In addition to the DHCS required reporting, Partnership is also required to report the HEDIS performance for Health Plan Accreditation (HPA). Rate performance and scoring is based on the NCQA Health Plan Rating Methodology. The MY2025 Annual Summary of Performance Report for both the DHCS and HPA was posted on the Partnership HealthPlan website in August 2025. Partnership uses annual HEDIS results to evaluate clinical quality outcomes in a standardized way, and to evaluate health inequities for our members by race, ethnicity, language, and geographic region.

6. 2025 Timely Access Data

Partnership’s Provider Relations department gathers Timely Access data through an annual survey. This survey identifies the time before providers’ third next available appointments for adult and pediatric primary care, newborn visits, and urgent care visits. This survey is used to evaluate appointment care access for Partnership members.

7. 2025 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Partnership has chosen Press Ganey (PG) to conduct member surveys in alignment with the National Committee for Quality Assurance (NCQA). These surveys aim to gather information about members' experiences with their health plan and healthcare providers. The feedback collected helps our plan understand the experiences of covered members/patients and their families across the provider network and health plan delivery.

The CAHPS (Consumer Assessment of Healthcare Providers and Systems) surveys ask adult members and parents or guardians of child members to provide feedback on a range of categories, such as:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Coordination of Care
- Ease of Filling Out Forms
- Rating of Health Care
- Rating of Personal Doctor
- Rating of Specialist
- Rating of Health Plan
- Effectiveness of Care Measures

This needs assessment report will focus on the composite scores for the following performance measures concerning adults and children: Rating of Health Care, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Rating of Personal Doctor, and Rating of Specialist.

The CAHPS survey for Measurement Year (MY) 2025 and Reporting Year (RY) 2026 will cover the period from July 1, 2025, to December 31, 2025.

8. 2025 Health Disparities Dashboard

The 2025 health disparities data is taken from Partnership's HEDIS Disparity Analysis Tableau dashboard, in the MCAS County Oversampling Data section. In 2025, Partnership used the assessment methodology developed by the multidisciplinary team to assess health disparities in our newly expanded member population. Both years' analyses are available to all Partnership employees via a Tableau dashboard. This analysis stratifies HEDIS measures by race and ethnicity, language, gender, and housing status. A separate analysis was conducted to assess Partnership's effort to provide culturally and linguistically appropriate services (CLAS). Partnership utilized the measurement year 2024 (MY2024) Managed Care Accountability Set (MCAS) County Oversample data file to evaluate 13 clinical HEDIS measures for this analysis. The rates for each measure are comprised of the members included in each measure's audit for Partnership's DHCS/MCAS required reporting summary of performance report. Partnership's HEDIS vendor, Inovalon, provided the random member sample generated for each measure, along with member race/ethnicity demographic information. Inovalon is classified as a direct data source. This report provides data on health disparities specific to Partnership members.

B. Other Data Sources

In addition to the specific sources listed above, Partnership integrates data from member-reported health appraisals, data collected through health services programs and case management activities, as well as member feedback following participation in a Partnership intervention. Internal staff development, including mandated training courses, is monitored through Partnership's Learning Management System (LMS).

Partnership regularly reviews published research in areas impacting our population. Partnership leaders and clinicians subscribe to journals that describe evidence-based care, and promising practices to implement among members with complex needs and those with behavioral health or substance use disorders. These journals may include research that addresses SDoH, health equity, and population health management strategies. Partnership also reviews national data sources, such as the CDC and the US Preventive Services Task Force to track national trends and align ourselves with emerging care protocols. For specific demographic information in our various regions, we reference United States Census Bureau reports, which includes the SAIPE State and County Estimates for 2024.

C. Population Segmentation

After reviewing Partnership's overall population needs, the member population is segmented into subpopulations with similar needs and characteristics. Each of these subpopulations are further assessed to identify any additional needs and disparities. This process pulls information from a variety of reports that may include but are not limited to member demographics, health/risk assessments, laboratory results, disease morbidity reports, HEDIS scorecards, member and provider satisfaction surveys, as well as reports and analyses of over and under-utilization of care. Partnership reviews population segmentation on an annual basis to evaluate for disparities, potential inequities, and to ensure that all populations are served. However, a number of factors may influence Partnership to conduct additional reviews of population segmentation, such as state findings, natural disasters, and standard business practices.

In addition to evaluating member needs, Partnership also analyzes programs and activities no less than annually. Partnership uses the results to inform and refine its interventions, including those activities and resources to address health care disparities, and evaluate whether Partnership and community resources are sufficient to address member needs.

III. Key Findings

A. Member Demographics

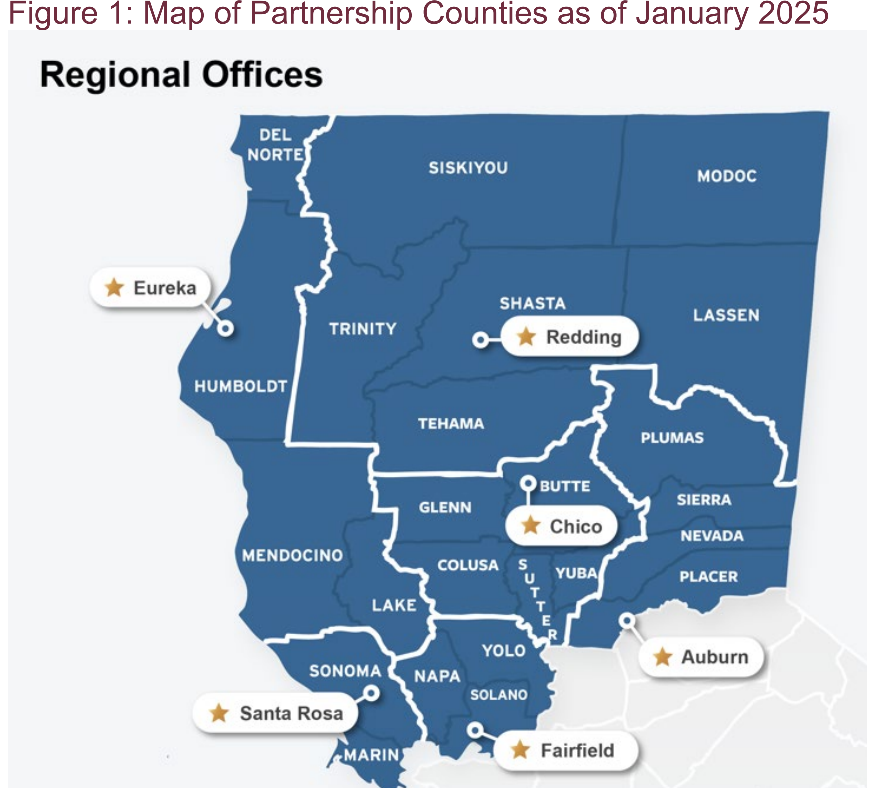
1. Membership/Group Profile

While member demographic information can fluctuate month to month, at the close of 2025, Partnership served approximately 893,608 Medi-Cal beneficiaries in 24 counties in Northern California. With the passing of H.R. 1 in mid-2025, membership will continue to fluctuate in 2026. Partnership primarily serves children and adults under the age of 65. In 2025, Partnership served approximately 465,144 members between the ages of 21-64, 324,088 members between ages 0-20, and 104,376 members aged 65+. The needs of this population vary and are further described under the Local Community Needs Assessment and throughout this document.

2. Geographic Distribution

Partnership's 6 regional offices are centrally located in Fairfield, Redding, Santa Rosa, Eureka, Auburn and Chico (see Figure 1 below).

Figure 1: Map of Partnership Counties as of January 2025

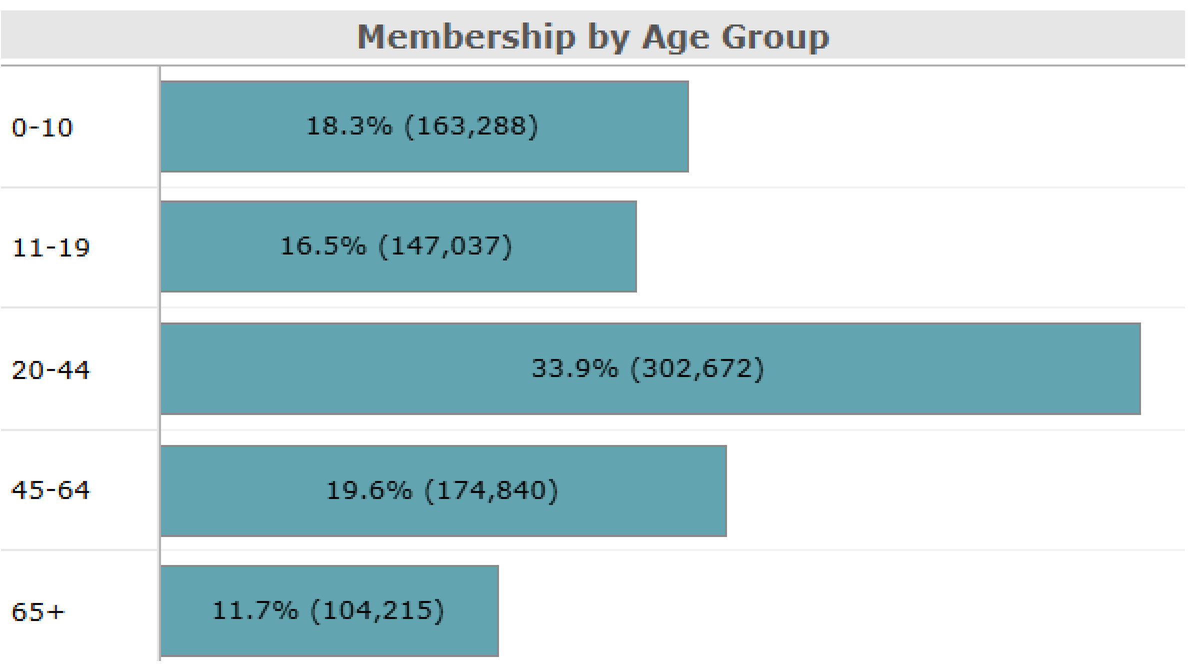


Partnership, 2025

3. Age and Gender

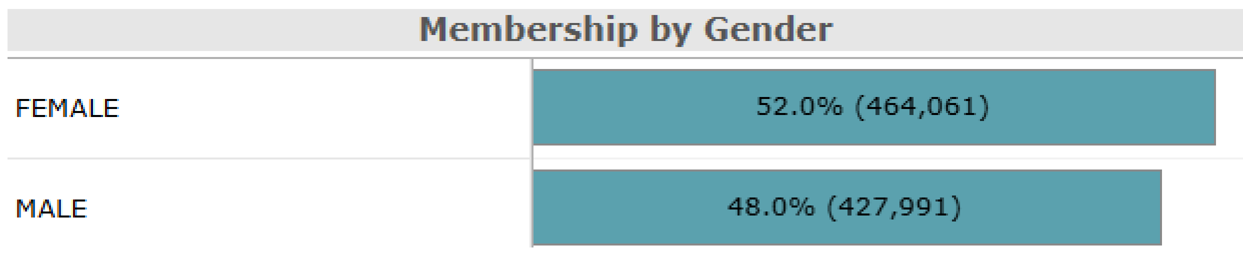
DHCS' definition of children and adolescents is 0-20.[5] According to December 2025 Partnership enrollment data, 18.3% of members are ages 0-10, 16.5% of members are ages 11-19, 33.9% of members are ages 20-44, 19.6% are ages 45-64. Additionally, 52% of members are female while 48% are male (see Figures 2 and 3). There were 11,078 babies born to Partnership members during 2025.

Figure 2: 2025 Partnership Membership by Age Group



Source: December 2025 Member Enrollment Data, Partnership

Figure 3: 2025 Partnership Membership Gender



Source: December 2025 Member Enrollment Data, Partnership

4. Race/Ethnicity

The largest ethnic groups across all 24 counties are White (38%) and Hispanic (34.3%). Figure 4 illustrates the racial and ethnic composition of Partnership's members as of

[5] DHCS Member Information, 2026

December 2025. One limitation with the race/ethnicity category is Hispanic as a category tends to outweigh other races, and multi-racial categories tend not to be reported at all. Furthermore, there are different rates of multiethnic reporting by members when signing up for Medical when compared to the census. This limits the accuracy of interpretation or racial disparities, such that small differences may not need to be intervened upon.

Figure 4: 2025 Partnership Membership by Race and Ethnicity

Membership by Race and Ethnicity

WHITE	37.8% (338,396)
HISPANIC	34.4% (307,799)
UNKNOWN	13.6% (122,077)
OTHER	4.6% (41,140)
BLACK	3.6% (31,932)
ASIAN	2.5% (22,374)
NATIVE AMERICAN	1.7% (15,498)
ASIAN INDIAN	1.6% (14,386)
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	0.2% (1,444)

Source: December 2025 Member Enrollment Data, Partnership

5. Primary Language

English continues to be the primary language spoken by Partnership's members. Based on Partnership's December 2025 enrollment data, 75.8% of members identify as English speaking and 24% identify as limited English proficiency (LEP). Historically, Partnership had 3 threshold languages – Spanish, Russian, and Tagalog. However, new threshold languages are added as needed. As such, in 2025, Punjabi was added as a threshold language. Members identifying as Spanish speaking total 20.6%. Russian, Tagalog, and Punjabi speakers account for 1.4% of LEP members, while 2.2% of the population speaks a language other than the 4 threshold languages. This data

demonstrates a need to ensure LEP members can access care in their own language to stay healthy.

Figure 5: 2025 Partnership Membership by Primary Language

Membership by Language

to view all languages, click on the (+) above the top language

Language	Membership
ENGLISH	75.8% (676,595)
SPANISH	20.6% (183,648)
OTHER	2.1% (18,612)
RUSSIAN	0.6% (5,565)
PUNJABI	0.5% (4,657)
TAGALOG	0.3% (2,278)
UKRAINI..	0.1% (447)
HINDI	0.0% (211)

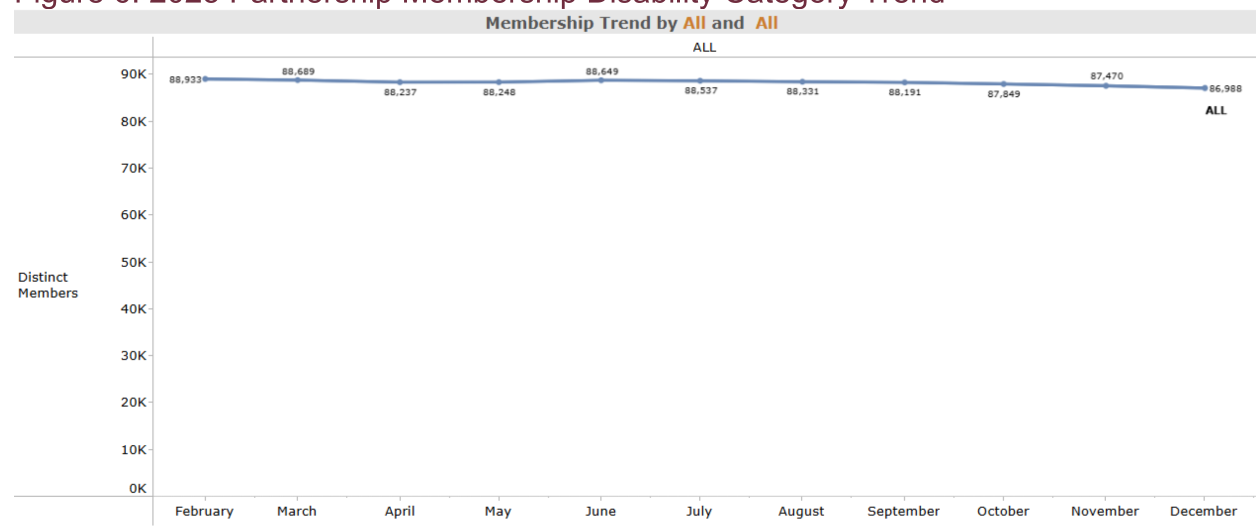
Source: Partnership's December 2025 Member Enrollment Data

6. Disability

Based on December 2025 Partnership enrollment data, approximately 97,609 members are disabled as shown in Figure 6. Furthermore, 9,466 of all disabled members are ages 0-20; 68,612 are ages 21-64; and 22,856 are ages 65 and older. Finally, 49,989 of all disabled members are males, while 47,620 are females.

Furthermore, California Children's Services (CCS) supports children with complex physical health needs. As of December 2025, this program had 10,124 member enrollees. Together this data demonstrates there is a significant number of members with disabilities that may require additional care and resources to remain healthy.

Figure 6: 2025 Partnership Membership Disability Category Trend



Source: Partnership's 2025 Member Enrollment Data

IV. Local Community Needs Assessment

A. Summary of Local Community Needs Assessments

Since January 2024, Partnership's service area has covered 24 counties, each with a diverse demographic makeup.

Since late 2023, Partnership has actively collaborated with Local Health Jurisdictions (LHJs) to engage in the assessment and health improvement planning processes led by each LHJ. This collaboration involved participating in and supporting each county's Community Health Assessment (CHA) or Community Health Needs Assessment (CHNA), and Community Health Improvement Plan (CHIP). Through this collaboration and a review of the available CHA reports (or similar documents) from the 24 counties, a range of priority need areas and gaps in services or care were revealed. Partnership aims to align its activities with the identified priority needs across its service area.

The Local Community Health Assessment section of this report was compiled using the most recent publicly available CHA, CHIP, and/or CHNA reports from the 24 counties, published primarily between 2022 and 2025 by LHJs and/or non-profit hospitals. Although the 24-county service area is geographically expansive and ethnically diverse, there were common priority needs mentioned across each county, many of which could be categorized as SDoH.

The most prevalent SDoH issues across all 24 counties can be grouped into the Healthy People 2030 categories: economic stability; healthcare access and quality; neighborhood and built environment; education access and quality; and social and

community context. Recognizing the prominent themes of the assessments collectively and their alignment within these categories helps to provide clarity on the SDoH impacts to the health of our members.

Economic Stability

- Theme: Economic Instability and Poverty
    - High poverty rates, unemployment, economic instability, and disparities in access to social services.
- Theme: Food Insecurity
    - Rising rates of food insecurity, limited access to supermarkets, and challenges in promoting healthy eating habits.

Healthcare Access and Quality

- Theme: Limited Access to Healthcare
    - Barriers to accessing primary, specialty, and dental care are prevalent, including transportation challenges, and healthcare provider shortages.
- Theme: Behavioral and Mental Health Needs
    - High rates of suicide, substance use disorders, and the need for comprehensive mental/behavioral health services.
- Theme: Chronic Disease and Injury Prevention
    - High rates of chronic illnesses like heart disease, diabetes, and obesity, as well as unintentional injuries including overdose and motor vehicle collisions.

Neighborhood and Built Environment

- Theme: Homelessness and Housing Affordability
    - Lack of affordable housing, homelessness, and associated stressors impacting health and stability.
- Theme: Transportation and Geographic Isolation
    - Transportation limitations and geographic isolation, especially in rural areas, hinder access to healthcare, resources, and economic opportunities.
- Theme: Environmental and Physical Risks
    - Vulnerability to wildfires, extreme heat, and drought, as well as disparities in access to green spaces and safe neighborhoods.

Education Access and Quality

- Theme: Educational and Technological Disparities
  - Low educational attainment and limited internet access hinder opportunities for economic mobility and access to telehealth services.

Social and Community Context

- Theme: Community and Social Support Needs
  - A strong need for fostering community connections, safe neighborhoods, and guidance through healthcare systems, along with leveraging trusted leaders and institutions.

A scan of the county's health assessments reveals widespread concerns about access to care, behavioral health, and other social determinants of health. Many counties struggle with a lack of healthcare providers, transportation barriers, and economic instability. Behavioral health issues, including mental health challenges and substance use, are consistently identified as major priorities. Social determinants such as income inequality, housing insecurity, and food deserts disproportionately impact marginalized communities, amplifying health disparities.

Disparities in health outcomes are commonly noted with racial minorities, LGBTQ+ individuals, and Indigenous populations facing unique challenges. For instance, African American residents in Marin County experience lower life expectancy and higher premature death rates, while Indigenous communities in Mendocino and Shasta Counties report historical trauma and exclusion. Maternal and child health disparities, coupled with high rates of adverse childhood experiences (ACEs), further underline the need for targeted interventions to support vulnerable populations.

Despite these challenges, counties have identified opportunities to improve health outcomes through collaboration and leveraging community strengths. Resilience, close-knit communities, successful partnerships, resourcefulness, and existing support programs offer a foundation for positive change which can be leveraged to improve health outcomes through targeted interventions and collective action.

1. Butte County

In 2024, Butte County published its Community Health Improvement Plan (CHIP),[6] focusing on three priority areas: Access to Care, Behavioral Health, and Food Security. These priorities were identified based on the six health needs outlined in the 2023

[6] Butte County Community Health Improvement Plan 2024-2027

Community Health Assessment (CHA).[7] While ongoing efforts are required to address these critical areas, the county has valuable assets at its disposal, including public, nonprofit, and tribal healthcare providers, as well as Community Health Workers. Existing programs, such as the Boys and Girls Club, the Butte County Department of Behavioral Health, culturally tailored support groups, and numerous organizations and collaboratives dedicated to combating food insecurity, will play an integral role. The CHIP aims to harness these resources, focusing on strengthening and improving the county's overall health outcomes in these areas.

2. Colusa County

Colusa County Public Health completed its CHA in 2024, identifying seven strategic issues: Access to Medical Healthcare Services, Access to Behavioral Healthcare Services, Access to Existing Services and Resources, Affordable Housing, Lack of Economic Opportunity and Sustainability, ACEs Prevention and Response, and Environmental Health Risks.[8] The assessment also highlighted the county assets, which are strong community engagement and collaboration, abundant resources, and supportive programs like the Mobile Health Clinic, Safe Haven, and the Emergency Domestic Well Program, all of which will support efforts to improve community health.

3. Del Norte County

Del Norte County recently completed their 2024 CHA,[9] which identified multiple health needs. These health needs include high rates of substance abuse and mental health challenges, chronic diseases, insufficient oral and healthcare access, poor maternal and child health outcomes, and environmental health risks. Del Norte's CHA revealed multiple strengths which include a resilient community, abundant outdoor resources like trails and beaches, and supportive programs such as CalFresh and WIC that foster collaboration and well-being. These efforts aim to address disparities while leveraging the community's strengths.

4. Glenn County

Glenn County published its CHIP[10] in November 2025, serving as a blueprint for addressing local health needs. It is based on the 2024 CHA,[11] which identified seven priorities: access to resources, medical provider shortage, behavioral health systems, transportation, ACEs, income, and safety. The CHIP focuses on four top priorities:

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[7] Butte County Community Health Assessment Report 2023
[8] Colusa County Community Health Assessment Report 2024
[9] Del Norte County 2024 Community Health Assessment
[10] Glenn County Community Health Improvement Plan Report 2025
[11] Glenn County Community Health Assessment Report 2024

improving access to resources, addressing the medical provider shortage, strengthening behavioral health systems, and enhancing transportation. Despite its small size, Glenn benefits from key assets such as a senior center, substance use disorder programs, and transportation options. Additional strengths include strong interagency partnerships, local non-profit support networks, school-based programs, food distribution services, and community organizations that offer outreach, education, and social support. Leveraging these established networks ensures a coordinated, community-driven approach to enhance health outcomes and equity across the county.

5. Humboldt County

Humboldt County's last CHA was completed in 2018.[12] The CHA showed a range of community health concerns such as access to primary, specialty care and mental health services. New data was revealed during the Community Health Improvement Planning cycle, and Humboldt released an Enhanced Community Health Assessment in 2022, focusing on the Oral Health Assessment and the Youth Report on Substance use in Humboldt County.[13] The 2022 Enhanced Community Health Assessment is the most recently available report, however, Humboldt is actively engaged in a new CHA, initiated in 2025, and Partnership continues to meaningfully engage with this work. The Oral Health Assessment discussed individuals who had complex health or behavioral health conditions, and housing and transportation concerns which impact accessing needed care. This report also identified a lack of access to routine dental care among the population surveyed, with over 90% of respondents stating they had challenges with accessing dental services. The oral health report shared that many of the barriers are due to financial constraints, travel challenges, and lack of providers which has led to a higher number of visits to the emergency room among adults. The Youth Report on Substance Use in Humboldt County is based on a survey called "Your Thoughts on Substance Use in Humboldt." The survey showed responders in Humboldt were largely concerned with the uptake of alcohol and drug use as a means to cope with ACEs. Respondents also expressed the need for community to better support against substance use, and the need for additional substance use prevention.

The 2024 Community Health Needs Assessment (CHNA) by the Southern Humboldt Community Healthcare District focuses on its 775-square-mile service area in northwestern California.[14] The findings align with public health concerns identified in the 2018 Humboldt CHA and the 2022 Enhanced Assessment, but they also highlight emerging challenges within the service area. These include the growing risks posed by wildfires and drought to community health and safety, as well as the limited availability

[12] 2018 Humboldt County Community Health Assessment
[13] 2022 Enhanced Humboldt County Community Health Assessment
[14] Southern Humboldt Community Healthcare District 2024

of affordable housing and unreliable high-speed internet, which are obstacles to economic growth and the recruitment of skilled workers.

6. Lake County

Lake County's most recent CHNA was completed in 2025. The highest priority needs identified were disparities in access to education, housing availability and affordability, and social and economic context (including economic vitality, social inclusion, civic engagement, and place attachment), while lower priority needs included healthcare access, community safety, mental health, climate and natural environment, and financial stability. The CHNA also identified community strengths, including cross-sector CHNA Steering Committee and robust community engagement.

7. Lassen County

As of December 2025, Lassen County has not yet finalized their CHA. However, work is nearly complete. This process began in December 2023 and has been ongoing throughout 2024 and 2025. This is Lassen County's first CHA, and they have faced challenging staffing conditions, which have made it difficult to finalize.

Other local health assessments have been completed. According to the most recent 2022 CHNA completed by Banner Lassen Medical Center, Lassen's priority needs include: access to care, chronic disease management, and behavioral health.[15] The same assessment also identifies areas of strength for Lassen, such as health behaviors (lower rates of physical inactivity and sexually transmitted diseases), clinical care (uninsured and dentists), and social and economic factors (unemployment and income inequality). In these areas, when compared to the state, Lassen has health data that is stronger.

8. Marin County

Marin County's 2025 CHA revealed six priority health needs: housing and homelessness, access to care, mental and behavioral health, climate and environment, chronic disease and disability, and income and employment. Housing costs are extreme (median home $1.4M), homelessness disproportionately affects Black residents, and mental health concerns—including a suicide rate of 14.4 per 100k—are rising. Climate risks such as wildfires (291% higher than state average) and flooding compound vulnerabilities. Despite overall affluence, income inequality (Gini 0.47) and racial health gaps persist.[16]

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[15] 2022 Banner Health Community Health Needs Assessment
[16] 2025 Marin County Community Health Assessment

9. Mendocino County

The 2024 CHNA for Mendocino County identifies five priority health issues: mental health, community safety, healthcare access, diabetes, and chronic conditions. Mental health needs remain substantial, influenced by limited behavioral health providers, geographic isolation, and high rates of substance use. Community safety concerns including injuries, violence, and substance-related harms continue to affect adolescents and adults, particularly in rural and under-resourced areas. Healthcare access is hindered by ongoing shortages of primary and specialty providers, long travel distances, and transportation barriers, which delay care and worsen health outcomes. Diabetes remains a major concern, with rising prevalence linked to socioeconomic barriers, food insecurity, and limited access to preventive services. Chronic conditions including tobacco use, oral health needs, and other preventable health issues continue to contribute to avoidable illness and early mortality. These challenges are intensified by social determinants of health such as poverty, unstable housing, food insecurity, transportation limitations, and historical trauma in tribal communities, all of which deepen disparities for Indigenous and geographically isolated populations.

10. Modoc County

Modoc County released their last CHNA in January 2024.[17] Modoc's CHNA identifies significant health and socio-economic challenges, particularly in its classification as a rural frontier county. Modoc faces high poverty, unemployment, low educational attainment, and limited access to healthcare. It has higher rates of chronic disease, risk behaviors, and poor physical and mental health when compared to California. These factors are contributing to increased disability and earlier mortality. However, Modoc benefits from less pollution, including cleaner air and water, than most other counties in the state. The community has identified mental health, substance use, chronic disease, and domestic violence as notable concerns. Barriers to health include poverty, inadequate job opportunities, limited healthcare access, and insufficient public transportation. Prenatal care rates are also a concern with less births receiving early care at significantly lower rates than California's average. While Modoc has significantly higher rates of homeownership, the median household income is low with nearly 30% of all children living in poverty. Key recommendations include economic and workforce development, improving transportation, offering more community activities and recruiting additional healthcare providers to address healthcare service gaps and improve health outcomes.

[17] 2024 Modoc County Community Health Needs Assessment

11. Napa County

Napa County completed its recent CHIP in November 2024, identifying five key health priorities: housing, behavioral health, access to health services, racial equity and LGBTQIA+ inclusion, and economic stability.[18]

Key challenges were identified in the housing sector, including the rising cost of living, low wages, and limited availability of affordable housing options. In the area of mental health, systemic and cultural challenges persist, such as a shortage of mental health professionals, clinician burnout, increased patient caseloads, and the stigma surrounding access to care. County residents reported significant difficulty accessing healthcare services due to several factors: long wait times, reliance on emergency departments (ED) as a first point of care, a complex healthcare system, and barriers to accessing transgender healthcare services. Racism was also cited as a major barrier for residents of color, with limited representation in leadership positions, and challenges in interactions with law enforcement. Many families highlighted the need for higher wages and greater employment opportunities to meet the high cost of living.

Despite these persistent challenges, Napa has notable strengths, including strong system cohesion, efficient emergency response capabilities, access to green spaces, and a high-quality public service sector. These assets, alongside community stakeholder engagement, will be instrumental in supporting ongoing action planning and improving the health priority areas identified in the CHIP.

12. Nevada County

Nevada County's 2025-2027 CHIP identified the following health areas of focus:

1. Increase access to comprehensive healthcare, prevention, and social services by meeting people where they are.
2. Expand access to affordable early learning and care (ELC) experiences in quality, developmentally appropriate, supportive settings through advocacy and promotion.
3. Increase vaccination rates for children.[19]

Healthcare access included lack of specialty providers, siloed healthcare delivery system, and gaps in care coordination. Issues were identified within the county's ELC provider network, such as limited geographic access to affordable care programs and transportation barriers for families with low socioeconomic status. Nevada County is in the bottom 25% of CA Counties in terms of reported immunizations. The county's assets include a strong network of community-based organizations, dedicated

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[18] 2024 Napa County Community Health Improvement Plan
[19] 2025 Nevada County Community Health Improvement Plan

healthcare providers, and active partnerships among local agencies. These resources contribute to ongoing efforts to improve health outcomes and address gaps in service delivery.

13. Placer County

Placer County's 2024-2029 CHIP report highlighted the following health priorities: lifestyle and preventative health concerns, aging and older adults, and the built environment.[20] Lifestyle and preventive health concerns highlighted the need for improved access to nutrition, physical activity, and chronic disease management, with a focus on reducing health disparities. Aging populations face challenges related to healthcare access, service availability, and aging in place, especially in rural areas. The built environment priority aims to improve infrastructure to support healthy living, such as safer housing, better transportation, and more accessible public spaces. Placer's assets include a robust network of healthcare providers, community organizations, and strong partnerships that support these initiatives and work to reduce health inequities and enhance the well-being of all residents.

14. Plumas County

Plumas County's 2023-2028 CHIP identified three priorities selected by the community.[21] The three priority health issues were: Drug and Alcohol Abuse and Overdose, Limited Access to Preventive Services, and Suicide. Other areas of focus included priority gaps, such as resource knowledge, coordination, and navigation, family support, harm reduction, and sustainability.

15. Shasta County

Mercy Medical Center Redding released their most recent CHNA in June of 2025, which covers all of Shasta County and parts of Tehama County.[22] This CHNA prioritized five health needs for the community: access to primary and dental care; access to behavioral health care; affordable and supportive housing; basic needs such as transportation and food security; and community belonging and freedom from violence. When compared with Shasta County's Community Health Assessment from 2023,[23] it is clear that many health concerns in the county continue to persist. With almost every area of the county identified as medically underserved, high rates of cancer, mortality, and substance abuse are likely contributable to poor access to care. Although Shasta County has a high school graduation rate much higher than the State overall and a

[20] Placer County 2024-2029 Community Health Improvement Plan
[21] Plumas County Community Health Improvement Plan 2023-2028
[22] 2025 Community Health Needs Assessment, Mercy Medical Center Redding
[23] 2023 Shasta County Community Health Assessment

poverty rate on par with the State, it still experiences challenging economic disparities across many of its census tracts, with multiple tracts having 20% or more of residents living in poverty for 30 years or longer. These economic challenges are compounded by rising housing costs and a lack of affordable childcare, which affects many low-income families. Additionally, the county has a notably high rate of children entering foster care, particularly infants, and struggles with high levels of emotional abuse and maltreatment.

The Indigenous community in Shasta County also faces unique challenges, including a lack of inclusion, barriers to maintaining cultural practices, and inadequate mental health resources. There is an emphasized need for more programs supporting Indigenous welfare, cultural preservation, and services for youth. Despite these challenges, the community's strengths lie in its cultural traditions, elders, and practices, which could play a central role in fostering community well-being.

16. Sierra County

Sierra County's 2023 CHA findings, based on both data analysis and community feedback, highlighted the following priority health needs: teen alcohol use, teen tobacco and vaping, adult tobacco use, teen physical fitness, teen mental health, adult obesity, excessive drinking, access to healthy foods, mental health, and commute alone.[24] While Sierra's CHIP report is soon to be published, the 2023 CHA report is the most recently available county health assessment. The county's assets include abundant natural resources, outdoor recreational activities, strong community support, and community-driven health initiatives.

17. Siskiyou County

Siskiyou County published their CHNA in June of 2025, which identified multiple high priority health needs including: vital unmet conditions related to transportation, education, food, and economic stability; income opportunity and humane, supportive housing; access to healthcare including specialty and dental care; access to mental/behavioral health and substance use; and injury and disease prevention management.[25] Geographic distance and barriers contribute significantly to food deserts, limited access to healthcare, public transportation, limited broadband access and fewer economic opportunities. Communities that are 1.5hr+ from the I-5 Highway are ranked in the bottom 99% of healthy communities. Other themes that arose were strengthening community relationships and improved workforce infrastructure. Siskiyou was able to identify 139 resources with potential to help meet the needs of the county service area.

[24] Sierra County Health Assessment 2023
[25] 2025 Siskiyou County Community Health Needs Assessment

18. Solano County

Solano County released their CHA in June 2020. The current CHA covers the period from 2020 to 2025, identified eight priority health areas, which include: socioeconomic challenges, lack of access to safe and secure housing, barriers to accessing healthcare, poorer educational outcomes compared to the state average, higher rates of domestic violence hospitalizations, injury deaths (both intentional and unintentional), and violent crimes, as well as elevated rates of opioid use and suicide ideation.[26] The CHA also identified barriers to healthy eating and active living, and poor maternal and infant health outcomes. Following the CHA, Solano released its CHIP in January 2023.[27] The current CHIP covers the 2023–2028 implementation period, with the next review cycle scheduled to begin in 2027 to ensure readiness for a 2028 planning cycle. The CHIP outlines several strategic priorities to address the top health needs identified in the CHA: workforce development, community and youth engagement, equity-driven investments, harm reduction, alongside enhanced access to healthcare services.

19. Sonoma County

Sonoma County released their joint Community Health Assessment and Improvement Plan in 2023. Sonoma assessed 12 priority health needs on the subjects of climate change, healthy food access, economic security and housing, education, structural racism, access to clinically and culturally responsive care, coordinated systems of care, chronic disease prevention, communicable disease prevention, youth mental health, adult mental health, and substance use. The 2023 Improvement Plan outlines 4 priority areas for action: to address structural and institutional racism, improve community members' connection to resources, improve system of care coordination, and strengthen capacity of mental health and substance use services.[28] In addition, the four hospital systems that serve Sonoma released their own CHNAs and CHIPs for their service areas in Petaluma and Santa Rosa for 2025. These assessments identified similar priorities to those in the county's Improvement Plan—specifically, access to care, behavioral health, chronic disease management, and member equity.[29]

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[26] 2020 Solano County Community Health Assessment
[27] 2023 Solano County Community Health Improvement Plan
[28] 2023 Sonoma County Community Health Assessment and Improvement Plan
[29] 2025 Kaiser Permanente, Santa Rosa Community Health Needs Assessment
2024–2026 Providence St. Joseph Health, Community Health Improvement Plan: Petaluma Valley Hospital (Providence, 2024)
2024–2026 Providence St. Joseph Health, Community Health Improvement Plan: Santa Rosa Memorial Hospital (Providence, 2024)
2024 Sutter Santa Rosa Regional Hospital, Community Benefit Plan (Sutter Health, 2024)

20. Sutter County

Sutter County published its 2023-2028 CHIP in 2023, outlining three health priorities for the next 3-5 years: combating homelessness, building resilient communities (with a focus on adverse childhood experiences, behavioral health, and nutrition/food access), and reducing STIs.[30] In its 2022 CHA, Sutter County highlighted numerous community resources that promote health and well-being, including parks, bike paths, and senior activities.[31] The Sutter-Yuba Homeless Consortium addresses homelessness, while programs such as Family S.O.U.P. and the Yuba/Sutter Resiliency Connection support families and foster resilience. Cultural groups celebrate diversity, and agriculture is showcased through farmers' markets. The Sutter County Public Health Branch works to ensure equitable access to these resources and will leverage them to address the three health priorities.

21. Tehama County

St. Elizabeth Community Hospital, which serves and is located in Tehama County, adopted and released their most recent CHNA[32] in June of 2025. This CHNA prioritized five health needs for the community: access to primary, specialty, and dental care; access to behavioral health care; basic needs such as education, transportation, and food security; navigation of care; and community belonging and freedom from violence. These interconnected issues significantly impact health, leading to premature death and reduced life expectancy among the population. The insights gained from this assessment, combined with those of the 2023 CHA[33] from Tehama County Public Health (updated February 2025) helped to develop Tehama's CHIP,[34] which was published in July of 2025. This plan covers the period of 2025-2028 and utilizes the MAPP framework to organize collaborative workgroups focused on objectives related to healthcare access, behavioral health services, and food access.

22. Trinity County

Trinity County most recently released a Community Health Equity Assessment in 2023, highlighting the many needs of the county.[35] Main drivers of health inequity identified were poverty, isolation, limited economic opportunity, and lack of affordable housing. Other significant health disparities include inadequate access to a supermarket; high risk of living in a wildfire-prone area; highest rates of childcare cost burden compared to the rest of California; twice the rate of premature death when compared to the state,

[30] Sutter County Community Health Improvement Plan 2023
[31] Sutter County Community Health Assessment 2022
[32] 2025 Community Health Needs Assessment – St. Elizabeth Community Hospital
[33] 2023 Community Health Assessment Tehama County
[34] Tehama County Community Health Improvement Plan 2025-2028
[35] 2023 Trinity County Health Equity Assessment

including the highest rates of suicide in the state, and higher rates of deaths related to unintentional injuries. Trinity also found educational disparities; lower rates of internet access compared to California; higher rates of violent crime higher rates of suicide, and higher rates of death from unintentional injuries, motor vehicle collisions and overdose. Approximately 1 in 5 Trinity residents had one or more disabilities with higher rates among American Indian/Alaska Native residents. Challenges also include higher rates of risk-adjusted hospitalizations due to chronic conditions; transportation limitations; technology limitations, and inadequate and unequal insurance coverage. Over half of Trinity community members also identified economic instability and the physical environment as a root cause of inequity, with many families experiencing hardship but not qualifying for social service assistance.

Trinity's CHIP was published in 2024 and covers the 2024-2028 period.[36] This plan identified two key focus areas: mobilizing healthcare to underserved regions, and expanding substance use disorder resources through collaboration with local partners.

23. Yolo County

Yolo County's most recent CHA was completed in 2023 and covers the 2023 – 2025 period.[37] Eleven significant health need were identified, including: access to resources that ensure basic stability, such as housing, jobs and food; behavioral health and substance use care; prevention for injury and disease; access to healthy eating and exercise; primary, specialty, extended care, and dental care; healthcare system navigation; social connection; safe places to live, and transportation.[38] Other areas of concern are around homelessness, poverty, housing costs, disparities in education, and life expectancy. Following the CHA, Yolo released its latest CHIP in 2026.[39] The plan emphasizes health equity and prevention-focused strategies to address the county's most significant needs. Together, these priorities provide a roadmap for improving community health over the next three years.

Yolo County has a variety of assets. It maintains some of the highest vaccination rates in their area due to strong community connection. The county also offers several resources to support physical health needs such as farmer's markets, neighborhoods, and local trails. In addition, Yolo benefits from a variety of trusted leaders and institutions, and ample employment opportunities.

[36] Community Health Improvement Plan 2024-2028 Trinity County Public Health Branch
[37] 2023-2025 Yolo County Community Health Assessment
[38] 2023-2025 Yolo County Community Health Assessment
[39] 2026 Yolo County Community Health Improvement Plan

24. Yuba County

Yuba County's CHIP for 2023-2028 outlined key priorities aimed at enhancing the well-being of the community.[40] These priorities included healthcare access, mental health services, and the creation of safe neighborhoods and built environments. The community's strengths, identified in the 2022 CHA, such as a lower cost of living compared to urban centers, access to natural areas like mountains and the ocean, and strong local resources such as public transportation and available services in areas like nutrition and legal support provide a solid foundation for the county's efforts to foster a healthier and more vibrant community.[41]

B. Social Determinants of Health (SDoH)

Social Determinants of Health, also known as, "social influencers of health," as defined by the World Health Organization (WHO), are "the conditions in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These conditions are in turn shaped by a wider set of forces: economics, social policies and politics."[42] Healthy People 2030 offers several examples of SDoH including income, polluted air, access to healthy foods and physical activity, and safe housing.[43]

A standardized collection of individual member SDoH is not available. There is no validated means of using diagnosis codes or claims data reliably to indicate 1 or more social determinant of health, and the data is quite incomplete; therefore, it is not useful for meaningful analysis. Instead, Partnership uses the Small Area Income and Poverty Estimates (SAIPE) State and County Estimates for 2024, County Health Rankings & Roadmaps data, and local, publicly available Community Health Assessment reports to understand the drivers that influence the health of our population. We use this data, along with data provided by our county public health agencies, provider partners, and community-based organizations, to gain insight into the needs of our members and the communities where they live. This helps foster collaborative efforts with local agencies in order to improve the social supports that help meet the needs of our members.

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[40] 2023 Yuba County Community Health Improvement Plan
[41] 2022 Yuba County Community Health Assessment
[42] World Health Organization. "Social Determinants of Health." *Health Topics*.2025
[43] Healthy People 2030, Social Determinants of Health

1. Income

Income plays a major role in SDoH, specifically as it relates to health outcomes. More income often leads to better health outcomes, and vice versa. Below is a table detailing the median household income among Partnership's different counties.[44]

Table 1: SAIPE State and County Median Income Estimates 2024

Partnership Northern Region	Median Household Income
California	**$100,130**
Del Norte	$58,773
Humboldt	$58,960
Lassen	$68,185
Modoc	$57,390
Shasta	$70,620
Siskiyou	$60,432
Tehama	$62,822
Trinity	$50,481

Partnership Southern Region	Median Household Income
California	**$100,130**
Lake	$55,489
Marin	$145,395
Mendocino	$67,303
Napa	$116,139
Solano	$94,968
Sonoma	$105,956
Yolo	$87,386

Partnership Eastern Region	Median Household Income
California	**$100,130**
Butte	$65,143
Colusa	$69,149
Glenn	$66,061
Nevada	$98,873
Sutter	$74,183
Yuba	$74,273
Placer	$115,845
Plumas	$72,068
Sierra	$69,104

Source: United States Census Bureau 2025

Poverty also plays a major role in SDoH, specifically as it relates to health outcomes. More poverty often leads to poorer health outcomes, and vice versa. Below is a table detailing the percentage estimates for poverty among Partnership's different counties.[45]

Table 2: SAIPE State and County Poverty Estimates 2024

Partnership Northern Region	Percent in Poverty
California	***11.8%***
Del Norte	19.9%
Humboldt	18.0%
Lassen	17.2%
Modoc	17.1%
Shasta	14.6%
Siskiyou	17.3%
Tehama	18.2%
Trinity	23.0%

Partnership Southern Region	Percent in Poverty
California	***11.8%***
Lake	19.7%
Marin	9.9%
Mendocino	13.4%
Napa	7.8%
Solano	10.1%
Sonoma	8.4%
Yolo	17.4%

Partnership Eastern Region	Percent in Poverty
California	***11.8%***
Butte	18.7%
Colusa	13.6%
Glenn	15.5%
Nevada	9.6%
Sutter	12.6%
Yuba	13.5%
Placer	6.8%
Plumas	13.0%
Sierra	13.5%

[44] SAIPE Data, U.S. Census Bureau, 2025
[45] SAIPE Data, U.S. Census Bureau, 2025

Source: United States Census Bureau 2025

2. Air Pollution and Wildfires

In 2025, 148 wildfires in Partnership's regions burned more than 77,814 acres. With the increasing rate of wildfires in California, there is an increased possibility of impacts on Partnership's covered counties' health. Although 2025 was a significantly less destructive fire year for Partnership's regions overall, fires do increase the possibility of adverse pulmonary effects such as chronic bronchitis, asthma, and decreased lung function.[46] Long-term exposure to poor air quality can increase premature death risk among people 65 and older.

County Health Rankings and Roadmaps measures air pollution as the average daily density of fine particulate matter in micrograms per cubic meter. Across the state of California, this measure was 12.6 in Reporting Year 2025 (MY2020).[47] The Partnership County with the highest rates of air pollution is Plumas at 21.1.

Table 3: Air Pollution – Particulate Matter by Partnership County in 2025

Partnership Northern Region	Air Pollution-Particulate Matter
California	***12.6***
Del Norte	10.3
Humboldt	8.8
Lassen	12.4
Modoc	10.4
Shasta	9.8
Siskiyou	10.9
Tehama	13.3
Trinity	10.2

Partnership Southern Region	Air Pollution - Particulate Matter
California	***12.6***
Lake	9.6
Marin	8.6
Mendocino	12.4
Napa	10.3
Solano	12.4
Sonoma	8.3
Yolo	15.9

Partnership Eastern Region	Air Pollution - Particulate Matter
California	***12.6***
Butte	16.1
Colusa	12.8
Glenn	17
Nevada	12.4
Sutter	16.7
Yuba	16.3
Placer	13.1
Plumas	21.1
Sierra	10.8

Source: 2025 County Health Rankings & Roadmaps

The following table shows how many fires occurred and the amount of acreage burned in each county in 2025. Siskiyou and Shasta County were the counties with the most acreage burned in 2025 at 40,390 and 21,215 acres, respectively.

46 Environmental Protection Agency (EPA), 2025
47 County Health Rankings, Air Pollution: Particulate Matter, 2025

Table 4: Number of Wildfires and Acreage Burned per Partnership County in 2025

Partnership County	Number of Fires in 2025	Acres Burned in 2025
Butte	9	272
Colusa	1	14
Del Norte	2	47
Glenn	1	20
Humboldt	2	415
Lake	8	190
Lassen	16	1,540
Marin	0	0
Mendocino	3	302
Modoc	13	4,228
Napa	3	6,892
Nevada	3	57
Placer	8	515
Plumas	2	30
Shasta	18	21,215
Sierra	0	0
Siskiyou	22	40,390
Solano	12	550
Sonoma	0	0
Sutter	0	0
Tehama	11	394
Trinity	5	324
Yolo	2	164
Yuba	7	255
Total	**148**	**77,814**

Source: 2025 Fire Season Incident Archive | CAL FIRE

3. Adult Smoking

According to the CDC, cigarette smoking continues to be a main cause of preventable conditions such as disease, disability, and death among the U.S. population. The California Department of Public Health stated in their “2024 Results of the 2023 California Youth Tobacco Survey” that 6.4% of California high school respondents used tobacco in the last 30 days since completing the survey.[48] Vaping also continues to be a concern. Reponses showed that 26.5% of California high school respondents report being exposed to secondhand vapor in a car or room in the last 2 weeks, and about two thirds (64.3%) shared that they were exposed to secondhand vapor outdoors.

[48] 2025 California Department of Public Health Results of the 2024 California Youth Tobacco Survey

Smoking affects almost every organ of the human body; it can also cause cancer in various parts of the body. Smoking can be a contributing factor to a variety of diseases including cancer, heart disease, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease (COPD). Secondhand smoke can also increase the risk for health concerns.[49] With the growing prevalence of e-cigarettes and vaping products marketed to adolescents, it is important to continue to educate young people and parents on the harmful effects of tobacco use.

County Health Rankings and Roadmaps say that on average, 10% of adults in Reporting Year 2025 (MY2022) were current smokers in California. Adult smoking rates were higher than the state average in all of Partnership's counties, except for Marin; rates of smoking in Partnership counties ranged from as low as 8% to as high as 19%.

Table 5: 2025 Rate of Adult Smoking by Partnership County

Partnership Northern Region	Adult Smoking Rate
California	***10%***
Del Norte	19%
Humboldt	17%
Lassen	17%
Modoc	14%
Shasta	14%
Siskiyou	16%
Tehama	17%
Modoc	14%

Partnership Southern Region	Adult Smoking Rate
California	***10%***
Lake	14%
Marin	8%
Mendocino	15%
Napa	13%
Solano	13%
Sonoma	11%
Yolo	13%

Partnership Eastern Region	Adult Smoking Rate
California	***10%***
Butte	14%
Colusa	15%
Glenn	16%
Nevada	16%
Sutter	16%
Yuba	16%
Placer	12%
Plumas	13%
Sierra	15%

Source: 2025 County Health Rankings & Roadmaps. Red indicates higher than California average adult smoking rate.

4. Physical Inactivity

Low physical activity relates to several diseases such as diabetes, cancer, hypertension, cardiovascular disease, and premature mortality. Physical activity can improve sleep, cognitive ability, bone and musculoskeletal health. Physical activity not only affects individuals, but also communities.[50]

The 2025 County Roadmaps and Rankings measure physical inactivity as the percentage of adults aged 18 and over reporting no leisure-time physical activity, with higher values indicating less physical activity. In Reporting Year 2025 (MY2022), the

[49] Center for Disease Control and Prevention. Secondhand Smoke
[50] Center for Disease Control and Prevention. Physical Inactivity

California state average was 22%. Among counties covered by Partnership HealthPlan, the Northern Region had physical inactivity rates equal to or higher than the state average, with the exception of Shasta (19%). In contrast, the Southern Region and Eastern Region matched the state average but also displayed variations with some counties showing higher rates than state levels. Sonoma (17%), Marin (13%), Nevada (21%), Placer (17%), Plumas (19%), Shasta (19%), and Sierra (21%) had rates of physical inactivity that were better than the state average.

Table 6: 2025 Rate of Physical Inactivity by Partnership County

Partnership Northern Region	Physical Inactivity
California	***22%***
Del Norte	27%
Humboldt	22%
Lassen	24%
Modoc	22%
Shasta	19%
Siskiyou	22%
Trinity	23%
Tehama	25%

Partnership Southern Region	Physical Inactivity
California	***22%***
Lake	22%
Marin	13%
Mendocino	22%
Napa	23%
Solano	22%
Sonoma	17%
Yolo	25%

Partnership Eastern Region	Physical Inactivity
California	***22%***
Butte	23%
Colusa	27%
Glenn	27%
Nevada	21%
Sutter	27%
Yuba	25%
Placer	17%
Plumas	19%
Sierra	21%

Source: 2025 County Health Rankings & Roadmaps. Red indicates higher than California average.

5. Severe Housing Problems

As of November 2024, the most recently publicly available data, there are approximately 187,084 unhoused people in California.[51] Additionally, 26% of California's households experienced at least one of the following housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.[52] Severe housing problems remain a significant issue in California. In Reporting Year 2025, many of Partnership's service area members continued to experience severe housing problems, especially in counties such as Humboldt (24%), Yolo (24%), Mendocino (23%), Napa (23%), Glenn (22%), Marin (22%), Nevada (22%), Sonoma (22%), and Tehama (22%). The 2025 reporting year reflects data from 2017-2021, see the following table.[53] Partnership's Southern Region experiences higher levels of severe housing problems, likely due to its proximity to the San Francisco Bay Area and Sacramento, while the Eastern Region

[51] HUD 2024 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations

[52] County Health Rankings, Severe Housing Problems, 2025

shows notable challenges in counties such as Glenn and Nevada. This data demonstrates there is a need for stable housing in Partnership's service area.

Table 7: 2025 Rate of Severe Housing Problems by Partnership County

Partnership Northern Region	Severe Housing Problem
California	***26%***
Del Norte	17%
Humboldt	24%
Lassen	14%
Modoc	12%
Shasta	20%
Siskiyou	18%
Trinity	19%
Tehama	22%

Partnership Southern Region	Severe Housing problem
California	***26%***
Lake	21%
Marin	22%
Mendocino	23%
Napa	23%
Solano	21%
Sonoma	22%
Yolo	24%
Napa	23%

Partnership Eastern Region	Severe Housing Problem
California	***26%***
Butte	20%
Colusa	16%
Glenn	22%
Nevada	22%
Sutter	20%
Yuba	21%
Placer	16%
Plumas	16%
Sierra	19%

Source: 2025 County Health Rankings & Roadmaps

6. Food Environment Index

The Food Environment Index (FEI) accounts for access to healthy foods and food insecurity. Food insecurity is defined "as a household-level economic and social condition of limited or uncertain access to adequate foods."[54] Many areas across Partnership's 24 counties are designated as food deserts—areas where healthy and fresh foods are not readily available for people to access. In these regions, processed foods high in sugar, sodium, fat, and additives often dominate what is available. Additionally, some communities lack food pantries or other supplemental food resources, further restricting access to healthy foods.

The FEI considers three factors: the distance someone lives from a grocery store or supermarket, the availability of locations to purchase healthy foods within communities, and financial barriers to accessing healthy foods. According to the County Health Rankings and Roadmaps Reporting Year 2025 (MY2022), California scored a high 8.7 on a scale from 0 (worst) to 10 (best).

Partnership's regions show a range of scores reflecting regional disparities:

- Northern Region: FEI ranges from 6.4 in Modoc County to 7.7 in Shasta County.

[54] County Health Rankings, Food Environment Index, 2024

- Southern Region: FEI is highest in Marin County (9.5) and lowest in Lake County (7.9).
- Eastern Region: FEI is highest in Placer County (9.0) and lowest in Colusa County (6.8).

Counties with the highest scores include Marin (9.5), Napa (9.0), Placer (9.0), Solano (8.9), and Sonoma (8.9), indicating better access to healthy foods. In contrast, rural counties such as Modoc (6.4), Sierra (6.2), Colusa (6.8), Del Norte (6.8), and Siskiyou (6.9) face significant challenges. This data suggests that rural counties generally encounter more difficulties accessing healthy foods, underscoring the need for targeted interventions to address food insecurity in these areas.

Table 8: 2025 Food Environment Index (FEI) in Partnership Counties

Partnership Northern Region	FEI
California	***8.7***
Del Norte	6.8
Humboldt	7.6
Lassen	7.5
Modoc	6.4
Shasta	7.7
Siskiyou	6.9
Trinity	7.2
Tehama	7.1

Partnership Southern Region	FEI
California	***8.7***
Lake	7.9
Marin	9.5
Mendocino	7.6
Napa	9.0
Solano	8.9
Sonoma	8.9
Yolo	8.5

Partnership Eastern Region	FEI
California	***8.7***
Butte	7.6
Colusa	6.8
Glenn	7.5
Sutter	7.5
Nevada	8.2
Yuba	7.2
Placer	9.0
Plumas	8.5
Sierra	6.2

Source: 2025 County Health Rankings & Roadmaps

C. Disease Prevalence

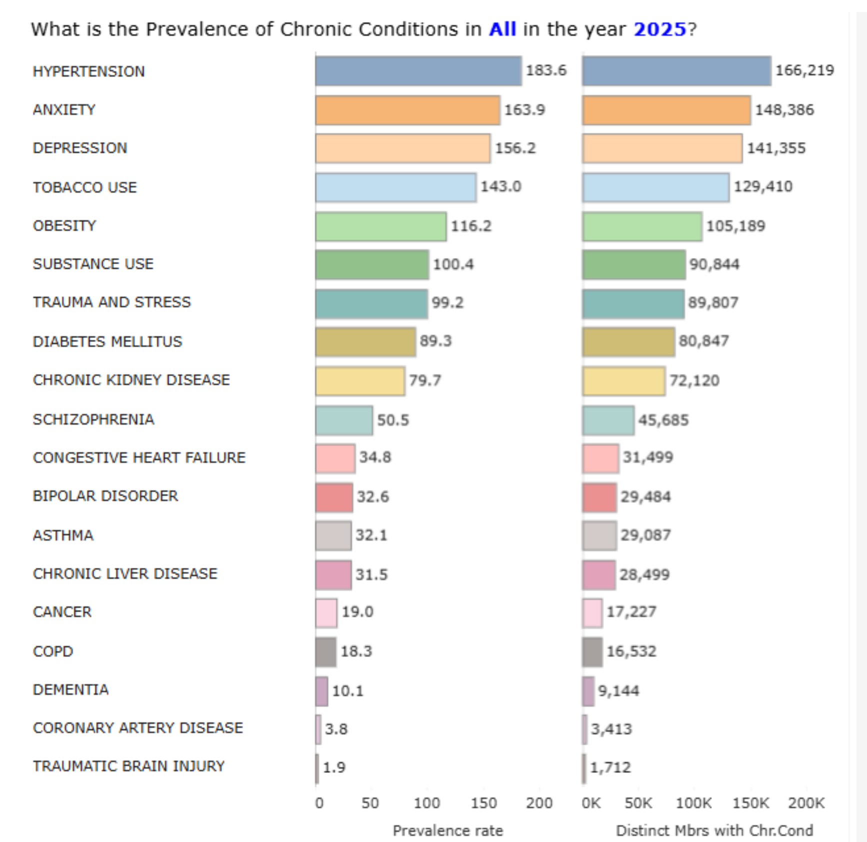
1. Chronic Disease

The 2025 Partnership Integrated Claims and Encounter data highlighted many chronic diseases that are prevalent in adults and children. Chronic diseases can be defined as conditions that last 1 year or more and either require continuing medical attention, limit day-to-day living, or both. Partnership bases estimates of chronic disease prevalence on claims and encounter data, while recognizing the limitations of this data to represent the true prevalence of disease. Furthermore, the true prevalence of chronic disease is likely higher than what claims data reflects.

Figure 7 shows a collection of chronic diseases among the adult population. The 6 most prevalent chronic condition claims for adults were: Hypertension (183.6 per 1000 adult

members), Anxiety (163.9 per 1000 adult members), Depression (156.2 per 1000 adult members) Tobacco Use (143.0 per 1000 adult members), Obesity (116.2 per 1000 adult members), and Substance Use (100.4 per 1000 adult members). The top three (3) chronic diseases identified in the table below among the adult population has potential to impact daily living if left untreated. As such, this data demonstrates a significant need to address these top conditions.

Figure 7: 2025 Adults Chronic Conditions Prevalence Data Per 1000 Members



Source: 2025 Partnership Integrated Claims and Encounter Data, Partnership

Figure 8 shows a collection of chronic diseases among the pediatric population. The 6 most prevalent chronic conditions found in pediatric claims were: Anxiety (82.41 per 1000 members), Trauma and Stress (70.32 per 1000 members), Depression (56.90 per 1000 members), Obesity (44.11 per 1000 members), Asthma (36.21 per 1000 members) and Substance Use (21.85 per 1000 members). The top three chronic diseases identified in the pediatric population are related to mental health. Poor mental health can impact daily functions.[55] As such, this data demonstrates a significant need to address anxiety, trauma/stress, and depression among the pediatric population.

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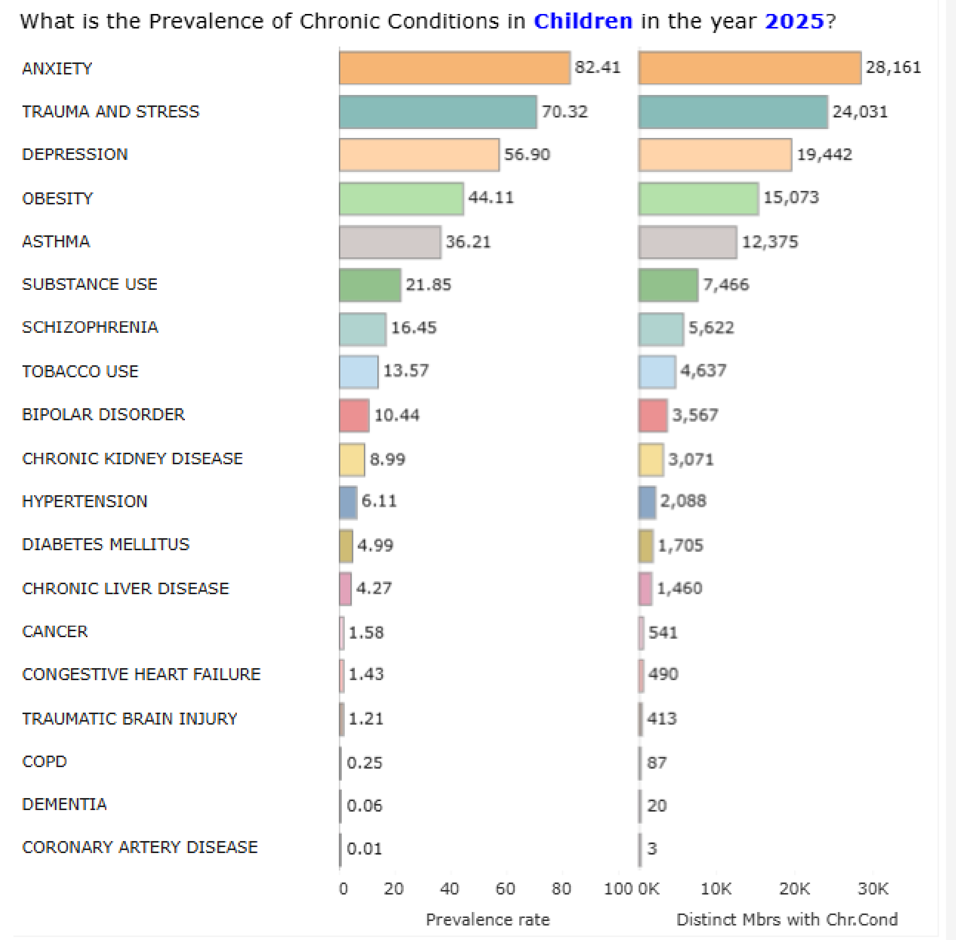
[55] OASH, HHS.gov

Figure 8: 2025 Children Chronic Conditions Prevalence Data Per 1000 Members



Source: 2025 Partnership Integrated Claims and Encounter Data, Partnership

2. HEDIS® Scores

Partnership uses HEDIS measure performance to assess how well the health plan is providing preventive care and serving members with chronic diseases (see appendix A). The DHCS Minimum Performance Level (MPL) is set at the 50th percentile and the High-Performance Level (HPL) is set at the 90th percentile amongst health plans nationwide. Appendix A shows the HEDIS scores for all DHCS tracked performance measures for Reporting Year 2025 (MY2024). In MY2023 Partnership was responsible for reporting its HEDIS measure performance in 4 regional reporting units: Northeast (Shasta, Siskiyou, Lassen, Trinity, Modoc), Northwest (Humboldt, Del Norte), Southeast (Solano, Yolo, Napa), and Southwest (Sonoma, Mendocino, Marin, Lake).

In 2024, Partnership added 10 new counties (Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba). Starting in MY2024, Partnership reported plan-

wide performance for all 24 counties, which included drilldowns of plan-wide performance at the following regional levels: NorthBay (Marin, Napa, Solano, Sonoma, Yolo), Rural Upper Central (Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba), and Rural Upper North (Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Trinity).

a. Controlling High Blood Pressure

Hypertension affects almost one-half the U.S. adult population and is an important risk factor for cardiovascular disease.[56] The HEDIS MPL for Controlling High Blood Pressure was set at the 50th percentile of 64.48% for the 2025 Reporting Year (MY2024).[57] Partnership's plan-wide performance was 69.59%. In the 2025 reporting year, Partnership's NorthBay regional performance for this indicator went above the MPL with a performance of 67.20%. In contrast, both Rural Upper Central and Rural Upper Northern region went below the MPL with a performance of 63.26% and 61.13%, respectively.

b. Comprehensive Diabetes Care

The HEDIS MPL around the Comprehensive Diabetes Care measure indicator for poor diabetes control (HbA1c level >9%) was set at the 50th percentile of 33.33% for the 2025 Reporting Year (MY2024). This measure is HEDIS's only measure where lower scores are considered better; this is because performance is inversely related to the percentage reported. Partnership achieved a plan-wide performance of 32.60%. Partnership's NorthBay and Rural Upper Central region for this indicator went below the MPL with a performance of 34.34% and 39.48%. By contrast, the Rural Upper regional performance was 32.02%.

c. Preventive Care

One goal of Healthy People 2030 is to increase preventive care for people of all ages;[58] yet, it is estimated that only 5.3% of adults 35 years and older in the United States get all recommended preventive care services.[59] Getting preventive care helps prevent disease and premature death by using preventive screening tests such as colorectal and breast cancer screening for adults, tracking of child development milestones, and various vaccinations for all ages. It is of utmost importance to help people comprehend the importance of getting preventive care in a timely manner to stay healthy and reduce

[56] Center for Disease Control and Prevention (CDC), 2024
[57] Partnership Health Plan of California HEDIS Measures, 2025
[58] Health.gov Healthy People 2030 Literature Summary, n.d.
[59] Healthy People 2030

health inequities. Partnership believes this work is foundational to help our members and our communities stay healthy.

(1) Adult Cancer Screening

Timely cancer screenings are a major component of preventive care for adult members. Partnership annually monitors and assesses 3 cancer metrics. Breast cancer and cervical cancer screenings are metrics that are a part of both the DHCS MCAS and NCQA health plan accreditation measure sets in MY2024. Colorectal cancer screening is a HEDIS measure that was included in the NCQA health plan accreditation measure set starting in MY2024. Partnership has included a colorectal cancer screening measure as part of the Primary Care Provider Quality Improvement Program (PCP QIP), Partnership's largest pay-for-performance program; it is also part of initiatives to encourage appropriate testing for early detection of colon cancer.

The DHCS-specified MPL for Breast Cancer Screening ECDS (BCS – E) was set at the 50th percentile benchmark of 52.68% for the 2025 Reporting Year (MY2024). Partnership's plan wide performance of 56.29% was slightly above the DHCS 50th percentile benchmark. The Rural Upper Central and Rural Upper North went below the MPL standing at 31.15% and 52.28%, respectively. However, the NorthBay region went above the MPL at 59.08%.

Cervical Cancer Screening showed similar trends. The MPL for this measure set at the 50th percentile of 57.18% for the 2025 Reporting Year (MY2024). The plan wide performance for this indicator was just above the MPL, with a result of 59.12%. The Rural Upper Central and Rural Upper North went below the MPL standing at 45.39% and 57%. In contrast, the NorthBay regional performance went above the MPL at 61.97%.

Partnership's plan wide colorectal cancer screening rate for MY2024 was 32.99% which is just under 33rd percentile benchmark of 34.30%, part of the National Medicaid Benchmarks published by NCQA. DHCS made colorectal cancer screening an accountable measure in their MY2026 Managed Care Accountability Set (MCAS) and a DHCS-specified MPL for this measure is forthcoming. Only 3 of our 14 legacy counties performed above the 33rd percentile for colorectal cancer screenings. Partnership is active liaising with vendors and providers to connect members to easier at-home testing options when clinically appropriate.

(2) Pediatric Well-Care and Immunizations

Well-child visits and vaccines play a vital role in ensuring children stay healthy. They are also metrics DHCS continued to heavily focus on for 2025. Well-child visits track growth

and milestones, opening the door for parents to address any questions or concerns they may have around their child's health. Children who are not protected by vaccines are more likely to contract and pass on certain diseases.[60] A recent study identified common barriers to getting to well-child visits, including difficulty in requesting time off from work, childcare, and other stressors.[61] Addressing social determinants of health plays an important role for improving attendance of well-child visits. The DHCS 50th percentile benchmark for child and adolescent well-care visits (WCV) was set at 51.81%. Additional metrics had the following benchmarks: well-child visits within the first 30 months of life (W30+2) at 69.43% and well-child visits within the first 15 months of life (W30+6) at 60.38%. Partnership's data for WCV, W30+2, and W30+6 is organized into three regions: North Bay (Yolo, Solano, Napa, Sonoma, Marin), Rural Upper Central (Tehama, Plumas, Butte, Glenn, Colusa, Sutter, Yuba, Sierra, Nevada, Placer), and Rural Upper North (Del Norte, Siskiyou, Modoc, Humboldt, Trinity, Shasta, Lassen, Mendocino, Lake). Partnership's plan-wide performance for WCV went below the MPL at 48.83%. All regions performed below the MPL for the WCV metric: North Bay (51.74%), Rural Upper Central (47.15%), and Rural Upper North (47.13%). However, for W30+2, North Bay and Rural Upper North regions performed above the MPL at 72.69% and 71.68%, while Rural Upper Central region remained below at 61.54%. This trend remained consistent for W30+6, North Bay and Rural Upper North regions performed above the MPL at 66.25% and 68.21%, while Rural Upper Central region remained below at 50%. Performance remains strong in both North Bay and Rural Upper North regions for W30+2 and W30+6. However, persistent gaps in performance in the Rural Upper Central region indicates a clear need to implement targeted interventions to improve W30+2 and W30+6 as well as WCV rates across all regions.

The MPL for Childhood Immunizations Status (CIS-Combo 10) was set at the 50th percentile of 27.49% for the 2025 Reporting Year (MY2024). For children ages 0-2 who received all the recommended immunizations by the time they turned 2 years old, plan wide performance slightly surpassed the MPL at 28.22% (see appendix A). The North Bay region went above the MPL at 34.67%, while Rural Upper Central and Rural Upper North performed below the MPL at 21.79% and 18.22%, respectively.

The DHCS MPL for Immunizations for Adolescents (IMA Combo 2) was set at the 50th percentile of 34.30%. The plan wide performance for adolescents receiving the recommended Tdap and meningococcal vaccines by age 13 was above the MPL, at 40.39%. Both Rural Upper Central and Rural Upper North performed below the MPL at 29.97% and 29.54%. In contrast, the North Bay region performed above the MPL at

[60] Center for Disease Control and prevention (CDC), 2024
[61] Wolf et. al., 2020

48.53%. This data demonstrates a need to address vaccination rates among the pediatric population in our Central and Northern service areas.

3. Serious Mental Illness/Serious Emotional Disturbances (SMI/SED)

Partnership provides mild to moderate mental and behavioral health services for its members through Carelon Behavioral Health. Partnership does not provide services to members who have severe mental and behavioral health needs, otherwise known as members with serious mental illness/serious emotional disturbance (SMI/SED), and/or members who have both. NCQA defines SMI as "someone over 18 years of age having (within the past year) a diagnosable mental, behavioral or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities." NCQA defines SED as "a diagnosable mental, behavioral or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities." Partnership does support coordination of care for members with SMI/SED and/or both and helps connect them to the appropriate level of care.

When a Partnership member has a higher level of impairment beyond mild to moderate, and needs specialty mental health services (SMHS), the member's PCP or mental health provider can refer the member to the county mental health plan. Partnership will help coordinate a member's first appointment with a county mental health plan provider to help them choose the right care for them. These include SMHS for Medi-Cal members who meet services rules for SMHS. These services may include outpatient, residential, and inpatient services.[62]

Partnership's regulatory body, the Department of Health Care Services, has two definitions of members who qualify for SMHS,[63] otherwise known as members with SMI/SED and/or both. These definitions are differentiated by age. Recipients 21 years and over must have a significant impairment that is due to a suspected or diagnosed mental health disorder. Recipients under 21 years of age must meet at least 1 of 2 criteria. Criteria 1 is: the member has a significant impairment, a probable reason to believe there is deterioration or lack of developmental progress in key life functions, or there is a need for SMHS. Criteria 2 is: the member's condition listed in criteria 1 is due to a suspected or diagnosed mental health disorder, or a significant trauma that could result in future mental health concerns.

[62] Partnership HealthPlan of California Medi-Cal Member Handbook, 2025
[63] Department of Health Care Services, Non-Specialty Mental Health Services, 2022

Due to limited data availability, the number of members accessing SMHS through county mental health serves as a proxy for the number of Partnership members with SMI/SED and/or both. Figure 9 shows that in 2025, there were 28,291 unique members that accessed specialty mental health services through county mental health and received at least one service. The same figure shows this number further broken down by region. The number of members who access SMHS through county mental health, and therefore the estimated number of members with SPMI, are as follows: 7,213 members in Chico region, 5,496 members in Eureka region, 4,858 members in Fairfield region, 4,035 members in Redding region, 3,828 in Auburn region, and 2,934 in Santa Rosa region. Due to difficulty in data collection, Partnership is unable to provide data on how many members have been referred to SMHS. Nonetheless, this data shows there is a significant number of members with SMI/SED and/or both who need coordination of care and resources from the county to get the care they need.

Figure 9: Partnership Mental Health Utilization Overview - Utilizer Rates by Data Source, 2025

Source: Partnership Data, 2025

D. Access to Care

There are many barriers to accessing health care within the general population, but populations in rural communities and in low-income areas are more significantly affected. Such barriers include, but are not limited to, access to fewer health care providers, cultural and linguistic challenges, broadband access for telehealth, and transportation challenges. Health literacy challenges can also contribute to a person's ability to access and use health care services.

1. Provider Availability

Lack of PCP availability is the most common barrier for Partnership members wanting to attend annual checkups and get routine screenings and vaccinations. These appointments are important both for preventive health care and for identifying the need for specialty care and other services. County Health Rankings provides a ratio of the population to primary care providers in Reporting Year 2025 (MY2022).[64]

For California as a whole, the ratio of individuals to providers described in Reporting Year 2025 (MY2022) was 1,200:1. For this current reporting year, nearly half of the counties Partnership serves has a worse patient to provider ratio compared to the last reporting period. Of the remaining counties, nine improved, two counties remained the same, and one county had no reporting data compared to the previous year's data. Marin and Placer had some of the best ratios of individuals to providers at 680:1 and 820:1, respectively, while Glenn and Trinity had two of the highest ratios at 7,080:1 and 7,890:1, respectively. Sierra county did not have any data to compare for this reporting year and last year. Despite these countywide numbers, Partnership contracts with a robust primary care network, and is able to meet the DHCS access and availability standards for primary care.

Table 9: Ratio of Population to Primary Care Providers by County

Ratio of Providers to County Population	
California Average: 1,200:1	
County	**Ratio**
Marin	680:1
Placer	820:1
Yolo	840:1
Sonoma	990:1
Napa	1,010:1
Solano	1,140:1
Mendocino	1,250:1
Sutter	1,310:1
Shasta	1,370:1
Plumas	1,380:1
Nevada	1,400:1
Modoc	1,420:1
Siskiyou	1,460:1
Del Norte	1,590:1
Humboldt	1,630:1
Butte	1,790:1

[64] County Health Rankings, Primary Care Physicians, 2025

Tehama	1,810:1
Lake	2,440:1
Colusa	3,650:1
Lassen	3,740:1
Yuba	4,220:1
Glenn	7,080:1
Trinity	7,890:1
Sierra	-

Source: County Health Rankings & Roadmaps, 2025. Primary Care Physicians. Green indicates that compared to the previous year's data, provider availability improved (i.e., there were less patients per provider). Red indicates that compared to the previous year's data, provider availability worsened (i.e., there were more patients per provider).

Partnership's most recent Grand Analysis Network Adequacy Report showed a rise in access to care grievances due to an increase in membership of 33.5% from 2023 to 2024. The report revealed that between January 1, 2024, and December 31, 2024, 42% of standard member grievances and 34% of appeals and second level grievances were related to provider access. Access issues mainly consisted of long wait times for providers, and transportation issues such as the driver arriving late and missed rides. Partnership did not meet the 2.47 grievances per 1,000 member threshold but did meet the access Appeals and Second Level Grievances threshold for 2024. This same report also revealed that between January 2024 to December 2024, Partnership met its goal of less than 20 referrals per 1,000 members for out-of-network requests.[65]

Physical access at provider facilities can be a challenge for Partnership's seniors and members with disabilities. One of the ways of assessing a facility's physical accessibility is through a Physical Accessibility Review Survey (PARS), which tracks any changes in a facility's physical accessibility. Physical access is categorized as either "Basic" or "Limited." A facility categorized as "Basic" has met all 29 critical elements used to identify a site's capability of accommodating members who are seniors and/or persons with disabilities. Elements, or domains, include parking, the exterior and interiors of the building, the restroom(s), and the exam room(s). If a facility is categorized as "Limited," it is missing any critical elements. For reviews done in 2025, 174 out of 289 inspected facilities were categorized as Limited; and 115 inspected facilities were categorized as Basic.[66]

[65] Partnership HealthPlan of California Grand Analysis: Network Adequacy Report: Assessment of Network Adequacy, 2025
[66] Partnership HealthPlan of California PARS report, 2025

2. 2025 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS survey gives members an opportunity to give feedback about their ability to access care and their satisfaction with the care received. The CAHPS survey measure year or period is 2024 (July 1, 2024 – December 31, 2024) and the reporting year is 2025. The CAHPS adult composite scores for reporting year 2025 showed that the ratings increased in most areas, including rating of all health care, getting needed care, getting care quickly, coordination of care, and rating of specialist (see the following table). However, rates decreased for how well doctors communicate and rating of personal doctor, from 92.6% in 2024 to 90.6% in 2025 and 70% in 2024 to 65.7% in 2025, respectively.

The collective increases in performance measures suggest that compared to 2024, adult members are overall more happy with their care. Since trust between a patient and provider can be a key element to certain positive health outcomes,[67] a positive patient experience likely indicates a higher level of trust. Thus, favorable member experience scores could indicate members may be more likely to trust their doctor and are at lower risk of adverse health outcomes. Partnership's Provider Relations department works closely with local providers to improve access to care for our members.

Table 10: Measure Year (MY) 2024 and Reporting Year (RY) 2025 Adults CAHPS Health Care Performance Results

ADULT CAHPS Health Care Performance	***2024*** (Previous Reporting YR)	***2025*** (Current Reporting YR)
Rating of Health Care (% 9 or 10)	46.3%	55.8%
Getting Needed Care (% Always or Usually)	73.9%	74.5%
Getting Care Quickly (% Always or Usually)	68.0%	74.0%
How Well Doctors Communicate (% Always or Usually)	92.6%	90.6%
Coordination of Care (% Always or Usually)	78.8%	81.3%
Rating of Personal Doctor (% 9 or 10)	70.0%	65.7%
Rating of Specialist (% 9 or 10)	69.5%	70.3%

Source: 2024 CAHPS Medicaid Adult 5.1H Survey, 2025, Press Ganey (p. 9-10). Green indicates an increase in score from the previous reporting year. Red indicates a decrease in score from the previous reporting year.

[67] Lerch, S.P., Hänggi, R., Bussmann, Y. et al., 2024

Compared to 2024, the CAHPS child composite scores for reporting year 2025 increased in all areas: rating of health care, getting needed care, getting care quickly, how well doctors communicate, coordination of care, rating of personal doctor, and rating of specialist (see next table). These increases suggest that compared to 2024, pediatric members are happier overall with their health care. Since trust between a patient and provider can be a key element to certain positive health outcomes,[68] a positive patient experience likely indicates a higher level of trust. Positive member experience scores indicate that members may be more likely to trust their doctor, which can lead to better health outcomes. This data seems to demonstrate that the pediatric population is overall happier with their health care.

Table 11: Measure Year (MY) 2024 and Reporting Year (RY) 2025 Child CAHPS Health Care Performance Results

CHILD CAHPS Health Care Performance	***2024*** (Previous Reporting YR)	***2025*** (Current Reporting YR)
Rating of Health Care (% 9, or 10)	58.9%	72.9%
Getting Needed Care (% Always or Usually)	77.1%	77.9%
Getting Care Quickly (% Always or Usually)	78.9%	80.0%
How Well Doctors Communicate (% Always or Usually)	93.0%	93.3%
Coordination of Care (% Always or Usually)	80.4%	84.7%
Rating of Personal Doctor (% 9, or 10)	75.4%	78.6%
Rating of Specialist (% 9, or 10)	63.8%	73.8%

Source: 2024 CAHPS Medicaid Child 5.1H Survey, 2025, Press Ganey (p. 9-10). Green indicates an increase in score from the previous reporting year. Red indicates a decrease in score from the previous reporting year.

3. Third Next Available Appointment

Partnership's Provider Relations department conducts the annual Third Next Available (3NA) survey. This point-in-time survey assesses the availability of members' access to non-urgent primary care appointments for adult, pediatric, and newborn appointments, as well as urgent care appointments. The 3NA survey also assesses overall telephone accessibility during business hours using the number of rings before the phone is answered, minutes on hold, average wait time before seeing a provider, and if a return-call is received within 30 minutes.

PCPs are held to performance expectations with 2 specific standards of interest. Standard 1 is defined as "the percentage of providers who have a 3rd next available

[68] Lerch, S.P., Hänggi, R., Bussmann, Y. et al., 2024

primary care adult and/or pediatric primary care appointment in less than or equal to 10 business days.” Standard 2 is defined as “the percentage of providers who have a 3rd next available newborn and/or urgent primary care appointment in less than or equal to 48 hours.”

The results of the 3NA survey show the percentage of clinics meeting PCP standards in each of the Partnership regions. The results of this survey are displayed in the following table. On the high end for adult primary care, 89% of the clinics in the Redding region met Standard 1, while on the low end, 75% of clinics in the Eureka region met Standard 1 for the same measurement. For primary care pediatrics, the Redding region was the highest performing region at 93% of clinics meeting Standard 1 while 83% of the clinics met Standard 1 in the Auburn and Eureka regions, making it the lowest performing regions. For primary care newborn appointments, 97% of clinics in the Chico region met Stand 2, making it the highest performing region, while 82% of the clinics in the Eureka region met the standard for this same measurement, making it the lowest performing region. For primary care urgent care, 97% of the clinics in Chico met Standard 2, making it the highest performing region, while 83% of the clinics in the Auburn region met the standard, making it the lowest performing region. As shown in the following table, this data seems to demonstrate that for all appointment types in each region, most clinics are meeting the standard and are able to provide members, including pediatric members, with the care they need.

Table 12: 2025 Partnership Third Next Appointment Availability (Percentage of Clinics Meeting PCP Standards)

Third Next Available (3NA) Survey Findings 2025							
Provider Type	Standard	Percentage of Clinics Meeting PCP Standards					
		Auburn	Chico	Eureka	Fairfield	Redding	Santa Rosa
Primary Care Adult	3NA Non-urgent Care primary care appointments within 10 business days of request **Standard 1**	77%	86%	75%	76%	89%	77%
Primary Care Pediatrics	3NA Non-urgent Care primary care appointments within 10 business days of request **Standard 1**	83%	91%	83%	71%	93%	88%
Primary Care Newborn Appointments	3NA Newborn appointments within 48 hours of discharge **Standard 2**	92%	97%	82%	85%	85%	85%
Primary Care Urgent Care	3NA Urgent Care appointments within 48 hours of request **Standard 2**	83%	97%	94%	94%	94%	90%

Source: 2025 Partnership Third Next Available Survey, 2025 Summary

The results of the 3NA survey (see following table) show the median days for an established PCP appointment for primary care adults, pediatrics, newborn, and urgent care. All regions met standard 1 for Primary Care Adult with Chico performing the best at 2.2 median business days for an appointment. All regions met standard 1 for Primary Care Pediatrics with Auburn performing the best at 2.2 median days for an appointment. All regions met standard 2 for Primary Care Newborn appointments with Auburn performing the best at .75 day wait for an appointment. All regions met standard 2 for Primary Care Urgent Care appointments with Auburn, Chico, and Eureka performing the best at zero wait for an appointment from request time. Meeting standard 1 and 2 for median days of a requested PCP appointment improves patient satisfaction, fosters better health outcomes through timely care, and increases treatment compliance.

Table 13: 2025 Partnership Third Next Appointment Availability (Median Days)

Third Next Available (3NA) Survey Findings 2025							
Provider Type	Standard	Median Days (number of days) for Established PCP Appointment					
		Auburn	Chico	Eureka	Fairfield	Redding	Santa Rosa
Primary Care Adult	3NA Non-urgent Care primary care appointments within 10 business days of request **Standard 1**	2.25	2.2	4.75	6.67	5.33	4
Primary Care Pediatrics	3NA Non-urgent Care primary care appointments within 10 business days of request **Standard 1**	2	2.2	4.25	3.67	4.67	2.5
Primary Care Newborn Appointments	3NA Newborn appointments within 48 hours of discharge **Standard 2**	.75	.8	1.25	1	1.17	1
Primary Care Urgent Care	3NA Urgent Care appointments within 48 hours of request **Standard 2**	0	0	0	.3	.67	1

Source: 2025 Partnership Third Next Available Survey, 2025 Summary

When looking at 3NA primary care appointment access by county, 19 of the 24 counties did not meet all of the standards for appointment accessibility. For those sites that do not meet the standards, they are surveyed again and are provided with a corrective action plan, as needed.

4. Telemedicine

a. Telehealth Utilization Report

Telemedicine and telephone visit opportunities can help ensure access to needed health care. Partnership uses 2 sources of telehealth data for specialty care: The Telehealth Utilization Report and the eConsult Utilization Report. The Telehealth Utilization Report details video data and shows all video visits completed between a patient, provider, and specialist.

In 2025, adult telemedicine utilization had 41,574 visits scheduled with 26,681 completing their visit for a 64.2% completion rate through Partnership-contracted specialty telemedicine providers (see the following table). While the data shows an increase in both scheduled and completed telemedicine visits for 2025 when compared to 2024, the overall completed visit rate was slightly lower.

Table 14: Adult Telemedicine Appointment Details as of December 2025

Adult Telemedicine Appointment Details as of December 2025					
Scheduled Appointments	Completed Visits	Completed Visits Rate	No Show Rate	Cancelled Visits Rate	Avg. Business Days to Appt.
41,574	26,681	64.2%	10.1%	9.8%	23

Source: Adult Telemedicine Appointment Details Report, 2025, Partnership

For 2025, the number of scheduled pediatric telemedicine appointments was 7,638 and the number of completed pediatric telemedicine appointments was 4,796, with a 62.8% completion rate (see following table). The number of completed pediatric telemedicine appointments ranged from approximately 378-477 visits per month. The high of 477 occurred in October 2025 followed by 472 in April 2025. Since access to care is an important part of staying healthy, this data demonstrates that there is opportunity to increase the rates of access to care for the pediatric population through telemedicine.

Table 15: Pediatric Telemedicine Appointment Details as of December 2025

Pediatric Telemedicine Appointment Details as of December 2025					
Scheduled Appointments	Completed Visits	Completed Visits Rate	No Show Rate	Cancelled Visits Rate	Avg. Business Days to Appt.
7,638	4,796	62.8%	17.1%	0%	36.2

Source: Pediatric Telemedicine Appointment Details Report for 2025, Partnership

b. eConsult Utilization Report

The second source of telehealth data for specialty care is Partnership's eConsult Utilization Report. This report shows the utilization data of the online eConsult platform. This platform is where providers can directly message specialists regarding patient care; by using this method, the needs of the patients can be met without requiring a face-to-face visit.

As of December 2025, there were 1,011 adult eConsults completed. Of those, 55.1% were closed because the patient's needs were addressed by eConsult, while 41.1% were referred to face-to-face consultation.

Table 16: Adult eConsult Utilization Report, 2025 Partnership

Adult eConsult Utilization Report as of December 2025				
Submitted eConsults	Completed eConsults	Closed – Patient Needs Addressed	Average Time from Referral to Consult, in Days	Closed – Refer Face-to-Face
1,020	1,011	55.1%	2.3	41.1%

Source: Safety Net Connect Utilization Report, 2025 Partnership

As of December 2025, there were 50 completed pediatric eConsults. Of those, 68.0%. were closed because the patient's needs were addressed through eConsult, while 26.0% of consults were referred for face-to-face consultation.

Table 17: Pediatric eConsult Utilization Report, As of December 2025 Partnership

Pediatric eConsult Utilization Report as of December 2025				
Submitted eConsults	Completed eConsults	Closed – Patient Needs Addressed	Average Time from Referral to Consult, in Days	Closed – Refer Face-to-Face
50	50	68.0%	.7	26.0%

Source: Safety Net Connect Utilization Report, 2025 Partnership

Although telehealth has the ability to improve access to care, Partnership members living in rural and remote areas with limited broadband access may still struggle to receive the care they need. Rural members often require in-person visits to meet their medical needs. In addition, many Partnership members lack the equipment or knowledge needed to connect to a telemedicine appointment.

E. Member Experience of Care

1. Satisfaction with Health Plan

Partnership contracted with Press Ganey (PG) to perform the 2025 CAHPS survey. The report is based on data as of July 2025. PG reached out to 3,318 adult members and the guardians of 4,969 pediatric members to participate in the survey. There were 511 adult responses (15.4% of those surveyed) and 783 pediatric responses (15.8% of those surveyed).

The CAHPS results discovered that 86.5% of adult respondents answered "Always" or "Usually" when asked if they received helpful information or were treated with courtesy and respect. This measure is collectively referred to as Customer Service, which changed from 87.0% in 2024 to 86.5% in 2025. This slight change from 2024 to 2025

indicates that Partnership still has room to improve. The following table denotes changes in various measure between 2024 and 2025.

Other categories showed improved responses from the year prior. Adult members were more satisfied with the Rating of Health Plan (increase from 54.5% to 55.8%), Getting Needed Care (increase from 74.0% to 74.5%), and the Ease of Filling Out Forms (increase from 92.7% to 93.7%). The increase in these measures suggests that compared to 2024, adult members are more satisfied with Partnership. Thus, members may be more likely to trust their health plan and may experience better health outcomes.

Table 18: Measure Year (MY) 2024 and Reporting Year (RY) 2025 Adult CAHPS Summary Rates for Health Plan Performance

ADULT CAHPS Health Plan Performance	***2024*** (Previous Reporting YR)	***2025*** (Current Reporting YR)
Rating of Health Plan (% 9 or 10)	54.5%	55.8%
Getting Needed Care (% Always or Usually)	74.0	74.5%
Customer Service (% Always or Usually)	87.0%	86.5%
Ease of Filling Out Forms (% Always or Usually)	92.7%	93.7%

Source: Measure Year (MY) 2024 and Reporting Year (RY) 2025 CAHPS Medicaid Adult 5.1 H, 2025, Press Ganey (p. 10). Red indicates a decrease in score from the previous reporting year. *Green indicates an increase in score from the previous reporting year.*

The Measure Year (MY) 2024 and Reporting Year (RY) 2025 Child CAHPS survey results revealed that 72.9% of respondents completing forms on behalf of pediatric members rated their child's Health Plan as good or excellent (scores of 9 or 10), compared to 68.1% in 2024. This marks a notable increase. Another improvement was observed in Getting Needed Care, which increased from 77.1% in 2024 to 77.9% in 2025. However, the percentage of respondents reporting on Customer Service as "Always or Usually" decreased slightly from 91.2% in 2024 to 90.5% in 2025. A decrease was also observed with Ease of Filling Out Forms which decreased from 94.2% in 2024 to 93.1% in 2025. These results, as outlined in the following table, suggest that while pediatric members' interactions with Partnership improved, challenges remain in filling out forms and customer service. These factors may influence members' trust in their health plan and their likelihood of seeking care for health concerns as needed. This data seems to demonstrate that the pediatric population is overall happier with their health plan.

Table 19: Measure Year (MY) 2024 and Reporting Year (RY) 2025 Child CAHPS Summary Composite Rates for Health Plan Performance

Pediatric CAHPS Health Plan Performance	***2024*** (Previous Reporting YR)	***2025*** (Current Reporting YR)
Rating of Health Plan (% 9 or 10)	68.1%	72.9%
Getting Needed Care (% Always or Usually)	77.1%	77.9%
Customer Service (% Always or Usually)	91.2%	90.5%
Ease of Filling Out Forms (% Always or Usually)	94.2%	93.1%

Source: MY2024 CAHPS® MEDICAID CHILD 5.1H SURVEY 2024, Press Ganey (p. 12). Green indicates an increase in score from the previous reporting year. Red indicates a decrease in score from the previous reporting year.

2. Doctor Communication

Partnership uses the Measure Year (MY) 2024 and Reporting Year (RY) 2025 CAHPS survey data to evaluate how satisfied members are with the interactions they have with their doctors. The score is a composite, comprised of indicators measuring how well a member's doctor explained things, if they listened carefully, showed respect, and if the doctor spent enough time with them.

The percentage of adult members who felt their doctor communicated well with them always or usually decreased on aggregate from 92.6% in 2024 to 90.6% in 2025 as compared to the Quality Compass (QC) score shown in the following Figure 10. Aside from showed respect, Partnership scored slightly below Press Ganey's 2025 Benchmark in all aspects of how well doctors communicate with Partnership adult members. Having good communication with one's doctor can help build a relationship and fosters trust between the member and the provider,[69] which can be a proxy measure for health outcomes. Therefore, having good communication with one's doctor is important to ensure Partnership members have the best possible health outcomes.

Figure 10: 2025 Adult Composite CAHPS Survey Result

	2025 Valid n	**2023**	**2024**	**2025**
How Well Doctors Communicate (% Usually or Always)	282	92.9%	92.6%	**90.6%**
Dr. explained things	283	92.5%	93.3%	**90.5%**
Dr. listened carefully	282	93.0%	92.9%	**90.4%**
Dr. showed respect	282	94.9%	91.7%	**94.3%**
Dr. spend enough time	281	91.2%	92.4%	**87.2%**

[69] BMC Primary Care, 2024

Source: Measure Year (MY) 2024 and Reporting Year (RY) 2025 CAHPS Medicaid Adult 5.1H Survey, Partnership, 2025

The results of the Child CAHPS Survey show that members rated their care experience with children's providers higher than providers for adults. The percentage of child members who felt their doctor communicated well with them with a response of always or usually increased on aggregate from 93.0% in 2024 to 93.3% in 2025 as shown in Figure 11. This improvement was due to the metric of How Well Doctors Explained Things; this measure showed an increase from 93.6% in 2024 to 95.8% in 2025. On the contrary, Partnership showed a slight decrease in How Well Doctors Listened, How Well Providers Showed Respect, and If Doctors Spent Enough Time with Member. Having good communication with one's doctor is important to ensure Partnership pediatric members trust their doctors and will have the best possible health outcomes. This data demonstrates that the care givers of the pediatric population are generally happy with their providers.

Figure 11: Measure Year (MY) 2024 and Reporting Year (RY) 2025 Child Composite CAHPS Survey Result

	2025 Valid n	2023	2024	2025
How Well Doctors Communicate (% Usually or Always)	452	92.7%	93.0%	**93.3%**
Dr. explained things	454	93.8%	93.6%	**95.8%**
Dr. listened carefully	454	92.9%	94.7%	**94.1%**
Dr. showed respect	456	95.6%	96.3%	**96.1%**
Dr. spend enough time	447	88.4%	87.7%	**87.2%**

Source: Measure Year (MY) 2024 and Reporting Year (RY) 2025 CAHPS Medicaid Child 5.1 Survey, Partnership, 2025

F. Health Disparities

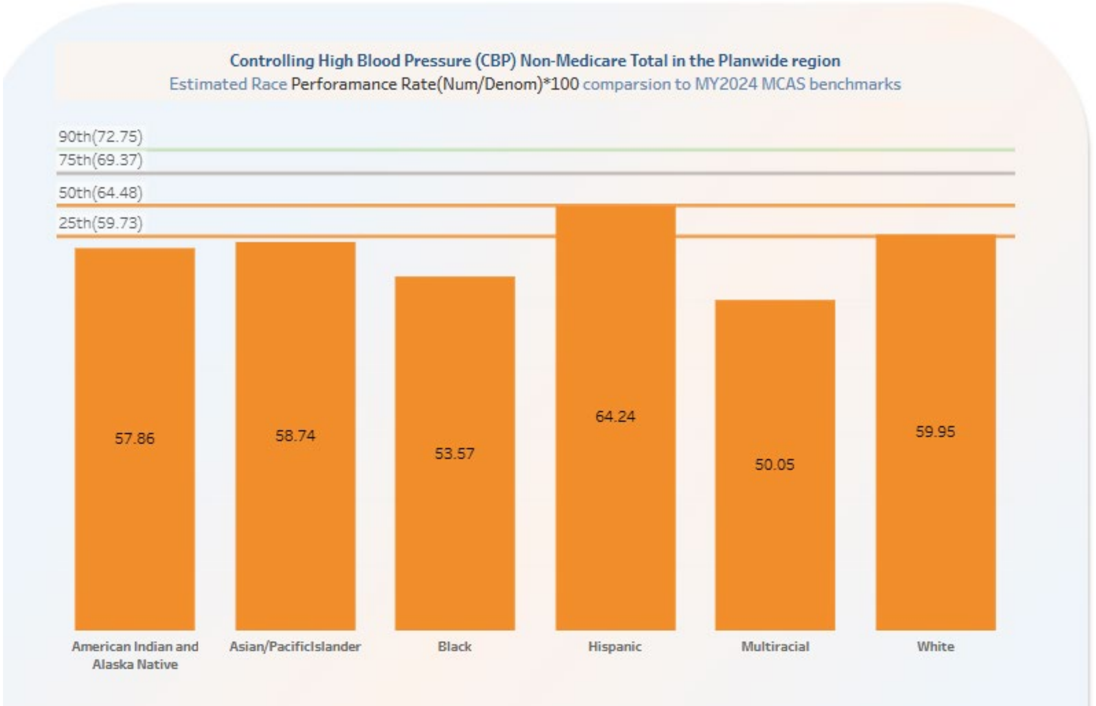
The 2025 health disparities data is taken from Partnership's Disparity Analysis tableau dashboard called the HEDIS Disparity Analysis Dashboard - MCAS County Oversampling Data. The following results are from the MY2024 Managed Care Accountability Set (MCAS) benchmarks.

1. Controlling High Blood Pressure (CPB)

The HEDIS Disparity Analysis dashboard found that performance across the majority of the racial and ethnic groups performed below the 50th percentile MPL of 64.48: the American Indian and Alaska Native came in at 57.86%, the Asian/Pacific Islander population came in at 58.74%, the Black population came in at 53.57%, the Multiracial came in at 50.05%, and the White population came in at 59.95%. The Hispanic group narrowly missed the 50th percentile at 64.24%. Controlling high blood pressure is an important part of staying healthy. As such, this data demonstrates there is a need to

better address controlling high blood pressure amongst all racial and ethnic groups, but particularly among the multiracial population as they performed the lowest. See Figure 12 below.

Figure 12: 2025 Controlling High Blood Pressure

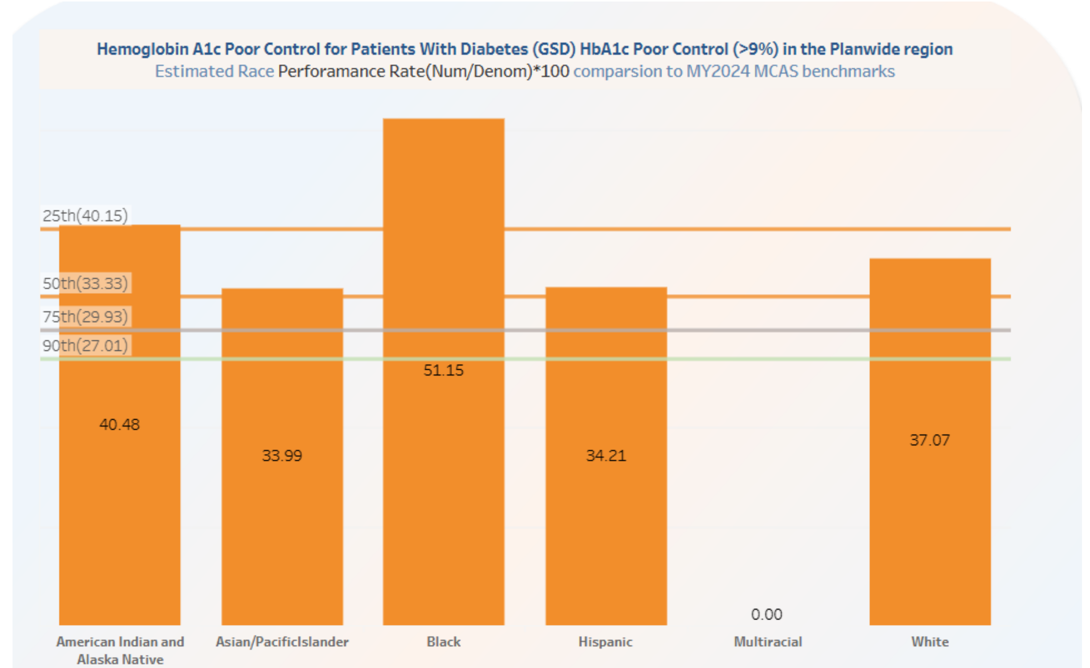


Source: 2025 Partnership HEDIS Disparity Analysis dashboard - MCAS County Oversampling Data

2. Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%):

The HEDIS Disparity Analysis dashboard found that when comparing the MCAS county oversampling data for each race/ethnicity group to the MCAS benchmarks, the disparity analysis shows that no race/ethnicity group met the minimum performance level. For this measure, the MPL was set at 33.33%, with observed performance rates of 40.48% (American Indian/Alaska Native), 33.99% (Asian/Pacific Islander), 51.15% (Black), 34.21% (Hispanic), and 37.07% (White). Therefore, the data in Figure 13 demonstrates there is a need to better address hemoglobin A1c control amongst all groups, but particularly among the African American/Black, adult population as they performed the worst.

Figure 13: Hemoglobin A1c Control for Diabetes – Poor Control

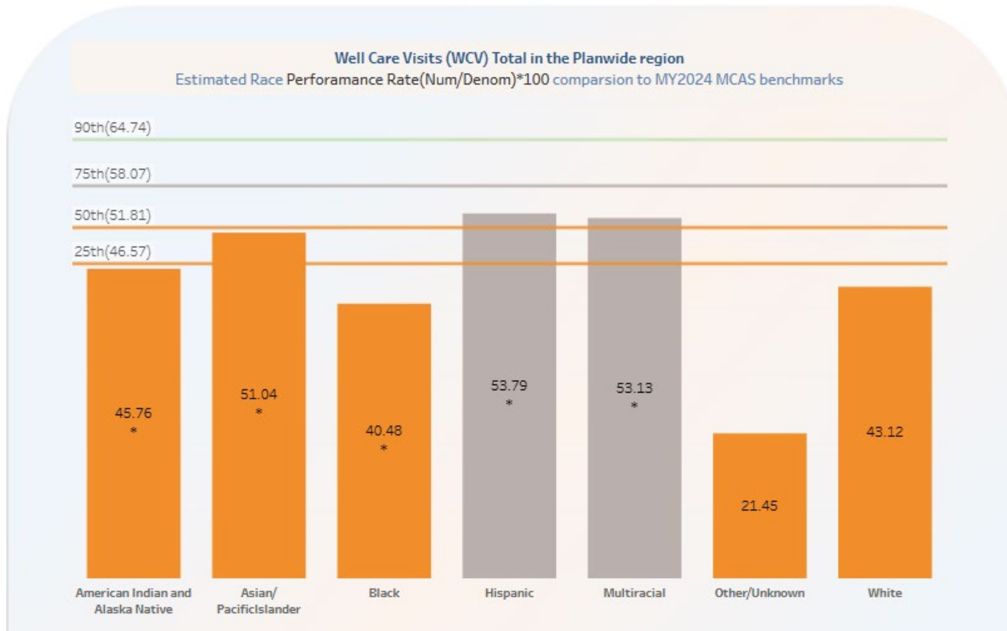


Source: [2025 Partnership HEDIS Disparity Analysis dashboard - MCAS County Oversampling Data]

3. Child and Adolescent Well Care Visits (WCV):

The HEDIS Disparity Analysis dashboard report on Well Care Visits (WCV) found that the majority of racial/ethnic groups did not meet the MPL 50th percentile of 51.81%, and no group performed above the 75th percentile of 58.07%. Specifically, the American Indian and Alaska Native population came in at 45.76%, the Asian/Pacific Islander population came in at 51.04%, and the White population came in at 43.12%. The Black or African American population came in at 40.48%, and the Other/Unknown (21.45%) populations performed the lowest, falling below the MPL 50th percentile. In contrast, the Multiracial (53.13%) population performed slightly above the 50th percentile. The Hispanic population performed the best (53.79%) and performed above the MPL 50th percentile. Well-child visits are an important part of staying healthy. As such, the data in Figure 14 demonstrates a clear need to address the low rates of well-child visits amongst most groups, and in particular, increase access to or utilization of well-care visits for the Black and Other/Unknown pediatric populations.

Figure 14: Child and Adolescent Well Care Visits

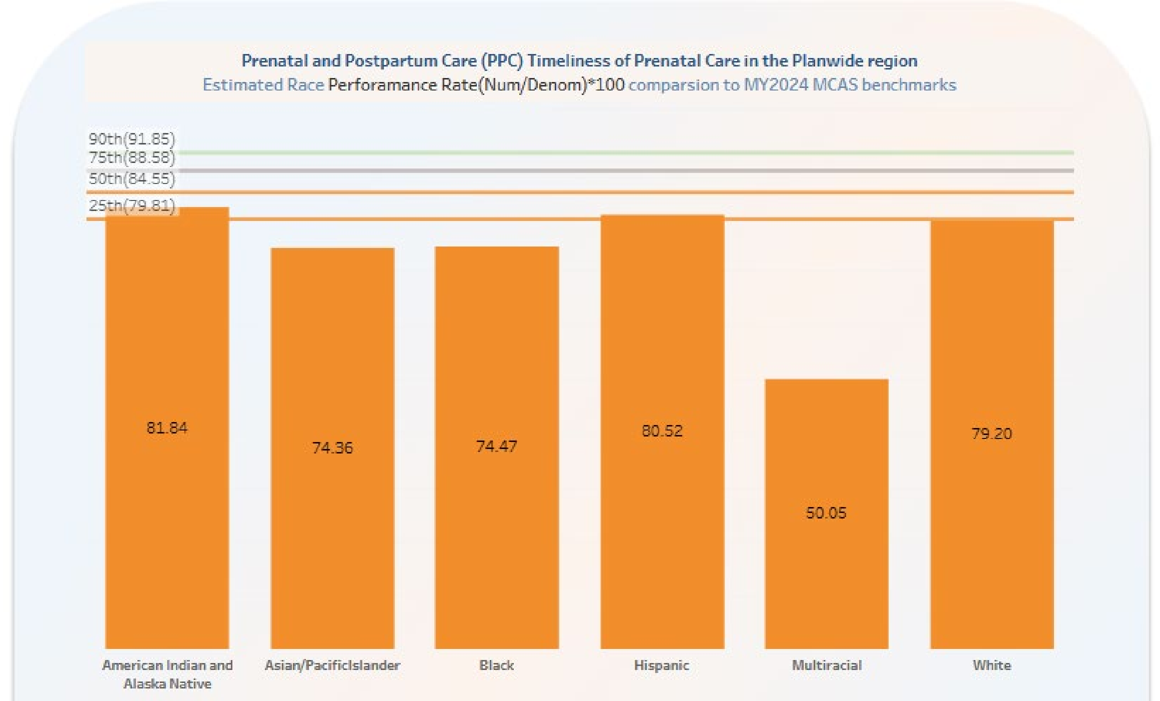


Source: 2025 [Partnership HEDIS Disparity Analysis dashboard - MCAS County Oversampling Data]

4. Prenatal and Postpartum Care (PPC):

The HEDIS Disparity Analysis dashboard report on the timeliness of Prenatal Care Visits (PPC) found that all groups had lower rates of completion, performing below the MPL 50th percentile of 84.55%: American Indian and Alaska Native came in at 81.84%, the Asian/Pacific Islander population came in at 74.36%, the Black or African American population came in at 74.47%, the Hispanic population came in at 80.52%, and the White population came in at 79.20%. The Multiracial population had the lowest rate of completion at 50.05%, as shown in Figure 15. Prenatal care is an important part of staying healthy. As such, the data in the figure demonstrates there is a need to address prenatal care access amongst all groups, but particularly among the Asian/Pacific Islander and multiracial pregnant population as they performed the lowest.

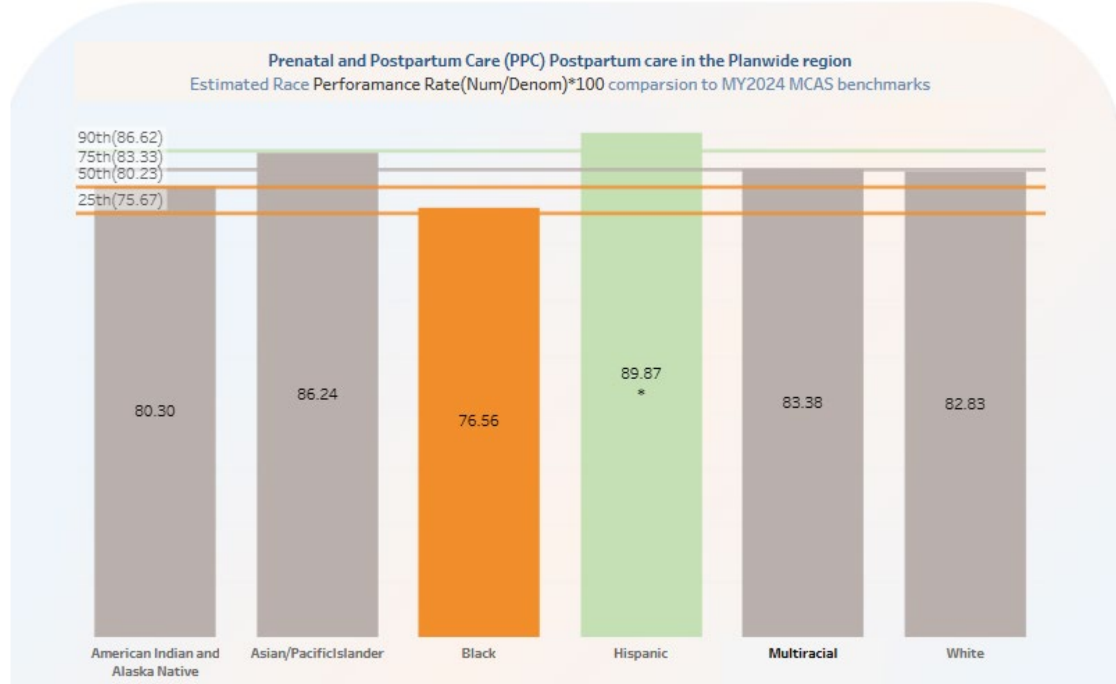
Figure 15: Prenatal and Postpartum Care (PPC - Pre)



Source: [2025 Partnership HEDIS Disparity Analysis dashboard - MCAS County Oversampling Data]

For Postpartum Care, the Black population (76.56%) was the only group with a completion rate below the MPL 50th percentile of 80.23%. In comparison, the American Indian and Alaska Native (80.30%), Asian/Pacific Islander (86.24%), Multiracial (83.38%), and White (82.83%) groups all had higher rates of completion, performing above the 50th percentile, as shown in Figure 16. The Hispanic population was the only group who performed above the 90th percentile (86.62%). Postpartum care is an important part of staying healthy. As such, there is clear need to address access to postpartum care among the Black group who are of childbearing age, as they performed the lowest.

Figure 16: Prenatal and Postpartum Care (PPC - Post)



Source: [2025 Partnership HEDIS Disparity Analysis dashboard - MCAS County Oversampling Data]()

G. Health Education, Cultural & Linguistic Gap Analysis

Partnership maintains a Health Education unit responsible for creating and providing health education materials at an appropriate reading and comprehension level for members. The Health Education unit creates some materials to meet the needs of various member-outreach activities carried out by the organization. Other health education materials are more readily available on the Member Portal through the Healthy Living Tool. There are additional external health education materials available for both member and provider access on Partnership's external website:

- Members: www.partnershiphp.org/Members/Medi-Cal/Pages/Health%20Education/Health-Education---Members.aspx
- Providers: www.partnershiphp.org/Providers/HealthServices/Pages/Health%20Education/HealthEducationProviders.aspx

Printed copies of materials are available to both members and providers. Educational and informing materials created by Health Education are reviewed and updated no less than every 5 years and are translated into all Partnership threshold languages of Spanish, Russian, Tagalog, and Punjabi; other languages are available upon member

request. Health Education reviews educational materials on the external website on an annual basis. This established process has been effective in providing materials to members, both directly and through providers.

Health Education has historically been responsible for aspects of the Cultural & Linguistic program, including evaluation of member grievances for issues arising from discrimination (which can include discrimination based on language), and performance of audits for delegates mandated to carry out various Cultural and Linguistic responsibilities; please note in 2025, review of discrimination-based grievance cases was transferred to the Health Equity department. Health Education also historically reviewed and recommended staff and provider training to promote awareness of diversity, equity, and inclusion to serve our members better as requested. However, this activity was also fully transferred over to the Health Equity Department in 2025 as a result of APL 24-016.[70]

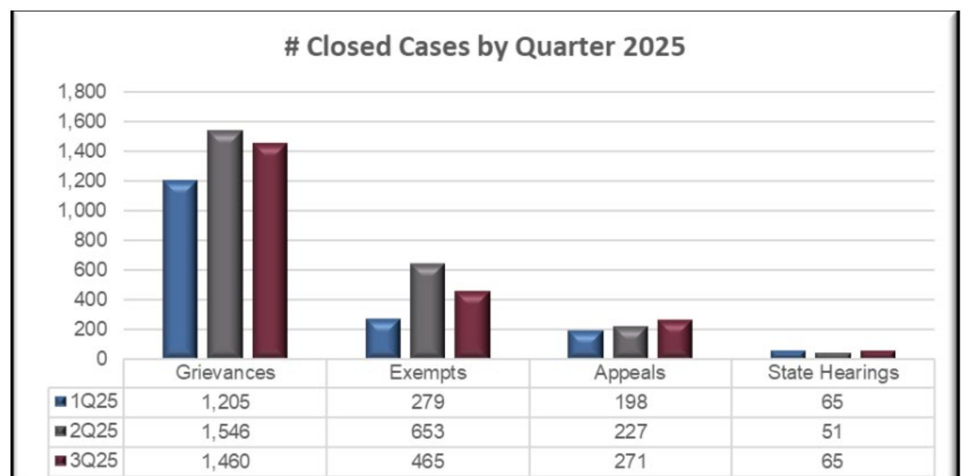
1. Grievance and Appeals

Grievance and Appeals (G&A) data is used to analyze member experience with the health plan and health care services, providing insight into member engagement with the health plan, and capturing reports of discrimination. Each year, Partnership compares the year-to-date results reported in the Fourth Quarter G&A Pulse report. This Pulse report captures data for the first 3 quarters of each calendar year. Time limitations prevent capture and use of fourth quarter data in this PNA.

By the end of the third quarter in 2025, the G&A team closed 4,211 cases (see Figure 17), representing a slight decrease from the 4,248 cases closed for member reported grievances in 2024. English speakers and the White population continue to be the groups that file the majority of grievances and appeals.

[70] APL 24-016 Diversity, Equity, and Inclusion Training Program Requirements

Figure 17: Number of Closed Cases by Quarter 2025



Source: 4Q 2025 Partnership Grievance & Appeals Pulse Report, Partnership

The top 5 ethnicities of people filing grievances in third quarter 2025 were White (56.8%), Other/Unknown (16.0%), Hispanic (15.2) Black (7.3%) and Asian (2.9%), as seen in Figure 18 below.

Figure 18: G&A Pulse Report by Members Ethnicities vs. Partnership Overall Membership by Ethnicity

3Q25 CASES BY ETHNICITY		
Member Ethnicity	% Cases	% Membership
White	56.8%	37.9%
Other/Unknown	16.0%	19.8%
Hispanic	15.2%	34.3%
Black	7.3%	3.6%
Asian	2.9%	2.5%
Native American	1.7%	1.7%
Hawaiian/Pacific Islander	0.1%	0.2%
Grand Total	100.0%	100.0%

Source: 4Q 2025 Partnership Grievance & Appeals Pulse Report, Partnership

In 2025, Partnership continues to identify a disparity in grievances reported by member race/ethnicity and by language. The grievances reported continue to not be proportionate to the percentage of different races/ethnicities and languages within Partnership's membership. Between 2024 and 2025, the proportion of grievances shifted further away from alignment with the demographics of Partnership members. This may indicate a lack of member trust in Partnership to take their concerns seriously, which can lead to less health seeking behaviors (e.g. attending primary care visits) and thus poorer health outcomes for the member population.

Grievances reported by White members increased from 56.0% in 2024 to 56.8% in 2025, which coincides with the percentage of White members increasing from 37.0% to 38.9% in the same period. Grievances reported by Hispanic members increased from 11.8% in 2024 to 19.6% in 2025, which coincides with the percentage of Hispanic members increasing from 32.2% to 34.3% in the same period.

Grievance reporting decrease most significantly between 2024 and 2025 by Native American members, where grievance reporting decreased from 19.6% in 2024 to 1.7% in 2025, although there was an overall decrease in the percentage of Native American members from 1.8% to 1.7%. The decrease in grievances among our Native American members may be attributed to a heightened focus on this population and the provision of dedicated staff support to improve their health outcomes through Partnership health plan benefits. See the table below.

Table 20: Grievances by Race/Ethnicity over Time

Member Race/Ethnicity	***2024 % of Cases***	***2024 % of Membership***	***2025 % of Cases***	***2025 % of Membership***
White	56.0%	38.9%	56.8%	37.9%
Other/Unknown	5.2%	17.9%	16%	19.8%
Hispanic	19.6%	33.6%	15.2%	34.3%
Black (African American)	0.4%	3.5%	7.3%	3.6%
Asian	15.8%	2.5%	2.9%	2.5%
Native American	19.6%	1.8%	1.7%	1.7%
Native Hawaiian or Pacific Islander	0.1%	0.2%	0.1%	0.2%

Source: 4Q2024 & 4Q2025 Partnership Grievance & Appeals Pulse Report, Partnership HealthPlan of California

Members who speak English continue to report grievances much more frequently than those who speak other languages or use sign language. See Figure 19 below.

Figure 19: G&A Pulse Report by Members Language vs. Partnership Overall Language Profile

3Q25 CASES BY LANGUAGE		
Member Language	% Cases	% Membership
English	92.5%	75.7%
Spanish	5.6%	20.8%
Other	1.3%	2.1%
Russian	0.3%	0.6%
Tagalog	0.2%	0.3%
Punjabi	0.0%	0.5%
Grand Total	100.0%	100.0%

Source: 4Q 2025 Partnership Grievance & Appeals Pulse Report, Partnership

The percentage of English-speaking members who reported grievances increased from 90.6% in 2024 to 92.5% in 2025. Grievances in Partnership's other languages were low in 2025, however, compared to 2024, grievances in Other, Russian, and Tagalog increased slightly. Spanish, and Punjabi decreased from 2024 to 2025. A lack of grievance can be a sign of lack of trust in an organization. Since trust is important for certain health outcomes,[71] this data suggests there is a disproportionate number of English members reporting their grievances compared to LEP members and therefore a need to be addressed.

Table 21: Grievances by Language over Time

Language	***2024 % of Cases***	***2024 % of Membership***	***2025 % of Cases***	***2025 % of Membership***
English	90.6%	76.2%	92.5%	75.7%
Spanish	8.0%	20.5%	5.6%	20.8%
Other	1.1%	2.0%	1.3%	2.1%
Tagalog	0.1%	0.3%	0.3%	0.6%
Russian	0.0%	0.6%	0.2%	0.3%
Punjabi	0.1%	0.5%	0.0%	0.5%

Source: 4Q2024 & 4Q2025 Partnership Grievance & Appeals Pulse Report, Partnership HealthPlan of California

[71] BMC Primary Care, 2024

2. Diversity, Equity, and Inclusion Training

a. Partnership Staff Training

Partnership is committed to ensuring both staff and members feel included and have equal opportunities for their mental, social, and physical wellbeing. One of the ways Partnership addresses inclusion is through an annual Health Equity Week for staff. A project team typically designs emails, videos, and interactive activities to raise staff awareness of the diversity of Partnership's employees and members, and how to respectfully interact with others. Health Equity Week will continue to take place in April. Below are the results of Health Equity Week 2025.

Table 22: LMS Completion Report for Health Equity Week 2025 Activities

LMS Activity	Approximate Completions
Health Equity Week 2025: Vince, a Member's Story	259
Health Equity Week 2025: Tale of Two Zip Codes	11

Source: LMS Training Report; Partnership Human Resource Department, 2025

Table 23: Vimeo and Townhall Completion Report for Health Equity Week 2025 Activities

Vimeo and Townhall	Approximate Completions
Health Equity Week 2025: Q&A Video with Population Health Director Dr. Delorean, Staff member Bethany Hannah	263
Health Disparities and Equity Town Hall Featuring Health Equity Discussion with Dr. Jalloh	1,109

Source: Vimeo 2025; Partnership Human Resource Department, 2025

Partnership also offers virtual and recorded training sessions for all staff to remind them of the legal rights of our diverse team and to educate them on how best to include others in office activities. There are several mandatory educational sessions per year for various types of Partnership staff. As additional training opportunities arise, they are made available to staff based on interest or assignment. Human Resources tracks staff participation through the Learning Management System (LMS). As of December 31, 2025, there were 1,696 Partnership employees. In 2025 Partnership employees completed the following trainings:

Table 24: Training Sessions for Partnership Staff

Partnership Training Sessions	Staff Assignment	Approximate Completions
Diversity Basics: Foundations	Assigned to all staff in April 2025 and all new hires, temps, & contractors	1,696
Cultural & Linguistics Program Overview and Staff Training	Assigned to new hires, new temps, and new contract employees only	376
Affordable Care Act – Section 1557	Assigned to new hires, new temps, and new contract employees only	374
TGI Training	Assigned to Partnership staff, temps, and contractors of Member Facing departments (pushed every 2 years)	704

Source: Partnership Human Resources, 2025

To promote awareness and understanding of diversity, equity, and inclusion, and to align with the requirements of APL 24-016[72], Partnership will continue to identify and mandate high-quality staff training(s) on an annual basis. Some staff may seek further training opportunities to gain better insight into their peers and Partnership's population. In 2026 and beyond, DEI trainings for Partnership will align with new DHCS regulatory requirements.

Provider Training

Partnership is committed to enhancing the member experience by actively reviewing and offering trainings to contracted providers, with a focus on reducing unintended bias, discrimination, and health disparities. In 2025, Partnership's Cultural and Linguistic and Health Education Team reviewed and updated the comprehensive Cultural and Linguistic toolkit designed to help providers document patient language needs in medical records, utilize interpreter services, and refer patients to culturally and linguistically appropriate community programs. In addition, Partnership's Director of Health Equity developed a training program in 2024 to align with DHCS's APL 24-016 Diversity, Equity, and Inclusion Training Program Requirements.[73] In 2025 Partnership

[72] APL 24-016 Diversity, Equity, and Inclusion Training Program Requirements
[73] APL 24-016 Diversity, Equity, and Inclusion Training Program Requirements

began offering providers regular DEI training to align with NCQA and DHCS quality standards. This training, called the Community, Access, Respect, Engagement and Service (CARES) Training, educates providers on the cultural diversity of our members, raises awareness of Partnership's cultural and linguistic policies, and provides guidance on available resources for supporting diverse populations. This training is provided to all existing contracted practitioners with Partnership and its completion is required during their recredentialing period every three years. This activity will continue to be supported by key staff in the Health Equity Department.

V. Review of Activities, Resources, and Opportunities

Each year Partnership leadership takes the opportunity to review existing programs, resources, and structures to ensure they meet member needs. Department directors collaborate with the executive team to review Partnership's strategic plan and ensure Partnership resources are aligned with its mission and the evolving environment. Departments prepare their budgets to ensure staffing, talent, and knowledge are available to meet Partnership's various initiatives. The 2026 PNA demonstrates how Partnership addresses member needs through various activities. To best support both health and overall wellbeing, Partnership works closely with provider and community resources to ensure members have access to a wide range of services. However, this PNA also revealed opportunities to address needs in the areas of organizational structure; social and environmental needs; member health and wellness; access to care; health disparities; and health education and culture and linguistics.

Over the years, Partnership has cultivated strong relationships with the provider community, public health, and community-based organizations on behalf of its members. As of January 2024, Partnership established 6 regional offices to maintain a community presence and ensure members have local access to someone who can address their concerns.

A. Organizational Structure

Partnership's new claims system was scheduled to go live in mid-2024 but has since been postponed to a later date in 2026. Once the new claims system is implemented, there are several other projects planned to help Partnership meet the needs of its population, including a move to a new Grievance platform. In 2025, Medi-Cal Connect, DHCS' Population Health Management Service platform, went live. As part of a larger initiative, this platform gives health plans and providers improved data access to inform

and guide care coordination, close gaps in care, and improve the health of our members.[74] Medi-Cal Connect and the new claims system will be sufficient for Partnership's future needs; the claims system will provide a framework on which Partnership may build additional IT structures to meet the needs of the organization and our members.

The position of Director of Health Equity was filled in January 2023, overseeing health equity activities and interventions designed to mitigate health disparities. In 2024, Health Equity branched off into its own department. To support this important work, the Health Equity department hired several staff in 2024. In 2025, the department continued to grow. Additional staff were hired, including one Cultural and Linguistic Liaison, a Supervisor of Health Equity Training, a Manager of Cultural Community, and a Project Coordinator. A second position for a Cultural and Linguistic Liaison was also created.

Within Partnership's Population Health department, there are teams who work to build relationships with community partners and other stakeholders; this work includes the mandate for Partnership to work collaboratively with the Local Health Jurisdictions in its service area on their Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP). The needs identified in the most recent versions of these reports are summarized earlier in this needs assessment. These teams represent Partnership at various county and community collaborative meetings and learn about the ongoing needs of communities. This is one way that Partnership remains informed about the needs of the counties and communities it serves. Through relationships established in these meetings, organizations work together to identify, conceptualize, and implement interventions for health concerns or disparities in the local communities. In addition to these community partner-facing teams within Population Health, Partnership's medical directors regularly meet with clinic medical directors to discuss the clinical needs of patients, and they work together to make connections and find solutions for the providers and the members. Finally, other Partnership teams attend community events and conduct qualitative, community-based research, often hearing firsthand of various needs of Partnership's members.

There are also staff assigned to collect information about available community resources and make these resources available on Partnership's external website (see Appendix D for a list of current Community Resources resources). Additionally, internal staff may use these community resources to augment Partnership's program offerings through closed-loop referrals (which differs in definition from DHCS' closed-loop referrals definition). Partnership members have the option to contact Partnership's

[74] Medi-Cal Connect, Frequently Asked Questions

Population Health Department to learn how to access local community resources. Population Health staff also routinely provide community resources to members during their various outbound call campaigns. Population Health staff track the resources provided to members, and conduct follow-up calls to ensure the resource(s) met the needs of the members. Partnership has identified many community resources that are integrated into member care and offers them as member needs arise. These community resources are sufficient for Partnership member needs, though they are continuously updated and improved as new resources emerge or change.

DHCS' California Advancing and Innovating Medi-Cal (CalAIM) initiative aims to expand community resources to meet member needs and encourages multi-sector collaboration to overcome social and environmental barriers to health. Partnership continues to look to community agencies and other organizations to implement community health workers, doulas, enhanced care management and community supports services to provide services to members in their communities and to support basic needs. The infrastructure to provide these services to members continues to evolve, but agencies may continue to develop training programs to meet the need for several of these positions. Partnership is working closely with provider groups and training organizations to develop this pool of workers and incorporate them into program offerings.

B. Social and Environmental Needs

1. Housing Shortage

California has a shortage of affordable housing. The most current 2024 data shows that California's homeless population grew by 3% since 2023, to over 187,000 people experiencing homelessness.[75] Partnership's service area in particular has a significant homeless member population and likely has an even larger percentage of members who struggle to maintain housing. The local Community Health Assessments and the County Health Rankings data also continue to highlight a lack of stable housing as a pressing issue. Housing and homelessness are chronic concerns for managed care plans; however, Partnership has dedicated staff and resources to manage these concerns and to collaborate with other community agencies in addressing these challenges. State funds and initiatives like the CalAIM Incentive Payment Program provide the means for managed care plans to offer grant funding to address housing concerns. As of January 1, 2026, Partnership is also required to cover up to six months of rental assistance for Medi-Cal Members who meet key eligibility requirements and are either homeless or are at risk of becoming homeless.[76] Lastly, as part of DHCS's

[75] The 2024 Annual Homelessness Assessment Report to Congress
[76] DHCS Transitional Rent, 2025

Incentive Payment Program (IPP), Partnership has awarded over $52 million to more than 100 CalAIM providers via grants to build capacity for programs such as Enhanced Care Management (ECM) and Community Supports (CS) services; both of these programs work to ensure the needs of the most vulnerable members are met.

2. Economic Instability (Low Income and Unemployment)

Partnership members experience more social and structural barriers to health and well-being than many in the state of California. Twenty of Partnership's counties have household incomes below California's state average.[77] The Community Health Assessments revealed that many of Partnership's counties face challenges around having sufficient employment and income. Unemployment can make it difficult for Partnership members to access basic needs like housing and food for themselves and their families. There are often insufficient resources in communities to provide living-wage jobs for residents. In collaboration with community partners, Partnership is working to increase workforce opportunities within its regions to address the widespread concerns of poverty, unemployment, and low household incomes.

Partnership also contracts with organizations that serve as Supervising CHW providers. These organizations provide CHW services to Partnership members. Some of these efforts included exploring how to expand the CHW network in collaboration with interested local public health departments as part of the mandated CHA/CHIP work. Finally, Partnership continues to offer a Member Scholarship Program aimed at helping our members secure funding towards education with a focus on health care, social services, or public service; the recipients of the 2026 scholarships will be announced in summer 2026 (see Appendix C). These local efforts have potential to create new jobs in Partnership's service area, which can ultimately help improve economic stability of the communities we serve.

3. Air Quality and Wildfires

Many Partnership members live under the persistent threat of wildfires. Wildfires can lead to poor air quality, loss of housing, stress and anxiety, and long-term effects from these factors. In early 2025, Partnership continued to use the Fire and Disaster Reporting email inbox for internal reporting, monitoring, and notifications around disasters in Partnership's service area. The inbox is used as a tool to share information with other member- and provider-facing departments within Partnership HealthPlan in the event an environmental disaster threatens to affect members, providers, or the

[77] US Census Bureau, 2024

community. In Q1 of 2025, during instances of a natural disaster, Partnership staff sent out informational emails from the Fire and Disaster Reporting inbox to keep leaders within the organization apprised of the situation(s). This allowed for seamless and centralized internal communication and enabled member- and provider-facing departments to be prepared to support members in their time of need. However, for the remainder of 2025 and into 2026, the use of the inbox was discontinued.

Another way Partnership supported member engagement with this topic in 2025 was through materials posted to Partnership's website. These materials are comprised of a Disaster Preparedness booklet and Emergency Kit Pocket Card. The booklet included information on creating an action plan, preparing an emergency kit, and listed common emergency resources available throughout the state. It also included a QR code that links members to Partnership's community resource pages if they want more information. The pocket card is a small checklist of items to pack in an emergency kit and go-bag in the event of an emergency. The pocket card can be printed out and easily stored in an emergency bag or in an easy-to-access space within the home for use. The resources allocated to these efforts are sufficient for Partnership member needs.

C. Member Health and Wellness

1. Chronic Disease

HEDIS performance measure reporting provides some insight into the overall health and wellbeing of health plan members. DHCS continues to roll out various programs under CalAIM, including under the ever-evolving Population Health Management (PHM) Policy Guide.[78] The PHM Policy Guide includes a variety of ongoing mandates, including a mandate for Managed Care Plans to include chronic disease basic population health management (BPHM) programs that address hypertension, diabetes, asthma, and depression. In 2025, Partnership continued to administer the BPHM programs, several of which target key populations. In mid-2025, a BPHM texting campaign was also rolled out to target members who do not qualify for the formal BPHM program but may still benefit from additional support; this campaign provides education and resources to members who have diabetes and/or hypertension. These programs continue to align with PNA findings showing that hypertension, tobacco use, and depression are some of the top most common chronic diseases in our adult population in 2025.

[78] Department of Health Care Services DHCS, 2026

For the last few years, Partnership has been required to offer BPHM programs. In 2024, as a result of identified disparities, Partnership modified its hypertension intervention to focus primarily on African American, Native American/Alaska Native, and Native Hawaiian/Other Pacific Islander members as part of Partnerships Populations of Focus. The core components of the modified intervention generally remained the same. Partnership continued to offer this program in 2025 and will continue to offer it in 2026. There are sufficient resources to continue performing this program.

Almost all the Partnership counties have adult smoking rates that are higher than the state average. As a result, Partnership's Population Health Department continues to ask questions about smoking behavior to our members during outbound call campaign scripts for all campaigns. In 2025, Partnership also conducted health education sessions on the health impacts of vaping and positive coping strategies for mental well-being across 3 schools in 3 counties. Efforts centered on reaching students from 5th through 12th grade. Each session included an interactive activity designed to reinforce key concepts from the lessons. Activities were incentivized to increase participation and engagement.

Partnership members in all regions face health challenges, though there are regional variations in health. For example, pediatric members with asthma who live in Partnership's Northern Region may have more difficulties controlling their asthma than those living in the Southern Region. Wildfires are more prevalent in Partnership's Northern Region than in the Southern Region, and this has potential to contribute to poorer asthma control. There may be other contributing factors as well. As such, in 2022, Partnership's Pharmacy department created an asthma management program for adults with asthma emergency department visits. However, to better align with CalAIM BPHM and due to Pharmacy staff capacity, the Asthma management project was modified over time and is now run by Population Health. The modified Asthma Emergency Department (ED) Visit Outreach Program Campaign was first rolled out at the end of 2024. In 2025, the Population Health department continued to run the Asthma Post ED Visit Outreach campaign which offers support to members who were recently seen in the ED for their asthma. As part of the program, members receive an asthma education handbook and those who may want additional help can speak with a pharmacist who can provide education on effective self-management of their asthma and use of medications. Members with repeat ED visits due to asthma exacerbation will be referred for additional support. There are sufficient resources to perform this new program.

The top 3 chronic diseases found among Partnership children in 2024 were mental health concerns (anxiety, trauma/stress, and depression). The CDC states that children

with ADHD often have other coexisting conditions (including anxiety disorder).[79] As such, one way Partnership addressed mental health conditions in children was through weekly ADHD new start reports. These reports helped identify Partnership pediatric members that had filled a new ADHD medication. The Pharmacy team then sent fax notifications to providers when one of their patients recently filled a new ADHD medication. The goal is for providers to encourage timely ADHD follow-up visits. This program has shown improved rates of follow ups and will continue into 2026. There are sufficient resources to perform this new program.

Partnership's local community needs assessments also showed that behavioral health concerns, such as poor mental health and substance use, are pressing concerns in Partnership's communities. One way Partnership worked to improve poor behavioral health outcomes in 2025 included continuing to actively participate in and support our school partners through implementation of the new Multi-Payer Fee Schedule which includes new and expanded behavioral health provider types.

Partnership also supported members with mental health concerns in 2025 through conducting outreach efforts to members with low utilization of non-specialty mental health services, demonstrating that some populations are not effectively utilizing these services; this outreach effort also aligns with a DHCS mandates.[80] As this is an annual DHCS requirement, this will take place again in 2026.

Furthermore, Partnership has rolled out several new programs to support members with a substance abuse diagnosis (SUD) including:

- A program to encourage follow up after an Emergency Department (ED) visit for members with a substance use diagnosis; this includes appointment assistance for members who have sought care through the ED to help address their needs through available SUD services, by county. Similar efforts are occurring for mental health.
- Looking at medication for addiction treatment programs to address prescribing gaps within our primary care service areas.
- Engaging with Regional Model counties to promote peer support services for members with a SUD diagnosis as part of a multi- year Performance Improvement Plan.

[79] CDC, 2024
[80] APL 24-012 Non-Specialty Mental Health Services: Member Outreach, Education, And Experience Requirements

There are sufficient resources to perform these new programs.

Depression was the third most common chronic condition among Partnership members in 2025. As such, in addition to the efforts listed above, Partnership has also continued to refine its BPHM program which offers to help members who recently suffered a stroke or a myocardial infarction to prevent depression symptoms. This program meets DHCS requirements for a depression intervention program and tests the benefits of having non-clinical staff provide lifestyle coaching for depression. It is possible that members who recently suffered a stroke or MI may develop depression symptoms. Therefore, this BPHM program has potential to decrease the number of Partnership members diagnosed with depression in the future. Currently, Partnership has staff dedicated to this program, although more staff resources are budgeted should current staffing prove insufficient.

2. Health Screening

Some Partnership regions continue to perform below the MPL for breast cancer screenings. To address the need for breast cancer screenings, Partnership continues to collaborate with Alinea Medical Imaging to bring mobile mammography imaging to rural communities and health centers lacking access to mammography sites. Mammograms are a proactive screening that detects breast cancer, and providers have the opportunity to follow up with anyone who has findings on their imaging. Throughout 2025, there were 75 mobile mammography days conducted in 17 Partnership counties (which include the following counties: Butte, Del Norte, Humboldt, Lake, Marin, Mendecino, Modoc, Napa, Nevada, Placer, Shasta, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo). In 2025, there was an improvement in the number of breast cancer screenings completed in comparison to the previous measurement year. This modest improvement helps demonstrate the success of this collaboration and will continue in 2026 to reach more members.

To help increase cervical cancer screenings in low performing regions, Partnership's Women's Health and Perinatal Workgroup conducted a 6-month Cervical Cancer Screening for high-risk human papillomavirus (hrHPV) Self-Swab pilot project in early 2024. In 2025, and into 2026, Partnership's Women's Health and Perinatal Workgroup will continue to provide support and education to our provider network to promote the hrHPV Self-Collect option for patients in clinic. Partnership has also conducted 1 on 1 provider trainings for 111 total sites. Other activities around this work include:

- Updating Cervical Cancer Screening (CCS) Measure Best Practices to include hrHPV Self Collect

- Integrating hrHPV Self-Collect into Improvement Academy materials (a quality improvement program for providers)
- Developing hrHPV Self-Collect instructions in multiple languages
- Reviewing available Health Education materials on this topic
- Identifying providers performing low in cervical cancer screenings and offering 1 on 1 education
- Developing a tracker with cervical cancer screening site performance to monitor Year-over-Year improvements

To address concerns around low colorectal screenings, Partnership also started a colorectal cancer screening pilot project in 2022 along with Exact Sciences to increase the number of colorectal cancer testing. In 2025 and into 2026, Partnership continues to support our providers using the bulk ordering option for colorectal cancer screening with Exact Sciences. The goal is to increase the number of colorectal cancer testing among the 45 years of age and older population.

3. Wellness Care

Partnership continues to make significant investments into expanding services for maternal and child health to improve gaps in care, which was partially highlighted in the disparities data. Partnership performs outreach to all members with babies from ages 0-30 months and children ages 3 to 6 years, offering incentives to attend well-care visits and encouraging vaccinations. Additional outreach campaigns target pre-teens to educate about the transition from pediatric visits to adult visits, as well as to inform of the importance of HPV vaccines. Furthermore, Partnership has allocated staff, and time to collaborate with public health officers, and other necessary stakeholders in the exploration and planning of school-based clinics, and other strategies to promote childhood wellness care. The resources allocated are sufficient for these efforts.

D. Access to Care

Partnership operates in a broad service area encompassing urban, suburban, rural, and frontier settings. Local community needs assessments findings continue to identify access to care as an ongoing issue. Partnership's provider network continues to be challenged by a shortage of providers, and an aging provider community. Because of this, Partnership continues to sponsor a workforce development program called the Provider Recruitment Program (PRP) (see Appendix E). The PRP offers a sign-on bonus for providers when they contract with Medi-Cal for the first time, and/or if they come from a county outside of the ones that Partnership serves. Partnership also continues to support a Provider Retention Initiative (PRI) program (Appendix F). The PRI is intended to recognize primary care clinicians, providers of perinatal services,

and/or obstetrics/gynecology, and psychiatrists who are deeply invested in the safety net population, while helping to incentivize additional years of service. Although this work is already in place, a long-term strategy is essential to address the provider shortage in Partnership's service area.

With oversight from Partnership's Board of Commissioners, and in collaboration with state and national initiatives, Partnership continuously works to make the provider recruitment program effectively support expanding access to primary care. In particular, Partnership is expanding efforts to strengthen recruitment of PCPs, behavioral health providers, mid-levels, and targeted specialists in the areas where access is impacted most.

Finally, Partnership works to prevent loss of access to care. Efforts include a variety of activities, such as:

- Continuing to support a primary care program using a telehealth service called TeleMed2U (see Appendix G)
- Continuing to support the mobile mammography program centered around providers located in areas without imaging centers or in proximity to imaging centers with significant barriers to access
- Supporting an Enhanced Provider Engagement (EPE) program that focuses on providers that are the lowest performing in the Primary Care Provider (PCP) QIP
- Continued support of the QIP program for primary care
- Utilization of Partnership's Transportation Services to allow members to attend provider appointments

E. Health Disparities

The PNA revealed notable care gaps among specific racial/ethnic groups. In particular, the HEDIS Disparity Analysis Dashboard for Controlling High Blood Pressure (CPB) demonstrated that performance across the majority of the racial and ethnic groups performed below the 50th percentile MPL of 64.48%: the American Indian and Alaska Native population came in at 57.86%, the Asian/Pacific Islander population came in at 58.74%, the Black population came in at 53.57%, the Multiracial population came in at 50.05%, and the White population came in at 59.95%. The Hispanic group narrowly missed the 50th percentile at 64.24%.

In Hemoglobin A1c Control for Patients with Diabetes (HBD), no race/ethnicity group met the minimum performance level. For this measure, the MPL was set at 33.33%, with observed performance rates of 40.48% (American Indian/Alaska Native), 33.99% (Asian/Pacific Islander), 51.15% (Black), 34.21% (Hispanic), and 37.07% (White).

For Child and Adolescent Well Care Visit completions, the majority of racial/ethnic groups did not meet the MPL 50th percentile of 51.81%. The American Indian and Alaska Native population came in at 45.76%, the Asian/Pacific Islander population came in at 51.04%, and the White population came in at 43.12%. The Black or African American (40.48%) population and the Other/Unknown (21.45%) populations performed the lowest, falling below the MPL 50th percentile. In contrast, the Multiracial (53.13%) population performed slightly above the 50th percentile. The Hispanic population performed the best (53.79%) and performed above the MPL 50th percentile.

For prenatal care, all groups had lower rates of completion, performing below the MPL 50th percentile of 84.55%: the American Indian and Alaska Native population came in at 81.84%, the Asian/Pacific Islander population came in at 74.36%, the Black or African American population came in at (74.47%), the Hispanic population came in at (80.52%), and the White population came in at 79.20%. The Multiracial population had the lowest rate of completion at 50.05%. Finally, for postpartum care the Black population (76.56%) was the only group with a completion rate below the MPL 50th percentile of 80.23%. In comparison, the American Indian and Alaska Native (80.30%), Asian/Pacific Islander (86.24%), Multiracial (83.38%), and White (82.83%) groups all had higher rates of completion, performing above the 50th percentile. The Hispanic population was the only group who performed above the 90th percentile (86.62%). These findings highlight significant health disparities across various racial/ethnic groups, with certain populations experiencing lower levels of care and worse health outcomes compared to others among these four measures.

To address some of these disparities for prenatal and postpartum care, Partnership will continue to perform outbound call campaigns that encourage the perinatal population to attend their pre and postpartum appointments and encourages families to attend well-child visits with their children. In addition to these efforts, and to address key disparities, Partnership hosted multiple photoshoots in 2025 aimed at increasing prenatal and postpartum care and well child visit rates among African American/Black, Alaska Native/American, and Hispanic pregnant members, though all pregnant members are welcome to attend. This intervention aimed to: increase supportive community interactions between fellow pregnant Partnership members and their families, offer social support, as well as raise awareness and promote the use of available Partnership benefits such as doula services, and Partnership's perinatal programs which encourage vaccines typically received during pregnancy, as well as PCP visits before and after pregnancy. These photoshoot events have shown promising results and will continue into 2026. Partnership will also continue to participate in efforts that support members recently diagnosed with diabetes, with special emphasis on the African American, Native American/Alaska Native, and Pacific Islanders populations.

Furthermore, multiple ethnicities/races face many health disparities, with recent data demonstrating lower completion rates of prenatal care visits among the American Indian/Alaskan Native population. As such, Partnership will continue its strategy to strengthen relationships and collaborative efforts with perinatal health providers within its service area to decrease known health disparities amongst this population. Partnership has also been an active participant in Tribal perinatal efforts. One effort is creating homegrown collaboratives to identify needs and work towards interventions. For example, in Siskiyou County, these efforts aim to streamline collaboration among clinical and community initiatives to support perinatal care and education, expand cultural awareness across the health system and build provider skillsets for addressing pregnancy related urgencies. There are also Tribal driven efforts focused on providing community support to access, and education for pregnant individuals and families in which Partnership plays a supporting role. Furthermore, Partnership continues to grow its Tribal Liaison position to provide a more formal point of contact and advocate for Tribal community needs in alignment with new DHCS mandates. While there are sufficient resources currently allocated to strengthen existing relationships, Partnership will continue to explore modifying our programs as additional health needs are identified.

Lastly, 2026 plans for community-based research include a tentative focus group, centered on four priority disparities, several of which were noted in this assessment: Postpartum Care Visits, Well-Care Visits, Childhood Immunizations, and Colorectal Cancer Screening. Focus group locations were selected based on where priority member populations are most represented—for example, sessions in Eureka will focus on Tribal members.

F. Member Benefits/Services Education, Health Education, and Culture & Linguistics

Partnership has an ongoing concern that its members lack knowledge around their benefits and how to use them, which may lead to care gaps. While managed care plans have several departments dedicated to member support, Partnership continues to recognize an opportunity to support efforts to increase member awareness of Partnership benefits, including development of videos, written materials, text messaging campaigns, and the distribution of educational materials at community outreach efforts in various threshold languages as appropriate.

One example is heavily promoting the Growing Together Program to Partnership's providers and community partners; this program promotes well-child visits and perinatal care with (see Appendix B for the update flyer). Another example is Partnership's

Member Services staff conducting in-person presentations. These presentations are referred to as “Member (or Community) Informative Sessions” and provide an educational and collaborative forum for new members and county partners while also building upon our organizational branding campaign centered around “Your Partner in Health”. At these sessions, Member Services staff provide an overview of Partnership’s services and the resources that are available to members. While onsite, Member Services staff provide in-the-moment support, helping members navigate their transition into Partnership. Partnership conducts these sessions primarily in English and Spanish. Sessions may also be conducted in other languages and are available on request. The overall goal with these sessions is to ensure Partnership members and community partners gain knowledge about Partnership’s benefits and services, and to leave a positive and lasting impression that Partnership is responsive and here to support all the communities we serve. Partnership will also continue to collaborate with community groups and plans to offer educational sessions to members about available benefits like vision, mental health services, and preventative care services.

Partnership also offers robust Community Resource pages on our external website (see Appendix D). These pages are a collection of local resources that are meant to supplement member needs. Each of Partnership’s counties has a dedicated county page. Partnership members also have the option to contact Partnership’s Population Health Department to learn how to access local community resources. Population Health staff also routinely provide community resources to members during their various outbound call campaigns. Population Health staff track the resources provided to members, and conduct follow-up calls to ensure the resource(s) met the needs of the member. These community resources are sufficient for Partnership member needs, though they are continuously updated and improved as new resources emerge.

Member grievance data provides insight into member engagement with the health plan, their experience of culturally and linguistically appropriate care, and reported rates of discrimination. Members who want to report grievances with their care must know how to report grievances using the appropriate channels and feel some assurance that their concerns will be taken seriously. Therefore, reported grievances may act as a proxy for trust in the agencies against whom the grievance is filed. While a general lack of trust in government and institutions may be the root cause for some distrust, Partnership works to overcome this through demonstrating responsiveness to member needs, as reflected in interactions with our members. This effort is ongoing and, while there are sufficient resources allocated, there are likely more opportunities to educate members on their rights and how to exercise them.

Finally, in alignment with DHCS and NCQA objectives, Partnership will continue its own organizational culture of diversity, equity and inclusion by offering regular staff and provider trainings. The goal of these trainings are to engage staff and providers in topics relating to equity (e.g., race, ethnicity, gender, and more) and the barriers members experience that prevent them from being healthy. Partnership also hosts an annual Health Equity Week to educate on and promote health equity for its members and staff. Activities from Health Equity week 2025 included a staff town hall highlighting a health equity discussion, inter-staff interviews, member stories, and more. Finally, Partnership's Director of Health Equity developed and implemented a mandatory Diversity, Equity, and Inclusion training for all Partnership network providers and other relevant stakeholders in 2025; a pilot rollout went live mid-year and will continue into 2026. This offering is sufficient and will continue to be offered to key stakeholders.

VI. Stakeholder Engagement

Partnership solicits stakeholder engagement on the PNA through multiple pathways. The Population Health department uses reports from pertinent departments to draft the report. The Quality Improvement and Health Equity Committee (QIHEC) and Population Needs Assessment Committees review and provide feedback as needed on the draft of the PNA, along with any proposed interventions. Population Health staff also gather member feedback through Partnership's Community Advisory Committee (CAC) (formerly known as the Consumer Advisory Committee) and Family Advisory Committee (FAC). The CAC reviews findings from the annual PNA, along with any proposed recommendations, and their feedback is incorporated in the final report as appropriate. Partnership also solicits stakeholder engagement on the PNA through several other committees as well.

The PNA then undergoes review by Partnership's Internal Quality Improvement (IQI) Committee, Partnership's Quality/Utilization Advisory Committee (Q/UAC), Partnership's Physician Advisory Committee (PAC), and by Partnership's Board of Commissioners before submission to the National Committee for Quality Assurance (NCQA), and as part of DHCS regulatory requirements.

Once final, the PNA is made available in a variety of forums for use and strategic planning by contracted health care providers, practitioners, and allied health care personnel. These forums may include, but are not limited to, provider newsletters, Provider Online Services via Partnership's website, and HEDIS training. Furthermore, the PNA is posted on Partnership's website. Lastly, Partnership identifies pertinent information related to member needs in the report and uses that information to update

current activities and/or design new interventions to address the identified needs as necessary.

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VIII. Appendix A: HEDIS® MCAS Regional Performance Report Year 2025; Measurement Year 2024

Select Report Year
Report Year 2025; Measurement Year 2024

HEDIS Plan Wide Performance
Report Year 2025; Measurement Year 2024
Performance Relative to Quality Compass® Medicaid Benchmarks

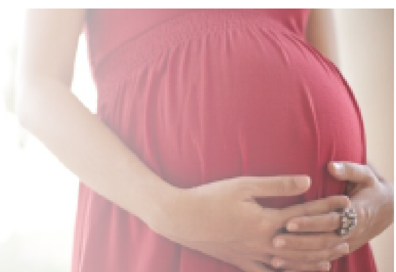
- **Above HPL** (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- **Below MPL** (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

Plan Wide Performance		National Medicaid Benchmarks			
Measures	**Plan Wide**	**25TH**	**50TH**	**75TH**	**90TH**
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	64.71%	59.47%	66.24%	72.22%	76.65%
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	56.29%	47.93%	52.68%	59.51%	63.48%
Cervical Cancer Screening (CCS)*	59.12%	49.64%	57.18%	61.56%	67.46%
Childhood Immunization Status (CIS) - Combination 10*	28.22%	22.87%	27.49%	34.79%	42.34%
Chlamydia Screening in Women (CHL) - Total	55.58%	49.65%	55.95%	64.37%	69.07%
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	69.59%	59.73%	64.48%	69.37%	72.75%
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	29.65%		35.70%		
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	29.01%	46.05%	53.82%	63.06%	73.12%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	33.27%	26.79%	36.18%	41.86%	49.40%
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	32.60%	40.15%	33.33%	29.93%	27.01%
Immunizations for Adolescents (IMA) - Combination 2*	40.39%	29.72%	34.30%	41.61%	48.66%
Lead Screening in Children (LSC)*	71.78%	53.12%	63.84%	71.11%	79.51%
Prenatal and Postpartum Care (PPC) - Postpartum care*	89.54%	75.67%	80.23%	83.33%	86.62%
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	85.40%	79.81%	84.55%	88.58%	91.85%
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	12.40%		19.30%		
Well Care Visits (WCV) - Total	48.83%	46.57%	51.81%	58.07%	64.74%
^Well Child 30 (W30) - Well child visits for age15-30 months	72.22%	65.53%	69.43%	73.09%	79.94%
^Well Child 30 (W30) - Well child visits in the first 15 months	67.05%	54.46%	60.38%	64.99%	69.67%

* Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population.
** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD).
*** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method.
^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024.
# The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median.

1

IX. Appendix B: Growing Together Program Flyer



The Growing Together Program

Our Growing Together Program supports members during and after pregnancy, and children from birth up to age 3. This program is offered to Partnership members at no cost. Learn how the Growing Together Program can help you.

The Growing Together Program features:

The Prenatal Program – earn up to $50 in gift cards!

This program encourages early prenatal care. Members will receive a $25 gift card for getting their flu vaccine while pregnant, and another $25 gift card for getting their Tdap vaccine between 27 weeks and delivery. Call us to join as soon as you know you are pregnant.

You will also get:

- A welcome call upon referral
- Up to 3 check-in phone calls throughout the program
- Information about doula benefits
- Support for prenatal visits
- Referrals to care coordination
- Health education

The Postpartum Program – earn up to $100 in gift cards!

This program encourages postpartum and well-baby visits. Members will receive a $50 gift card for each of their 2 postpartum exams ($100 total) between 7 to 84 days after delivery.

You will also get:

- A welcome call upon having your new baby
- Up to 2 check-in calls throughout the program
- Help to enroll your baby into Medi-Cal
- Support for postpartum and well-baby visits
- Referrals to care coordination
- Health education

PartnershipHP.org (800) 863-4155 HealthEd175_102324

The Healthy Baby Program – earn up to $200 dollars in gift cards!

This program encourages well-baby visits. Parents or caregivers will receive a $25 gift card each for taking their baby to the following visits:

- 2 well-child visits before 3 months
- 2 well-child visits before 9 months
- 2 well-child visits between 9-15 months
- 2 well-child visits between 15-30 months

Parents or caregivers can receive an extra $100 in gift cards if their baby receives all required vaccines, including 2 flu shots, by 24 months of age. A vaccine record must be submitted to Partnership's Population Health Department. Call us to enroll your baby as soon as they get Partnership.

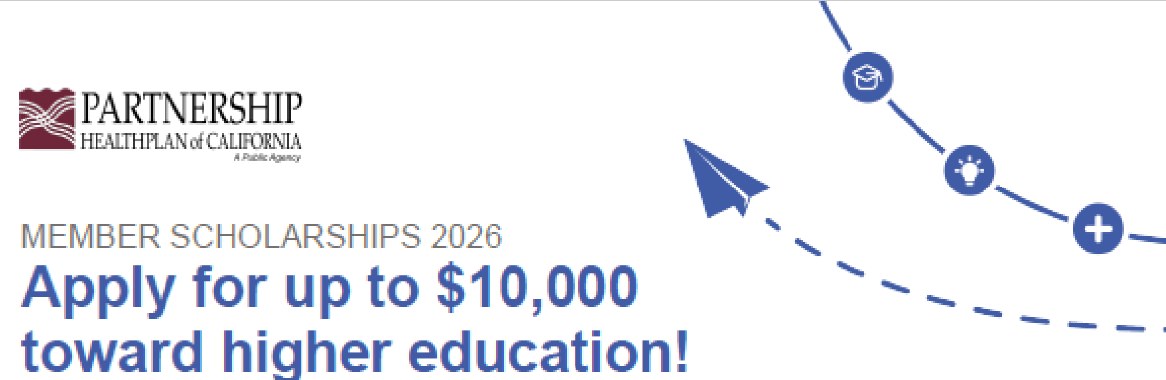
You will also get:

- A welcome call
- Referrals to care coordination
- Check-in calls at 3, 7, 14, 22, 26, and 30 months
- Support for well-baby visits and the recommended screenings and vaccines

To learn more or sign up for the Growing Together Program, call us at **(855) 798-8764**, Monday – Friday, 8 a.m. to 5 p.m. TTY users can call the California Relay Service at **(800) 735-2929** or **711**. You can also email us at PopHealthOutreach@partnershiphp.org.

This notice does not change your Partnership benefits or keep you from getting the care you need.

X. Appendix C: Member Scholarship Program



MEMBER SCHOLARSHIPS 2026

Apply for up to $10,000 toward higher education!

Partnership HealthPlan of California is now accepting applications for the **2026 Partnership Member Scholarship Program!** This program provides one $10,000 scholarship and four $5,000 scholarships. Scholarships are awarded on the basis of: the quality of responses to essay questions; the strength of the applicant's expression of interest in a career in health care, social service, or public service; and a letter of recommendation.

Who can enter: Current Partnership members, those who were Partnership members within the past 12 months, or foster care youth who were Partnership members within the past three years. The entrant must show they intend to pursue a career in health care, social service, or public service and must be enrolled at or applying to a higher education institution and enrolled within one year of the application due date.

How to enter: Entrants must complete the application form, including essay questions; obtain one letter of recommendation; and sign a waiver of confidentiality and release, as well as an accuracy statement. **Applications can be submitted from January 21 through March 18, 2026.**

Essay questions: (See application for details and word limits.)

1. How will your studies further your plans for a career in health care and/or human/public/social services fields? What are your career goals?
2. How has Partnership HealthPlan of California been a partner in your health/life? (This can be medical care, services, and/or supports that Partnership has helped provide.)
3. Optional: Is there anything else you want to share that makes you a good candidate to receive this award?

Scholarship winners: Partnership will review all entries and determine recipients. Scholarship winners will be announced in Summer 2026.

For more information, visit our Member Scholarship Program webpage.

If you have additional questions, email Communications@partnershiphp.org

XI. Appendix D: Community Resource Page

XII. Appendix E: Provider Recruitment Program

The Provider Recruitment Program (PRP) has been extended through our 2025 – 2026 fiscal year (FY). This program continues to support our contracted network in recruiting and retaining high-quality health professionals across our 24-county service area, ultimately enhancing Partnership members' access to care.

Important Updates:

- The FY 2024 – 2025 PRP cycle has concluded.
- To participate in the 2025–2026 PRP and be eligible for grant funding beginning July 1, 2025, organizations must have a fully executed FY 2025–2026 PRP agreement.
- A new Provider Retention Initiative (PRI) agreement is currently in development. Once the 2025 PRP agreement is fully executed, the PRI agreement may be made available to interested organizations.

Program Incentives Available (payable over five years):

- **$100,000** for physicians (providing services in family medicine, internal medicine, pediatrics, obstetrics, and psychiatry).
- **$120,000** for medical residents training in Partnership's 24-county region ($20,000 payable in program year three with a five-year commitment post-graduation).
- **$50,000** for nurse practitioners/physician assistants/certified nurse midwives (NPs/PAs/CNMs).

Additional Eligible Providers: Obstetric providers (obstetricians, family medicine physicians, NPs/PAs/CNMs, and women's health NPs) whose clinical care focuses on perinatal care, including labor and delivery.

Behavioral Health Professionals Program Highlights / Incentives Available:

- **$20,000** for licensed behavioral health professionals.
  - Licensed clinical social workers
  - Licensed marriage and family therapists
  - Licensed professional clinical counselor
  - Licensed clinical psychologists
- **$4,000/$5,000** for certified substance use disorder (SUD) and bilingual certified SUD counselors.

Application Process: We've adopted a grant lifecycle management platform to improve application efficiency.

Key Eligibility Criteria for PRP Support:

- For candidates actively practicing at the time of application, they must be from outside of Partnership's 24 counties.
- Providers in training or residency programs within Partnership's 24 counties are eligible for support.
- A reasonable effort must be made to request program support prior to making employment offers.

Questions:

Please contact the Workforce Development team at WFD@partnershiphp.org or visit our PRP webpage.

PartnershipHP.org (707) 863-4100

XIII. Appendix F: Provider Retention Initiative

Provider Retention Initiative

2025 – 2026

The Provider Retention Initiative (PRI) is now open for applications until June 30, 2026. The PRI is designed to recognize and retain primary care clinicians, providers of perinatal services (including labor and delivery) and/or obstetrics / gynecology, and psychiatrists who have devoted their careers to serving Northern California's safety net population. By incentivizing additional years of service, this Partnership initiative aims to preserve institutional knowledge, strengthen clinical leadership, and foster mentorship opportunities for emerging providers across our network.

Provider Eligibility:

The PRI is open to clinicians who deliver services to Partnership members through Partnership's contracted providers in our 24-county region.

PRI Incentives:

Three-year commitment required; awards are payable over three years.

- $45,000 for doctor of medicine (MD) / doctor of osteopathic medicine (DO)
- $30,000 for nurse practitioner (NP) / physician assistant (PA) / certified nurse midwife (CNM)

Payment Cycle:

Award	FY 25/26	FY 26/27	FY 27/28	FY 28/29
$45,000 MD/DO	$7,500	$7,500	$15,000	$15,000
$30,000 NP/PA/CNM	$5,000	$5,000	$10,000	$10,000

Key Criteria:

- Provider (MD/DO/NP/PA/CNM) has served organization and/or Partnership members for 15 years or more and is committed to at least three more years of service.
- Provider eligibility is limited to family medicine, internal medicine, obstetrics, pediatrics, and psychiatry.
- Provider must serve in a leadership or mentorship capacity within organization.
- Provider organization must submit a competitive grant application due to funding limitation.
- Provider organization must have a signed Provider Recruitment Program agreement with Partnership.

Questions:

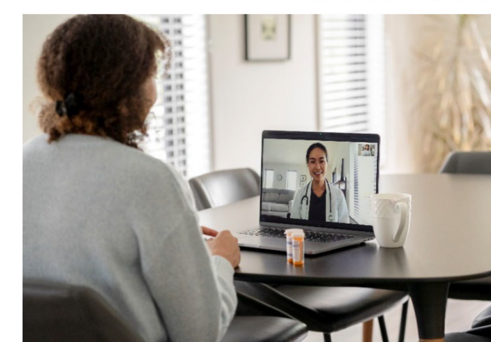
Please contact the Workforce Development team: WFD@partnershiphp.org

(707) 863-4100

XIV. Appendix G: At-Home Telehealth Specialty Visits

At-Home Telehealth Specialty Visits

Did you know you could have a telehealth specialty visit from your home?



You may be able to have this visit from your home if your main doctor refers you to see a specialist. This is a telehealth specialty visit. You can use any computer, laptop, tablet, or smart device to have a telehealth specialty visit. The specialty care doctor will help treat your health care needs and will work with you to take care of your issue. Ask your main doctor if a telehealth specialty visit from home is right for you.

Here is how it works:

1. Your main doctor refers you to a specialist
2. TeleMed2U and UC Davis are our telehealth specialty doctors. They will call you to set up your visit
3. The specialist's office will call you to confirm your visit. They will make sure you have what you need for your visit.
4. The specialist will give you a Zoom link. Use the Zoom link to log into the App when it is time to meet with the specialist.
5. If you need medicine, the specialist will send it to the pharmacy you choose.

Call or email the telehealth specialist if you have any trouble or if you need to reschedule your visit:

- Please send an email to referrals@telemed2u.com , or call or text **(855) 446-8628** for adult specialty care.
- Call UC Davis at **(800) 482-3284** for specialty care for kids.

Read the questions and answers below to find out more.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable) Meeting Date: June 17, 2026
Board Meeting Date: June 24, 2026

Agenda Item Number: 4.1

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
Finance Committee & Partnership Staff

Topic Description:
On April 22, 2026, the Board approved Budget Assumptions for Fiscal Year 2026-2027 and directed staff to prepare a comprehensive operational budget. in May, a Preliminary Health Care Budget for Fiscal Year 2026–2027 was prepared in accordance with the approved assumptions and the Final Health Care Budget for Fiscal Year 2026–2027 is now presented to the Board for review and approval.

Reason for Resolution:
To give the Board the opportunity to review and approve the Final Budget for Fiscal Year 2026-2027.

Financial Impact:
The impact to the HealthPlan is implicit in the budget.

Requested Action of the Board:
Based on the recommendation of the Finance Committee and Partnership Staff, the Board is asked to approve the Final Budget for Fiscal Year 2026-2027.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable) **Agenda Item Number:** 4.1
Meeting Date: June 17, 2026
Board Meeting Date: June 24, 2026

Resolution Number: 26-

IN THE MATTER OF: APPROVING THE FINAL BUDGET FOR FY 2026-2027

Recital: Whereas,

A. The Board has responsibility for establishing budget policy and specific budget approval.

B. In prior meetings, Partnership staff, the Finance Committee and Board provided direction and input.

C. The final Budget conforms to general assumptions established.

Now, Therefore, It Is Hereby Resolved As Follows:

1. The Board hereby approves the Final Health Care Budget for Fiscal Year 2026–2027 as presented.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 24th day of June 2026 by motion of Commissioner seconded by Commissioner and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

____
Dean Germano, Chair

____
Date

ATTEST:

BY: __________________________
Ashlyn Scott, Clerk

FY 2026-27

Annual Operating Budget

June 2026

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Introduction

The next phase of the Partnership budget process is to present the 2026-27 Operating Budget to the Finance Committee and Board of Directors for final consideration and approval. Partnership Staff has consolidated the prior components of the budget into one comprehensive summary. A version history is provided at the conclusion of this report to walk between the healthcare assumptions presented in May 2026 and the final healthcare costs presented below.

Outlook for 2026-27 State Outlook – May Revise

As of the May Revise the State presented a total budget of $349.4 billion total fund ($246.6 billion State General Fund) for FY 2026-27, $1.8 billion lower than estimated in January). The May Revise does not propose any significant new ongoing expenditures. General Fund revenues (excluding transfers and loans) are projected to be $16.8 billion higher than what was assumed in January for FY 2025-26 and FY 2026-27, largely driven by personal income tax. The May Revise maintains reserves and reduces previously forecasted operating deficits. The increased revenue and the restraint of not introducing new sizeable ongoing expenditures have allowed the Governor to present a balanced budget for FY 2026-27 through FY 2027-28. The next Governor and State Administration will be tasked with addressing outyear budget deficits.

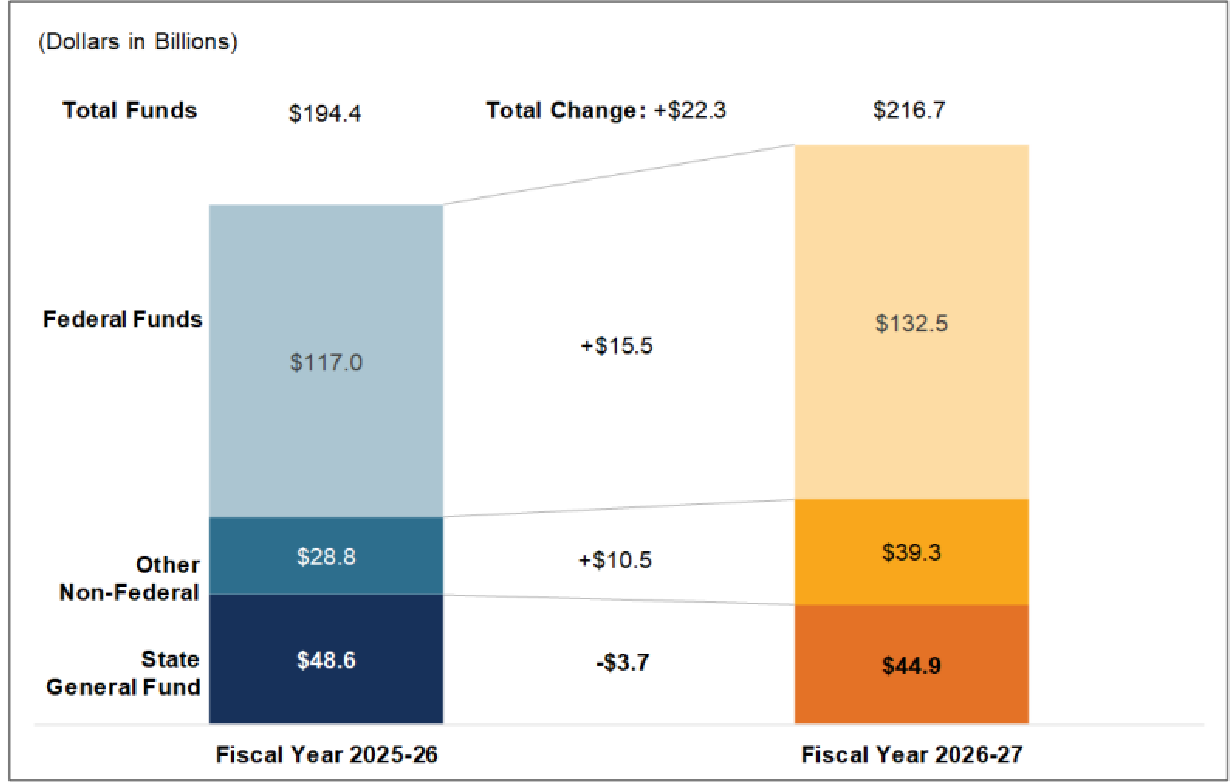
The May Revise combined reserves for FY 2026-27 are $29.9 billion, of which:

- $15.1 billion in the Budget Stabilization Account, an increase of $3.9 billion from the FY 2025-26 Enacted Budget.
- $4.5 billion in the Special Fund for Economic Uncertainties, no change from FY 2025-26 Enacted Budget.
- $10.3 billion deposit into the Public School System Stabilization Account, an increase of $6.2 billion from the January Budget.

Further the May Revises assumes a $9.7 billion transfer into the Surplus Holding Account, this account was established in 2024 and allows the State to set aside a portion of anticipated surplus funds and allocate them in a subsequent fiscal year.

Medi-Cal is a large portion of overall State expenditures and continues to be a focus of this Administration. The below Department of Health Care Services (DHCS) May Revise Highlights budget chart[1], outlines the May Revise year-over-year Medi-Cal program estimated expenditures.

Medi-Cal Year Over Year Change from FY 2025-26 to FY 2026-27



[1] https://www.dhcs.ca.gov/Budget/Documents/DHCS-FY-2026-27-May-Revise-Highlights.pdf

As displayed above, $216.7 billion total fund ($44.9 billion General Fund) was requested to operate the Medi-Cal program for FY 2026-27. This is a $5.7 billion total fund ($3.9 billion General Fund) decrease from the January Budget for FY 2026-27. The budget assumes 13.9 million individuals will receive coverage through the Medi-Cal program in FY 2026-27, which is a 3.75% membership decrease from revised FY 2025-26 membership. The DHCS Medi-Cal membership projections are inclusive of Managed Care and Fee-for-Service (FFS) members.

Notable May Revise Budget details that affect the Medi-Cal program are highlighted below.

- **Unsatisfactory Immigration Status (UIS) Members transitioned from Medi-Cal Managed Care to Medi-Cal FFS** - The May Revise proposes to transition all UIS members from Medi-Cal Managed Care to Medi-Cal FFS effective January 1, 2027. Per the DHCS this change is a result of federal prohibitions tied to risk-based payments for federally eligible emergency services for these members. The budget proposes to transition these members to full scope Medi-Cal FFS. Under the Administration's proposal, UIS members would lose Enhanced Care Management and Community Supports, which are currently available only through the Medi-Cal Managed Care delivery system. As of June 2026, Partnership serves nearly 88,000 UIS members.
- **Increased UIS Adult Member Medi-Cal Premiums** - The Governor's FY 2025-26 Budget included a $30 monthly premium for all UIS members aged 19 to 59 who are enrolled in full scope Medi-Cal. The May Revise proposed to increase the monthly premium to $50

effective July 1, 2027. Questions have been raised about whether the State would consider providing counties with indigent care funding to cover health care costs for UIS members who lose Medi-Cal coverage due to the implementation of premiums and the UIS member enrollment freeze that took effect January 1, 2026.

- **Eligibility Changes for Qualified Non-Citizens** - H.R.1 implemented federal eligibility changes for qualified non-citizens and narrowed eligibility for federal funding. As a result, effective October 1, 2026, this group will transition to state-only full scope Medi-Cal with no dental coverage. Effective January 1, 2027, these members that are enrolled in Managed Care will transition to limited-scope Medi-Cal FFS. Effective July 1, 2027, this group will shift to restricted-scope Medi-Cal FFS. The cost of this change is estimated to be $668.1 million General Fund in FY 2026-27.
- **Modify the Asset Test for Medi-Cal Eligibility** - The budget proposed to modify the asset limit for the Seniors and Persons with Disabilities population. As of January 1, 2026, Medi-Cal changed their asset test; limiting Medi-Cal eligibility to members with no more than $130,000 of assets for one person and an additional $65,000 for each additional family member. The budget proposed to modify the asset test effective January 1, 2027, Medi-Cal eligibility would be limited to members with assets of $2,000 for an individual and $3,000 for a couple. This change is expected to result in additional Partnership membership losses.
- **New Managed Care Organization (MCO) Tax** - The FY 2026-27 budget proposes adopting a new MCO Tax effective January 1, 2027, that would assess a higher tax rate on non-Medi-Cal plans. The new tax structure proposes to impose an $8.85 PMPM tax on Medi-Cal and Non-Medi-Cal plans. H.R. 1 and other federal changes require the tax rate of non-Medi-Cal and Medi-Cal plans to be uniform. The new tax revenue is expected to result in $575 million in FY 2026-27, $2.3 billion in FY 2027-28 and FY 2028-29, and $1.7 billion in FY 2029-30. Full details of the new MCO Tax have not been released at this time.
- **Existing MCO Tax Revenue Timing Adjustments** - The budget was adjusted to reflect changes in the timing of when existing MCO Tax revenues will be collected and expended. The budget proposes to spread this revenue over FY 2025-26, FY 2026-27, and FY 2027-28. Our understanding is the MCO tax revenue will be used to fund the Governor's May 2025 Proposition 35 spending plan. Subject to Centers for Medicare and Medicaid Services approval, the spending plan includes investments for the:
    - Continuation of Medi-Cal Targeted Rate Increases (TRI)
    - Time-limited supplemental payments, over and beyond TRI for primary care, specialty care, maternal health, and non-specialty mental health providers.
    - Behavioral Health Facility Throughputs
    - Graduate Medical Education
    - Medi-Cal Workforce
- **Elimination of the Adult Acupuncture Benefit** - This policy would eliminate the optional benefit for adult members effective January 1, 2027.
- **Implement Medi-Cal Efficiencies through Utilization Management** - This policy would implement applied behavioral analysis (ABA) and transportation utilization management controls. DHCS has established a joint Chief Financial Officer and Chief Medical Officer workgroup to discuss these new policies. DHCS will consider the feedback from this workgroup to help shape final policy requirements.

- **Revisions to Community Supports and Enhanced Care Management (ECM)** - The current budget proposes to scale back California Advancing and Innovating Medi-Cal (CalAIM). Specifically, the May Revise assumes General Fund reductions of $41.4 million in FY 2026-27 and $99.2 million ongoing for ECM tied to refined eligibility criteria, service definitions, utilization management criteria, and payment adjustments. Further General Fund reductions of $26.9 million in FY 2026-27, $58.8 million in 2027-28, and $51 million ongoing were included for Community Supports tied to refined referral pathways, eligibility criteria, service definitions, and utilization management criteria for select Medi-Cal community supports. The proposed policy changes would be effective January 1, 2027.

Other notable items:

- **Reduced Medical Assistance Percentage for Emergency Services** - The May Revise includes $669 million in increased General Fund costs in FY 2026-27 due to the emergency services federal match reductions (match reduced from 90 percent to 50 percent) for UIS adult expansion members. This change goes into effective October 1, 2026.
- **Eliminate Prospective Payment System (PPS) funding for State-Only Services for UIS Members** - The May Revise proposes to eliminate PPS rate funding for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) for state-only-funded services for UIS members effective no sooner than July 1, 2026. If implemented clinics would be reimbursed at the applicable Medi-Cal managed care rate for the period of July 1, 2026 to December 31, 2026. Effective January 1, 2027, clinics would be reimbursed at the applicable Medi-Cal FFS rate. FQHCs and RHCs are safety net providers that serve as the primary care backbone of Medi-Cal.
- **Funding for Hospitals in Immediate Financial Distress** – The May Revise allows for an augmentation of up to $50 million General fund in FY 2026-27 for the Department of Health Care Access and Information. This funding will provide limited financial support to hospitals with less than 10 days of cash on hand, whose patient mix is at least 50 percent government funded or uninsured. Given the fiscal hardships hospitals and specifically rural hospitals have faced this funding can serve as a stopgap to keep hospitals afloat as longer term solutions are explored.

In previous times of budgetary hardship, the State has implemented a variety of cost cutting measures in the Medi-Cal program outside of the budget. Based on recent discussions with DHCS and history we expect:

- Additional Managed Care rate efficiency adjustments to be implemented by January 1, 2027. This will result in Partnership revenue reductions. DHCS has indicated the following new efficiency adjustments are being considered for implementation: readmissions, short hospital stays, cesarean mix, cellulitis, durable medical equipment and outlier radiology utilization. Implementation of new revenue reductions through efficiency adjustments will create additional fiscal pressure.
- DHCS will continue to focus on cost-effective spending in managed care and expect pressures to be amplified.

- As noted in our prior budgets, Partnership has faced increased scrutiny from DHCS on contracted heath care cost levels, some of which resulted in prior year's downward rate adjustments.

FY 2026-27 Legislative Version of the Budget

On June 11, 2026, the legislative version of the budget was released and proposes a total budget of $355.9 billion total fund ($253 billion State General Fund) for FY 2026-27. The legislative budget is $6.5 billion greater than the Governor's May Revise proposal and earmarks $3.1 billion less to state reserves (inclusive of the surplus set-aside).

Notable legislative budget details that affect the Medi-Cal program are highlighted below.

- **Unsatisfactory Immigration Status (UIS) Members transition from Medi-Cal Managed Care to Medi-Cal FFS** – The legislature accepted the Governor's proposal to transition UIS members into the FFS delivery system but allowed UIS members to maintain their CalAIM benefits. The legislature notated they will work with the Administration to consider maintaining managed care for non-emergency services. As of June 2026, Partnership serves nearly 88,000 UIS members who are at risk of losing access to managed care providers.
- **Delayed UIS Adult Member Medi-Cal Premium Increases** - The legislature delayed the Governor's proposed monthly premium increase from $30 to $50 and deferred this decision to our incoming Governor.
- **Delayed UIS Dental Benefit Elimination -** The legislature delayed the Governor's proposed elimination of adult dental for UIS members until July 1, 2027.
- **Delayed Eligibility Changes for Qualified Non-Citizens** -The legislature delayed the transition of these members to limited-scope Medi-Cal to July 1, 2027, and indicated they are committed to maintaining Medi-Cal eligibility past July 2027.
- **Delayed Implementation of the Modified Asset Test for Medi-Cal Eligibility** - The legislature delayed the Governor's proposed asset test modification to July 1, 2027, and proposes a limit of $21,000 per individual in place of the proposed $2,000 per individual.
- **Approved the Proposed Managed Care Organization (MCO) Tax** - The legislature approved the Governor's proposed new MCO Tax effective January 1, 2027, that would assess a higher tax rate on non-Medi-Cal plans.
- **Rejected Elimination of the Adult Acupuncture Benefit** - The legislature rejected the Governor's proposed elimination of this optional benefit.
- **Delayed the Elimination of Prospective Payment System (PPS) funding for State-Only Services for UIS Members** - The legislature delayed the Governor's proposed elimination of PPS rate funding for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) for state-only-funded services for UIS members until July 1, 2027.
- **Funding for Distressed Hospitals** - The legislature increased distress hospital funding to up $190 million through additional forgivable loans. And an additional $250 million was allocated to support public hospitals.
- **Reproductive Health Care and Gender-Affirming Care** - The legislature added $40 million for reproductive health care and $26 million for gender-affirming care.

- **Increased County Administration Funding** – The legislature allocated additional funding over and beyond what was proposed in the May Revise for county workload tied to Medi-Cal and CalFresh and the impacts of H.R. 1.

National Medicaid Changes and Other Potential Federal Changes

H.R.1 implemented sweeping changes to Medicaid Nationally. Notable eligibility and financing changes, and Medicaid policy pressures are highlighted below.

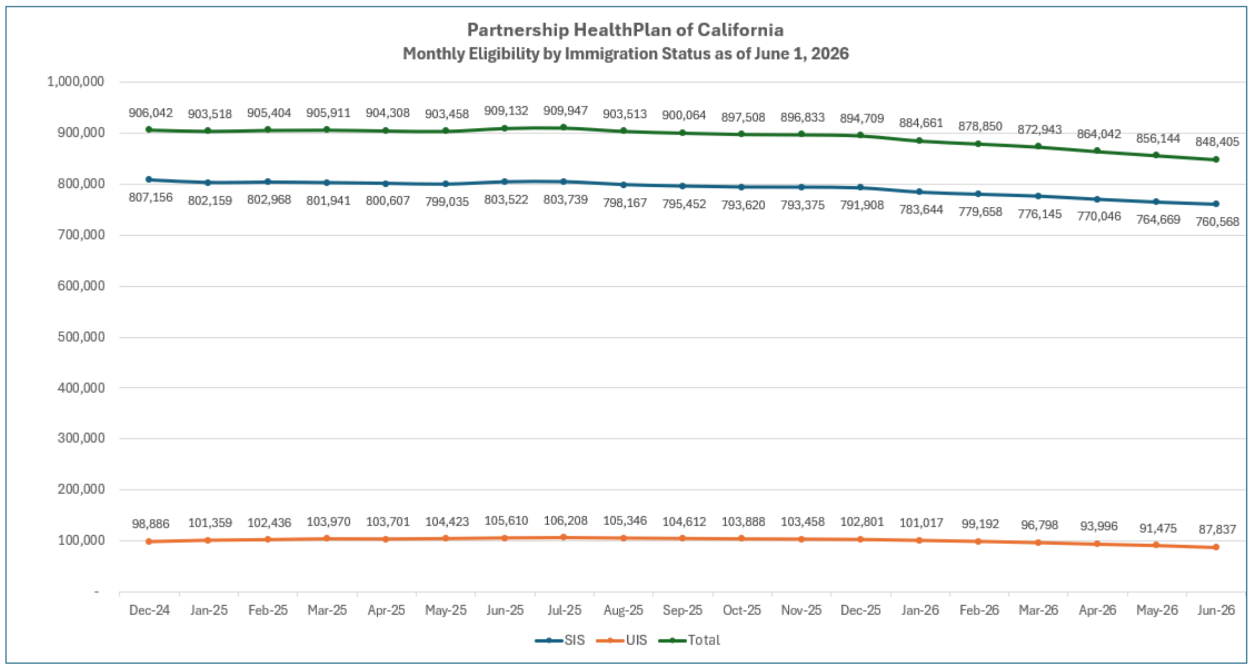
- **Medicaid Community Engagement and Work Requirements** - H.R. 1 mandated States to implement community engagement and work requirements for able-bodied adults aged 19 to 64 without children under 13. Effective January 1, 2027, these members must meet work, volunteer, school, or training requirements to keep Medi-Cal. Exemptions apply for pregnancy, disability, serious health conditions, and other circumstances. This change is expected to result in additional Partnership membership losses.
- **Semi-annual Adult Expansion Member Medicaid Eligibility** - Effective January 1, 2027, eligibility verification for the adult expansion population must occur every 6 months instead of annually as are result of H.R.1. This change is expected to result in additional Partnership membership losses.
- **Medicaid Retro Eligibility Changes** - Effective January 1, 2027, retroactive Medicaid eligibility will be reduced from 90 days to 30 days for the adult expansion population and reduced from 90 days to 60 days for all other members. This change is expected to result in additional Partnership membership losses.
- **Limit Medicaid Directed Payments to the Medicare Payment Levels** - Effective January 1, 2028, Medicaid State Directed Payments (SDPs) must be phased-down over a multiyear period to 100% of Medicare for expansion states while non-expansion States must be phased down to a 110% of Medicare. California hospitals heavily rely on supplement SDP funding. Each Medi-Cal hospital SDP program exceeds the new Medicare limit. DHCS has indicated they will not be able to backfill hospital SDP losses. The SDP funding reductions are expected to put significant financial strain on hospital systems.
- **Risk of Future Medicaid Changes** - There is risk that future CMS regulatory changes and additional rulemaking could further alter the Medicaid program without requiring federal legislative action. Additional uncertainty remains regarding whether federal lawmakers will pursue further Medicaid funding reductions.
    - In late May of 2026, CMS issued a proposed rule on Medicaid managed care SDPs that would implement provision 71116 of H.R. 1, cap SDP payment rates at 100% of Medicare payment rates, apply similar limits to certain targeted Medicaid fee-for-service payments, and establish consistent national standards to improve transparency and accountability.

Membership

As noted in our April assumptions, and as displayed in the June membership chart below, sizeable declines outside of prior eligibility trends have been observed in both the UIS category and in the members with satisfactory immigration status (SIS) category.

Partnership lost 46,304 members (nearly a 5.2% membership reduction) between December 2025 and June 2026. UIS membership declines are largely explainable due to recent federal and state policy changes along with dual SIS membership declines which can be attributed to the increased Medi-Cal eligibility asset limits that went into effect on January 1, 2026. Outside of the explainable membership losses, Partnership continues to see declines in the Child, Adult, and ACA Adult Expansion SIS categories which is concerning. We believe the required DHCS monthly eligibility data scrubbing against HHS eligibility lists, mixed immigration status households, and general confusion on when federal H.R. 1 policy changes go into effect are contributors to these declines.

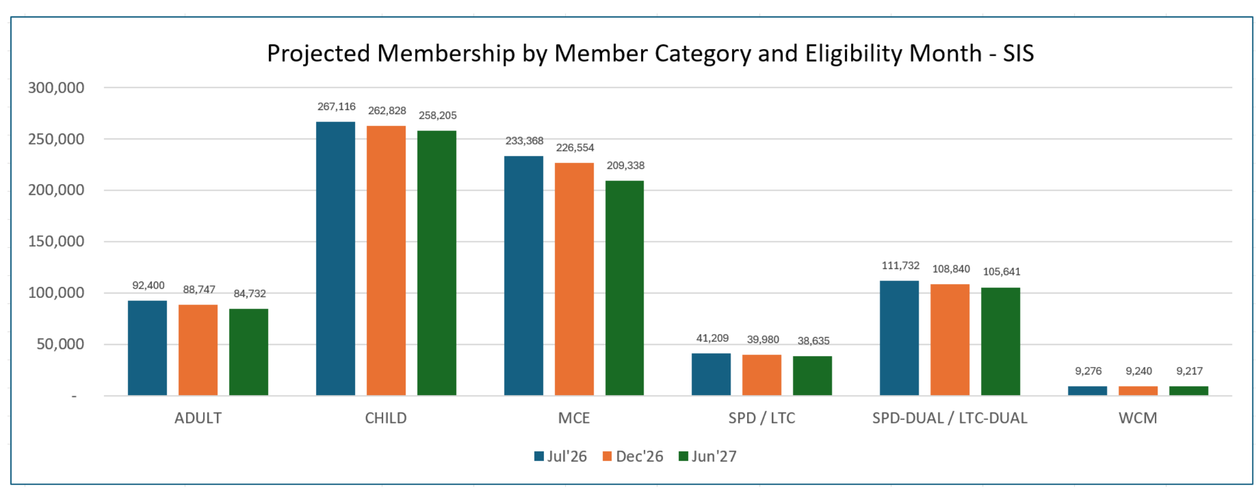
Partnership's recent membership reductions and the proposed UIS member transition from Managed Care to Medi-Cal FFS will significantly reduce the amount of revenue Partnership receives from DHCS. As of June 2026, Partnership serves 87,837 UIS members, the May Revise proposal would result in a 10.35% membership loss. Further, there is considerable uncertainty on how many members Partnership will lose because of upcoming January 1, 2027, H.R.1 eligibility changes.

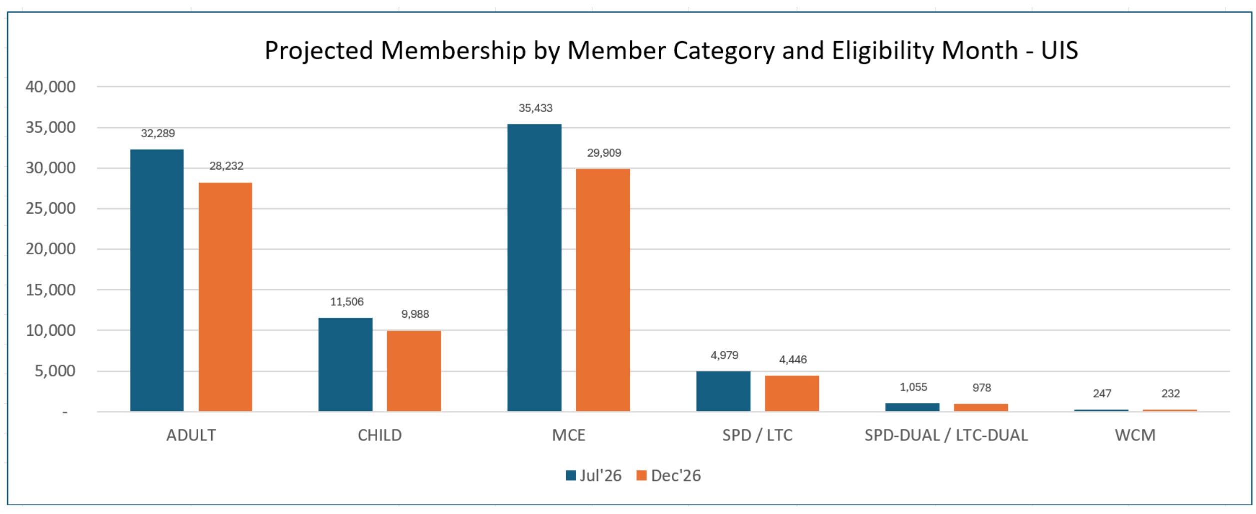


Partnership engaged our actuarial consultants to assist with membership projections for FY 2026-27 budget year given the recent volatility we have observed over the last several months. Based on the best available information and year-to-date membership trends, Partnership anticipates

SIS membership to drop to 705,768 by June of 2027. The charts below reflect estimated point in time membership assumptions for July 2026, December 2026, and June 2027 by membership category and membership type.

Enrollment losses represent the plan's greatest fiscal risk in the coming year as declining membership directly reduces revenue and is expected to compress margins. Further financial risk is tied to revenue adequacy for CY 2026 and CY 2027. With the observed and anticipated future membership loss, Partnership expects to serve a higher-needs population. It is unclear if the State will adjust CY 2026 revenue and how the forthcoming CY 2027 revenue will account for these uncertainties. Rate advocacy efforts are underway through our health plan associations specific to rate adequacy and risk mitigation protective measures.





Revenue

Partnership budgeted overall revenue of $6.0 billion, representing a $1.1 billion year-over-year decline, primarily driven by the assumed UIS population transition to Medi-Cal FFS. The budget incorporates CY 2026 draft rates received from DHCS for the period of July through December

2026. Given the CY 2027 draft rates will not be delivered to Partnership until the last quarter of CY 2026, Partnership relied on actuarial revenue projections for the period of January through June 2027.

Rate development continues to grow increasingly dynamic. Anticipated coverage volatility from the new H.R. 1 eligibility requirements, along with shifts in acuity mix, present added challenges to prospective rate development. Ongoing membership declines and new efficiency adjustments are expected to further pressure Partnership's future revenue. Additionally, DHCS revisions to draft CY 2025 and CY 2026 rates remain pending.

Medi-Cal State Capitation Revenue

2026-27: $5.9 billion | 2025-26 Δ : -$1.1 billion or -15.8%

Medi-Cal Base Capitation reflects offsetting variances driven by base revenue, membership trends, and other supplemental revenues. Because capitation premium revenue is directly tied to enrollment, the year-over-year decrease is primarily attributable to lower enrolled membership, including the anticipated UIS population shifting to Medi-Cal FFS and the H.R.1 eligibility requirements taking effect on January 1, 2027. Partnership continues to observe monthly enrollment declines in the Child, Adult, and ACA Optional Expansion cohorts and has incorporated assumptions to reflect these decreases even before the H.R.1 requirements take effect. Partnership worked closely with actuarial consultants to project our CY 2027 revenue for the anticipated members that we will continue to serve.

Revenues related to "at-risk" programs, including hospital directed payments and the voluntary rate range are recognized as top-line revenue. These programs account for an estimated $1.1 billion in total revenue. The contraction in membership and the total funding pool change for the Private Hospital Directed Payment (PHDP) program are the primary drivers of the year-over-year decrease in directed payment programs.

DHCS implemented a 0.5% quality withhold on plan capitated revenue effective January 1, 2024, and increased the withhold to 1% effective January 1, 2025, for all counties. The budget assumes a 1% withhold for CY 2026 and CY 2027. We do not have final details on the CY 2026 and CY 2027 withholds at this time and have held prior year measurement earn back percentages constant for budgetary purposes. Actual CY 2026 and CY 2027 outcomes may differ materially from these estimates due to the unknown impacts of membership mix changes and final program details.

Interest & Other Income

2026-27: $76.2 million | 2025-26 Δ : -$7.0 million or -8.5%

Interest and other income consist of interest income and building tenant revenue. Interest income is projected at $73.5 million, based on an assumed annual rate of return of 3 percent. The year-over-year decrease is primarily attributable to an assumed lower average cash balance and a lower rate of return. Building tenant revenue is projected at $2.7 million, reflecting occupancy of previously vacant space and modest lease renewal increases. Consistent with prior years, DHCS incentive grant revenue and related offsetting expenses are excluded from the FY

2026-27 budget due to uncertainty regarding the timing of award recognition. Revenue and related expenses will be recorded if awarded and recognized.

Health Care Expenses

The health care cost projections for FY 2026-27 were forecasted based on historical claims experience, anticipated membership reductions, and further adjusted for anticipated member acuity. Partnership utilized cost experience from January 2025 through December 2025 when developing these projections. All UIS member expenses were removed for the period of January to June 2027 based on the May Revise proposal. Completion factors were applied to incomplete CY 2025 months where appropriate to account for incurred but not yet reported claims.

The revenue and membership uncertainty noted above cascades down to health care expense uncertainty. The health care expense projections were revised in June based on:

- June 2026 membership trends
- Incorporating actuarial assumptions on leavers, joiners and stayers
- Refined FY 2026-27 acuity assumptions
- Additional claims data and other emerging information.
- Our estimates account for the anticipated transition of all UIS members effective January 1, 2027, to Medi-Cal FFS. If subsequent budgetary actions are made regarding this population, adjustments will be addressed in an off-cycle budget.

The associated revenue and costs tied to Governor's Proposition 35 spending plan are not included in the budget as estimable details are unknown at this time. Necessary adjustments may be addressed in an off-cycle budget.

The health care budget assumes an overall expense of $5.7 billion, representing a decrease of $1.1 billion, or 16.2%, from the FY 2025-26 budget. The budget will allow for flexible reallocation authority across budget categories as necessary. Additional considerations and estimates by cost category are provided in more detail, below.

Inpatient Hospital

2026-27: $1.4 billion | 2025-26 Δ : -$286.8 million or -17.5%

The Inpatient Hospital line item includes inpatient FFS, hospital capitation, and stoploss expenses. The year-over-year decrease is primarily driven by the disenrollment of UIS members from managed care effective January 1, 2027, as well as the implementation of H.R.1 related eligibility restrictions and more frequent eligibility redeterminations.

Despite the overall decline in enrollment, inpatient hospital costs are projected to increase on a PMPM basis due to higher acuity among the remaining membership. Anticipated impacts include longer average lengths of stay and increased severity, leading to higher unit cost trends.

Given ongoing uncertainty in Medicaid, Partnership must remain disciplined in managing health care expenses through appropriate medical management and prudent contracting decisions. As contract requests are evaluated, it is imperative to consider other hospital revenue sources that

are afforded to contracted providers in Medi-Cal managed care, including the PHDP program and the District Hospital Directed Payment (DHDP) program. While we recognize a phase-down of funding for these programs will occur beginning in CY 2028, DHCS has advised they will not have the ability to backfill these program losses and neither will plans given our revenue comes directly from the State.

We continue to highlight that Partnership is an outlier in its inpatient contracting levels relative to other Medi-Cal plans statewide, this puts further strain on the ability to implement contracting increases. The State's actuaries assess the reasonableness of Partnership's contracting levels inclusive of the hospital directed payments and have raised concerns on our inpatient payment levels during each rating period, some of which has resulted in downward inpatient rate adjustments.

Physician Services

2026-27: $1.1 billion | 2025-26 Δ : -$72.0 million or -6.3%

Physician Services include Proposition 56 payments (Prop 56), specialty capitation, primary capitation, and physician FFS expenses. FFS expenses are decreasing year-over-year due to the disenrollment of UIS members from managed care and impacts of H.R.1. However, the disenrollment of historically younger and lower-utilizing UIS members increases the concentration of medically complex members requiring ongoing physician care.

Primary Care spending is expected to remain slightly elevated due to increased demand for preventative services and stabilization efforts associated with transitional care management following acute episodes. Specialty Physician costs are projected to increase, driven by a higher prevalence of comorbid conditions and resulting increases in cost per visit. In addition, utilization for Indian Health Service (IHS) reimbursement have risen significantly.

Effective January 1, 2024, TRI rate increases were implemented for eligible contracted providers. This brought eligible provider minimum reimbursement levels for TRI procedure codes to at least 87.5% of the lowest Medicare locality in the state for certain Medi-Cal services. Noting a subset of the TRI procedure code rates exceed Medicare payment levels. The CY 2024 TRI payment levels will continue for FY 2026-27.

TRI will be further be augmented by the Proposition 35 time-limited supplemental payments for primary care, specialty care, maternal health, and non-specialty mental health providers. Details surrounding these new augmentations are unknown at this time and are not included in our health care expense estimates.

Long-Term Care

2026-27: $701.7 million | 2025-26 Δ : -$38.7 million or -5.2%

As noted in prior budget cycles, the Long-Term Care expense category is inherently difficult to forecast due to the timing and complexity of retroactive DHCS rate increases. Annual DHCS per diem rate increases remain the largest driver, reflecting inflationary pressures and cost-based reimbursement updates. Rates are often published several months after their effective dates and

issued in multiple revisions. This requires Partnership staff to perform detailed analyses to reconcile and adjust prior payments. In addition, under Assembly Bill (AB) 86, DHCS established the Workforce Standards Program, through which participating facilities receive an enhanced per diem rate. Workforce-related investments, including the AB 86 Workforce Standards Program and the implementation of SB 525 minimum wage requirements, are further elevating provider labor costs and contributing to higher reimbursement levels.

Ancillary Services

2026-27: $1.1 billion | 2025-26 Δ : -$142.2 million or -11.4%

Ancillary Services is comprised of FFS and capitated ancillary services, Outpatient Facility, Emergency Department, ECM, and Community Supports. The budget assumes decreases primarily driven by the UIS disenrollment from managed care, tighter eligibility H.R.1 requirements, and utilization management initiatives. Additional offsets by a continued rise in high-cost specialty drug spend, particularly advanced cell and gene therapies that are episodic in nature but carry a substantial fiscal impact.

Other Medical

2026-27: $457.8 million | 2025-26 Δ : -$37.4 million or -7.5%

The Other Medical category includes transportation, quality assurance, health care investment fund, nurse advice line, and the DHCS voluntary rate range program. Transportation expense is also projected to decrease due to lower utilization association with UIS disenrollment from managed care, H.R.1 eligibility restrictions, and utilization management initiatives. These reductions are expected to be partially offset by Public Providers Ground Emergency Transportation (PP-GEMT) rate increases and ongoing inflationary pressures, including higher fuel and operating costs driven by global supply instability.

The voluntary rate range program is also expected to decrease as this is tied to overall managed care revenue, primarily due to the exclusion and carve-out of UIS populations from managed care and the broader eligibility tightening tied to H.R.1. Beginning in Program Year CY 2026, Partnership will implement a 3 percent administrative fee to support operational, compliance monitoring and reporting requirements of this program.

The increase in quality assurance and medical administrative expenses is generally aligned with the overall growth in administrative costs and is primarily attributable to staffing and employee benefit assumptions, as described in the Administrative Expense section below.

DHCS Facility Directed Payment Programs

2026-27: $899.0 million | 2025-26 Δ : -$527.3 million or -37.0%

The following facility directed payments are included in this category: PHDP program, DHDP program, Designated Public Hospital Enhanced Payment program, the Designated Public Hospitals Quality Improvement programs, Health Equity Practice Transformation payments, and the new Children's Hospital Supplement Payment program. The significant decrease in directed payments is driven by reductions to the PHDP program statewide funding. These reductions were necessary to comply with H.R.1 grandfathering provisions.

Quality Improvement Programs (Incentives)

2026-27: $94.4 million | 2025-26 Δ : $5.2 million or 5.8%

The year-over-year increase in QIP expenses is due to the implementation of the Extended Care Facility QIP (EXT QIP) program on January 1, 2026. The EXT QIP, formerly known as the LTC QIP, was originally established in 2016. The program was suspended in August 2020 due to the COVID-19 pandemic, reinstated in January 2022, and subsequently sunset in December 2023 following the launch of the Skilled Nursing Facility Workforce Quality Incentive Program (WQIP) by DHCS. After WQIP was phased out of the State budget on December 31, 2025, Partnership's Board of Commissioners approved the EXT QIP, effective January 2026.

In addition, Partnership continues to invest in quality improvement programs and the member experience. The goal of these investments is to improve overall member experience and increase performance on quality metrics prioritized by the DHCS Quality Withhold program and to provide quality, equitable and cost-effective care for our members. As in previous periods, incentive funding remains contingent on final revenue projections.

Off-Cycle Budget

Partnership's enrollment projections reflect our best estimates of policy changes but are highly uncertain. They therefore depend on several assumptions about disenrollments, utilization, and costs. Given these uncertainties and given the timing of the State's enacted budget, Partnership staff expect to produce an off-cycle budget to account for any significant programmatic or cost changes after the June budget is finalized.

Administrative Expense

Overall administrative spending is budgeted at $391.9 million, an increase of $4.0 million, or 1.0%, over the prior year's budget. The year-over-year increase is primarily attributable to staffing and employee benefit cost assumptions. Excluding future capital requests, the administrative operating expense base remains generally consistent with the prior year. FY 2026-27 capital requests are expected to return to the Board for approval in the Fall of 2026. Administrative cost growth continues to be limited to essential operational requirements. The budget will allow for flexible reallocation authority across budget categories as necessary.

Employee Workforce

2026-27: $257.7 million | 2025-26 Δ : $9.8 million or 4.0%

Partnership continues to assess workforce needs in response to ongoing regulatory obligations and changes in Medi-Cal enrollment. For FY 2026-27, budgeted headcount is expected to remain consistent with FY 2025-26. As in the prior year, temporary resources remain incorporated into the staffing model and may be converted to permanent positions based on final operational requirements. The increase in workforce expense is primarily attributable to a projected 4.0% merit increase and an assumed overall 12% increase in medical, dental, and vision benefit costs. As reflected in the previously approved budget assumptions document, the proposed merit

increase is based on the latest Employment Cost Index for the Western Region published by the U.S. Bureau of Labor Statistics.

Occupancy

2026-27: $25.2 million | 2025-26 Δ : -$8.2 million or -24.4%

The year-over-year decrease in occupancy costs is primarily driven by lower projected depreciation expense. Depreciation associated with existing capital is included in the FY 2026-27 budget; however, depreciation associated with future project requests is excluded until those capital requests return to the Board for review and approval in the Fall of 2026.

Professional Services

2026-27: $39.5 million | 2025-26 Δ : No Change

Professional Services primarily include consulting, contracted claims processing, and other third-party processing vendors. The FY 2026-27 budget assumes these expenditures will remain consistent with the prior year across all Partnership regions. These costs will be revisited in the Fall of 2026.

Computer & Data

2026-27: $54.0 million | 2025-26 Δ : No Change

The FY 2026-27 budget assumes hardware, software, and data processing costs across Information Technology and other departments will remain consistent with the prior year across all Partnership regions. These costs will be revisited in the Fall of 2026.

Profit & Loss Statement

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Statement of Revenues and Expenses

Annual Capital & Operating Budget

	2026-27 Budget	2025-26 Budget	$ VARIANCE	2026-27 Budget PMPM	2025-26 Budget PMPM
REVENUE					
State Capitation Revenue	5,930,930,957	7,046,897,376	(1,115,966,419)	640.51	643.75
Interest Income	73,500,000	80,779,000	(7,279,000)	7.94	7.38
Other Revenue	2,679,900	2,447,000	232,900	0.29	0.22
TOTAL REVENUE	**6,007,110,857**	**7,130,123,376**	**(1,123,012,519)**	**648.74**	**651.35**
HEALTHCARE COSTS					
Physician Services					
PCP Capitation	100,128,377	119,415,716	19,287,339	10.81	10.91
Specialty Capitation	2,352,079	2,570,827	218,748	0.25	0.23
Non-Capitated Physician Services	970,121,708	1,022,631,615	52,509,907	104.77	93.42
Total Physician Services	**1,072,602,164**	**1,144,618,158**	**72,015,994**	**115.84**	**104.56**
Inpatient Hospital					
Hospital Capitation	165,694,928	206,752,864	41,057,936	17.89	18.89
Inpatient Hospital - FFS	1,178,540,266	1,423,506,378	244,966,112	127.28	130.04
Hospital Stoploss	9,181,839	9,999,852	818,013	0.99	0.91
Total Inpatient Hospital	**1,353,417,033**	**1,640,259,094**	**286,842,061**	**146.16**	**149.84**
Long Term Care	701,659,419	740,374,189	38,714,770	75.78	67.63
Ancillary Services					
Ancillary Services - Capitated	13,843,128	16,574,512	2,731,384	1.49	1.51
Ancillary Services - Non-Capitated	1,089,457,399	1,228,900,510	139,443,111	117.66	112.26
Total Ancillary Services	**1,103,300,527**	**1,245,475,022**	**142,174,495**	**119.15**	**113.78**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Statement of Revenues and Expenses
Annual Capital & Operating Budget

	2026-27 Budget	2025-26 Budget	$ VARIANCE	2026-27 Budget PMPM	2025-26 Budget PMPM
Other Medical					
Quality Assurance	98,339,060	92,329,487	(6,009,573)	10.62	8.43
Healthcare Investment Funds	218,584,865	241,427,350	22,842,485	23.61	22.05
Advice Nurse	1,560,000	1,729,200	169,200	0.17	0.16
Transportation	139,268,537	159,645,568	20,377,031	15.04	14.58
Total Other Medical	**457,752,462**	**495,131,605**	**37,379,143**	**49.44**	**45.23**
DHCS Facility Directed Payment Programs	899,026,750	1,426,371,794	527,345,044	97.09	130.30
Quality Improvement Programs	94,412,000	89,200,150	(5,211,850)	10.20	8.15
TOTAL HEALTHCARE COSTS	**5,682,170,355**	**6,781,430,012**	**1,099,259,657**	**613.65**	**619.50**
ADMINISTRATIVE COSTS					
Employee	257,660,943	247,828,143	(9,832,800)	27.83	22.64
Travel And Meals	3,023,332	2,294,006	(729,326)	0.33	0.21
Occupancy	25,240,416	33,393,279	8,152,863	2.73	3.05
Operational	12,461,223	10,909,163	(1,552,060)	1.35	1.00
Professional Services	39,490,454	39,490,454	-	4.26	3.61
Computer And Data	53,983,631	53,983,631	-	5.83	4.93
TOTAL ADMINISTRATIVE COSTS	**391,860,000**	**387,898,676**	**(3,961,324)**	**42.32**	**35.44**
Medi-Cal Managed Care Tax	-	-	-	-	-
Surplus / (Deficit)	**(66,919,497)**	**(39,205,312)**	**(27,714,185)**	**(7.23)**	**(3.58)**

Fund Balance

Total Fund Balance includes reserves for the State Financial Performance Guarantee, Capital Assets, and Strategic Use of Reserves (SUR). The State Financial Performance Guarantee allows for calculation of the reserve at two months' (2x) worth of state capitation revenue; the Guarantee also satisfies the regulatory requirements for State Tangible Net Equity (TNE) as well as Knox-Keene. Net capital assets are included as part of Fund Balance. Lastly, SURs are initiatives that were approved by the Board in previous years. The reserves for these SURs have been utilized over the years in a manner that has expanded member access, increased provider reimbursement, and improved overall operational efficiency; Partnership will continue to utilize the funds as approved. The remaining SUR balance is primarily comprised of funds set aside for the Drug Medi-Cal Program, quality initiatives and capital investments. Note also that Fund Balance includes an unrestricted amount that is projected to be negative, which represents the shortfall of funds needed to meet the reserve requirements. Like in prior county expansions, it is not uncommon to reflect a negative fund balance for the first several years of a coverage expansion. The total fund balance for the year ending June 30, 2027 is estimated at $1.4 billion.

Partnership Healthplan of California
Fiscal Year 2026/27 Fund Balance Analysis
Projected through June 2027
Fund Balance Analysis / TNE

Fund Balance at April 30, 2026		1,483,902,863
Actual Year to Date Surplus at April 30, 2026	26,352,650	
Projected Year to Date Surplus at June 30, 2026	14,131,892	
Projected (Deficit) for May - June 2026		(12,220,758)
Projected Fund Balance at June 30, 2026		**1,471,682,105**
Projected (Deficit) for Fiscal Year 2026/27		(66,919,498)
Estimated Fund Balance at June 30, 2027		**1,404,762,607**
Estimated Fund Balance Allocated at June 30, 2027		
Reserved Funds		
State Financial Performance Guarantee		1,102,845,000
Capital Assets		245,274,000
Strategic Use of Reserve-Board Approved		68,377,668
Unrestricted (Shortfall)		(11,734,061)
Estimated Fund Balance at June 30, 2027		**1,404,762,607**

Capital Projects

As part of developing the capital budget, each of the projects were evaluated based on the current economic conditions along with the strategic goals and priorities of the organization. For 2026-27, ongoing projects that were approved in previous years will continue until completion. No new capital projects are being presented in this current budget and additional capital projects will be deferred for Board presentation in the Fall of 2026.

Version History

This table was created for Committee Members to quickly review changes between the preliminary healthcare budget presented in May 2026 and the final budget presented above.

	FY 2026-27		Final vs HCC Assumptions Version △		
Health Care Categories	**Budget - Final**	**HCC Assumptions (1st Pass)**	**$**	**%**	**Notes**
Inpatient Hospital	$1,353,417,033	$1,342,360,258	$11,056,775	0.8%	Adjusted to account for acuity mix
Physician Services	$1,072,602,164	$1,070,455,955	$2,146,209	0.2%	
Long Term Care	$701,659,419	$719,325,240	($17,665,821)	(2.5%)	Adjusted to account for current LTC cost trends based on latest rate adjustments
Ancillary Services	$1,103,300,527	$1,089,077,296	$14,223,231	1.3%	Adjusted to account for acuity mix
Other Medical	$457,752,462	$458,872,239	($1,119,777)	(0.2%)	
DHCS Facility Directed Payment Programs	$899,026,750	$899,054,927	($28,177)	(0.0%)	
Quality Improvement Programs	$94,412,000	$98,412,000	($4,000,000)	(4.1%)	Refinement of Extended Care QIP estimate
Total Health Care Expense	**$5,682,170,355**	**$5,677,557,915**	**$4,612,440**	**0.1%**	

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 24, 2026

Agenda Item Number:
4.2

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
Compliance Committee and Partnership Staff

Topic Description:
The Compliance Dashboard outlines activities to track Partnership HealthPlan's Compliance Program and regulatory and contractual requirements.

Reason for Resolution:
To ensure Board members have the opportunity to review the Compliance dashboard biannually.

Financial Impact:
There is no measurable impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of the Compliance Committee, the Board is being asked to approve Partnership's Q12026 Compliance Dashboard.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date	**Agenda Item Number:**
June 24, 2026	4.2

Resolution Number:
26-

IN THE MATTER OF: APPROVING PARTNERSHIP HEALTHPLAN COMPLIANCE DASHBOARD FOR Q12026

Recital: Whereas,

A. Partnership is committed to conducting business in compliance with all required standards.

B. The Board has responsibility for reviewing and approving the organizational Compliance Dashboard.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve Partnership's Q12026 Compliance Dashboard.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 24th day of June 2026 by motion of Commissioner seconded by Commissioner and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

____
Dean Germano, Chair

____

ATTEST:

BY: ______________________________
Ashlyn Scott, Clerk

2026 Regulatory Affairs and Compliance Dashboard

Category	Description	Q1	YTD	Comments
DELEGATION OVERSIGHT	**Annual Delegate / Subcontractor Audits**	**0 / 0**	**0 / 0**	
When PHC delegates administrative functions that it is required by contract or regulation to perform, PHC retains the ultimate responsibility for the performance of these functions and must monitor and evaluate the performance of these functions when performed by a delegate.	Quarterly percentage to demonstrate the total number of annual delegate/subcontractor audits completed within 30 days following the planned months, as defined by the audit calendar.	**100%**	**100%**	Q1 - Five delegate/subcontractor audits were initiated between January and March.
	Oversight of Delegate Reporting	**5 / 5**	**5 / 5**	
	Percentage of timely submissions of regulatory reports.	**100.0%**	**100.0%**	Q1 - Five regulatory reports submitted and all were submitted timely
TRAINING	**Annual FWA Prevention Training**	**1568 / 1575**	**1568 / 1575**	
	Percentage of employees that have completed the annual FWA training. **Annual training released in Q4 2025**	**99.9%**	**99.9%**	Seven employees have not completed the required training. Six are on leave and HR is reviewing the status of the remaining employee.
	Annual HIPAA Training	**1568 / 1575**	**1568 / 1575**	
	Percentage of employees that have completed the annual HIPAA training. **Annual training released in Q4 2025*	**99.9%**	**99.9%**	Seven employees have not completed the required training. Six are on leave and HR is reviewing the status of the remaining employee.
	Annual Code of Conduct	**1569 / 1576**	**1569 / 1576**	
	Percentage of completed annual Code of Conduct employee attestations.	**99.9%**	**99.9%**	Seven employees have not completed the required training. Six are on leave and HR is reviewing the status of the
REGULATORY REPORTING	**DHCS Reports Submitted Timely**	**89 / 89**	**89 / 89**	
Regulatory Affairs works collaboratively with all PHC departments to implement and track the timely submission of regulatory reporting requirements to PHC's governing agencies.	Percentage of regulatory reports submitted timely by RAC to DHCS with no missed due date per RAC Master Tracker and Regulatory Reporting Calendar.	**99.9%**	**99.9%**	All reports were submitted timely.
	Report Acceptance Rate	**83 / 89**	**83 / 89**	
	Percentage of standard regulatory reports submitted by RAC and not rejected by DHCS for being incomplete, on the wrong template, or for other findings.	**93.2%**	**93.2%**	Q1 - Six reports were returned to RAC for additional information/corrections: •Q4 2025 Quarterly CBAS Report •Exhibit J - Corrections needed regarding subcontractor delegated functions. •Semi Annual Provider Directory Report Region 2 - Additional information requested for several providers •ECM-CS Q4 Report - Additional infornation requested regarding ECM/CS Provider Capacity and CS Members and Services •2025 SNC Exhibits Instructions and Attachments - Additional information requested regarding Carelon statistics •LTC Quarterly - Additional information requested regarding high percentage of out of network placement.
HIPAA REFERRALS	**Timely DHCS Privacy Notification Filings**	**39 / 39**	**39 / 39**	

Appropriate safeguards, including administrative policies & procedures, to protect the confidentiality of PHI and ensure compliance with HIPAA regulatory requirements.	Percentage of reportable notifications that PHC filed timely within applicable DHCS required timeframe. **Initial PIR within 24 hours, and final PIR within 10 business days. If either deadline is missed, the notification will be counted as untimely.*	**100.0%**	**100.0%**	Q1- 39 total reportable incidents submitted to DHCS all reported timely.
FWA REFERRALS	**Timely DHCS FWA Notifications**	**28 / 28**	**28 / 28**	
Regulatory Affairs oversees the Fraud, Waste and Abuse Prevention program intended to prevent, detect, investigate, report and resolve suspected and/or actual FWA in the PHC daily operations and interactions, whether internal or external.	Percentage of reportable notifications that PHC filed timely with DHCS within 10 business of discovery per contractual obligations.	**100.0%**	**100%**	Q1-28 total reportable incidents all reported timely.

***Threshold percentages for the above measures are as follows:**

≥ 95% = GREEN **90 - 94.9% = YELLOW** **< 90% = RED**

CAP Tracker

*Please note that the above threshold percentages do not apply here

Updated 06/01/2026

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 24, 2026

Agenda Item Number:
4.3

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
Partnership Staff

Topic Description:
Commissioner Brion Burkett's Board seat term expires at the conclusion of the June 24, 2026, Board meeting.

Commissioner Burkett has made numerous outstanding contributions to Partnership HealthPlan of California and the Commission (known as the Board) since August 2024, as a Consumer Board Representative He has provided excellent insight and has been a dedicated volunteer. His knowledge has been of great value to the Board, and he has kept the needs of our members, providers and the community as a guiding principle.

Reason for Resolution:
To provide Commissioner Burkett with the highest level of commendations and appreciation for his excellent service.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of Partnership staff, the Board is asked to approve the commendations and appreciation for the support Commissioner Brion Burkett has provided to Partnership and the Board.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:	**Agenda Item Number:**
June 24, 2026	4.3
	Resolution Number:
	26-

IN THE MATTER OF: COMMENDATIONS AND APPRECIATION FOR BRION BURKETT'S SERVICE TO PARTNERSHIP AND THE BOARD

Recital: Whereas,

A. Brion Burkett provided valuable advice and support to Partnership and the Board.

B. Brion Burkett was a faithful and active member of the Board.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the highest level of commendations and appreciation for Commissioner Burkett's outstanding service to Partnership and the Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 24th day of June 2026 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

____
Dean Germano, Chair

____
Date

ATTEST:

BY: __________________________
Ashlyn Scott, Clerk

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 24, 2026

Agenda Item Number:
4.4

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
Partnership Staff

Topic Description:
Commissioner Belle Knight's Board seat term expires at the conclusion of the June 24, 2026, Board meeting.

Commissioner Knight has made numerous outstanding contributions to Partnership HealthPlan of California and the Commission (known as the Board) since August 2024, as a Consumer Board Representative She has provided excellent insight and has been a dedicated volunteer. Her knowledge has been of great value to the Board, and she has kept the needs of our members, providers and the community as a guiding principle.

Reason for Resolution:
To provide Commissioner Knight with the highest level of commendations and appreciation for her excellent service.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of Partnership staff, the Board is asked to approve the commendations and appreciation for the support Commissioner Belle Knight has provided to Partnership and the Board.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:	**Agenda Item Number:**
June 24, 2026	4.4
	Resolution Number:
	26-

IN THE MATTER OF: COMMENDATIONS AND APPRECIATION FOR BELLE KNIGHT'S SERVICE TO PARTNERSHIP AND THE BOARD

Recital: Whereas,

A. Belle Knight provided valuable advice and support to Partnership and the Board.

B. Belle Knight was a faithful and active member of the Board.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the highest level of commendations and appreciation for Commissioner Knight's outstanding service to Partnership and the Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 24th day of June 2026 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

____
Dean Germano, Chair

____
Date

ATTEST:

BY: ______________________________
Ashlyn Scott, Clerk

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 24, 2026

Agenda Item Number:
4.5

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
Partnership Staff

Topic Description:
Commissioner Marcelo "Nunie" Matta's Board seat term expires at the conclusion of the June 24, 2026, Board meeting.

Commissioner Matta has made numerous outstanding contributions to Partnership HealthPlan of California and the Commission (known as the Board) since August 2024, as a Consumer Board Representative He has provided excellent insight and has been a dedicated volunteer. His knowledge has been of great value to the Board, and he has kept the needs of our members, providers and the community as a guiding principle.

Reason for Resolution:
To provide Commissioner Matta with the highest level of commendations and appreciation for his excellent service.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of Partnership staff, the Board is asked to approve the commendations and appreciation for the support Commissioner Nunie Matta has provided to Partnership and the Board.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:	**Agenda Item Number:**
June 24, 2026	4.5
	Resolution Number:
	26-

IN THE MATTER OF: COMMENDATIONS AND APPRECIATION FOR MARCELO "NUNIE" MATTA'S SERVICE TO PARTNERSHIP AND THE BOARD

Recital: Whereas,

A. Nunie Matta provided valuable advice and support to Partnership and the Board.

B. Nunie Matta was a faithful and active member of the Board.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the highest level of commendations and appreciation for Commissioner Matta's outstanding service to Partnership and the Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 24th day of June 2026 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

____
Dean Germano, Chair

____
Date

ATTEST:

BY: ____________________________
Ashlyn Scott, Clerk

FINANCIAL HIGHLIGHTS
Of The Partnership HealthPlan of California
For the Period Ending April 30, 2026

Financial Analysis for the Current Period

Total Surplus

For the month ending April 30, 2026, Partnership reported a deficit of $6.1 million, bringing the year-to-date surplus to $26.4 million. Key variances are outlined below.

Revenue

Total Revenue is lower than budget by $45.8 million for the month and $484.4 million for year-to-date. The following summarizes the year-to-date variances. Medi-Cal revenue is $86.1 million favorable to budget primarily due to retro membership and the prior and current period risk corridor adjustments. Directed Payments are $594.6 million unfavorable to budget due to lower than anticipated rates with a corresponding offset recorded in Healthcare Investment Funds (HCIF). Supplemental revenues are $9.7 million above budget, reflecting higher Proposition 56 revenue and higher than expected volumes for Maternity Kick, partially offset by the timing of DHCS submissions for American Indian Health Services (AIHS) payments. Interest income is $9.8 million favorable to budget due to higher interest rates than anticipated. The remaining $4.6 million favorable variance is attributed to other revenues.

Healthcare Costs

Total Healthcare Costs are lower than budget by $47.2 million for the month and $493.6 million year-to-date. The following summarizes the year-to-date variances. Non-Capitated Physician and Ancillary expenses are $133.3 million unfavorable to budget primarily due to adjustments to Incurred but Not Reported (IBNR) reserves which reflect the latest cost and utilization trends. Capitation expenses are $5.9 million favorable to budget due to changes in the funding methodologies for certain healthcare providers. Long-term care costs are favorable to budget by $4.8 million due to lower than expected utilization. Inpatient Hospital Fee-For-Service (FFS) expenses are favorable to budget by $47.0 million, driven by adjustments to IBNR reserves attributed to lower utilization. HCIF expenses are $556.9 million favorable to budget due to lower than anticipated Directed Payment rates, which are partially offset by the recording of the accrual for Community Reinvestments. Transportation costs are $4.1 million unfavorable to budget, attributed to increased utilization and an accrual for an increase in the Ground Emergency Medical Transportation – Public Provider (GEMT-PP) rate. Quality Assurance expenses are $16.4 million favorable to budget due to the timing of medical administrative costs.

Administrative Costs

Total Administrative costs are overall favorable to budget by $5.6 million for the month and $62.3 million for the year-to-date. The primary driver of favorability is in Employee costs due to the timing of the filling of open positions geared towards fulfilling our regulatory requirements, which offsets the utilization costs of consultants in the Professional Services category. Additionally, the favorable variance in Occupancy is due to the timing of building related costs including repairs, maintenance, and utilities, as well as the depreciation expenses that accompany capital asset purchases. Lastly, the favorable variance in Computer and Data is due to the timing of software purchases, which typically correlates to the variance in staffing.

FINANCIAL HIGHLIGHTS
Of The Partnership HealthPlan of California
For the Period Ending April 30, 2026

Balance Sheet / Cash Flow

Total Cash & Cash Equivalents decreased by $522.4 million for the month. Typical significant cash transactions include State Capitation payments received; healthcare cost payments to providers; and administrative and capital payments out to vendors, employees, and other entities. Items of note for the month include payouts of $391.4 million in directed payments for calendar year 2024 and $188.4 million in MCO quarterly tax payments.

General Statistics

Membership

Membership had a total net decrease of 7,586 members for the month.

Utilization Metrics and High Dollar Case

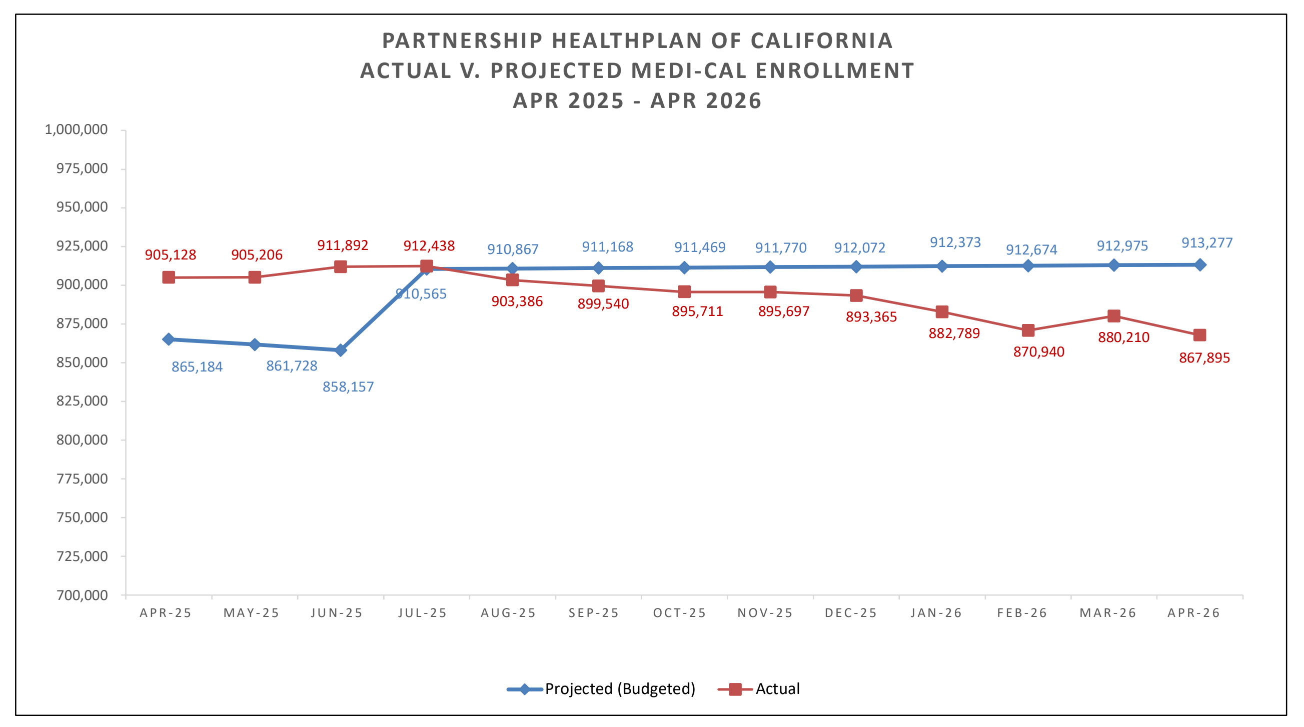
For the fiscal year 2025/26 through April 2026, 796 members reached the $250,000 threshold with an average cost of $497,450. For fiscal year 2024/25, 1,292 members reached the $250,000 threshold with an average cost per case of $513,792. For fiscal year 2023/24, 900 members reached the $250,000 threshold with an average claims cost of $512,459.

Current Ratio/Reserved Funds

Current Ratio Including Required Reserves:	**1.50**
Current Ratio Excluding Required Reserves:	**1.02**
Required Reserves:	**$ 1,430,019,743**
Total Fund Balance:	**$ 1,483,902,863**

Days of Cash on Hand

Including Required Reserves:	**110.18**
Excluding Required Reserves:	**48.43**



Member Months by County:

County	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Solano	102,189	102,658	103,987	104,011	102,676	102,240	101,767	101,583	101,555	98,608	97,031	98,109	96,112
Napa	27,339	27,450	27,826	27,732	27,619	27,642	27,529	27,480	27,355	26,951	26,540	26,659	26,242
Yolo	53,213	53,722	55,109	54,845	54,223	54,152	53,995	54,252	54,140	53,283	52,229	53,552	52,558
Sonoma	112,643	111,321	112,499	112,958	111,588	110,631	110,400	109,596	109,061	107,549	104,697	105,595	104,205
Marin	46,629	46,873	47,047	47,313	46,806	46,609	46,235	46,089	45,096	44,197	43,709	44,101	43,451
Mendocino	40,682	40,941	40,852	41,104	40,506	40,390	40,244	40,200	40,229	39,247	39,125	39,376	38,850
Lake	34,124	34,105	33,983	33,960	33,568	33,236	33,298	33,359	33,389	33,107	32,715	32,770	32,563
Del Norte	12,246	12,336	12,400	12,362	12,314	12,197	12,191	12,220	12,169	12,188	12,077	12,027	11,967
Humboldt	58,149	57,830	57,528	57,819	56,962	56,678	56,451	56,095	55,976	55,830	55,208	55,173	54,632
Lassen	8,767	8,764	8,656	8,575	8,358	8,439	8,412	8,406	8,491	8,375	8,305	8,255	8,204
Modoc	4,013	3,930	3,893	3,878	3,888	3,827	3,743	3,747	3,845	3,836	3,703	3,706	3,658
Shasta	65,219	65,101	65,377	65,400	64,714	64,742	64,786	65,062	64,124	64,876	63,940	64,314	63,758
Siskiyou	17,605	17,791	18,056	18,058	17,782	17,760	17,739	17,786	17,928	17,691	17,590	17,564	17,409
Trinity	5,321	5,325	5,250	5,193	5,220	5,103	5,169	5,118	5,081	4,955	4,955	5,000	4,962
Butte	85,897	85,920	85,649	84,789	84,665	84,532	84,241	84,407	84,874	84,412	83,486	83,679	83,341
Colusa	10,340	10,306	10,362	10,260	10,152	9,996	9,913	9,968	10,006	10,025	9,825	9,899	9,867
Glenn	13,690	13,682	13,647	13,764	13,687	13,672	13,523	13,497	13,456	13,358	13,182	13,222	13,064
Nevada	28,579	28,602	28,731	28,787	28,464	28,369	28,250	28,148	28,633	28,415	28,427	28,548	28,346
Placer	61,260	61,300	62,271	62,355	61,883	61,676	61,371	61,679	61,561	60,619	59,451	62,164	60,536
Plumas	5,886	5,807	5,755	5,784	5,783	5,616	5,575	5,478	5,429	5,395	5,292	5,270	5,278
Sierra	862	832	862	851	825	832	820	810	813	828	823	817	814
Sutter	43,739	43,829	44,348	44,796	44,471	44,294	43,923	44,223	44,067	43,956	43,584	44,445	43,563
Tehama	30,011	29,932	30,038	30,166	29,626	29,551	29,266	29,219	29,095	29,098	29,019	28,962	28,589
Yuba	36,725	36,849	37,766	37,678	37,606	37,356	36,870	37,275	36,992	35,990	36,027	37,003	35,926
All Counties Total	**905,128**	**905,206**	**911,892**	**912,438**	**903,386**	**899,540**	**895,711**	**895,697**	**893,365**	**882,789**	**870,940**	**880,210**	**867,895**

Medi-Cal Region 1: Sonoma, Solano, Napa, Yolo & Marin; Medi-Cal Region 2: Mendocino & Rural 8 Counties; Medi-Cal Region 3: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama & Yuba

Partnership HealthPlan of California
Comparative Financial Indicators Monthly Report
Fiscal Year 2025 - 2026 & Fiscal Year 2024 - 2025

FINANCIAL INDICATORS	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26			YTD	Avg / Month As of Apr-26
Total Enrollment	911,768	903,653	898,537	895,299	893,778	892,208	880,183	870,940	869,706	862,120			8,878,192	887,819
Total Revenue	593,945,794	596,614,742	614,951,654	605,173,794	589,922,935	597,186,401	597,564,630	582,105,182	598,248,494	584,419,840			5,960,133,466	596,013,347
Total Healthcare Costs	498,796,206	506,539,614	512,291,047	520,182,134	500,456,939	496,774,321	509,948,545	476,842,427	505,708,177	497,005,879			5,024,545,294	502,454,529
Total Administrative Costs	24,791,602	22,017,598	26,477,113	24,878,941	26,778,257	26,528,471	26,108,033	23,515,181	26,583,549	29,267,043			256,945,784	25,694,578
Medi-Cal Hospital & Managed Care Taxes	66,396,128	65,722,340	65,436,800	65,176,911	65,100,207	65,268,296	65,351,788	64,457,740	65,122,231	64,257,297			652,289,738	65,228,974
Total Current Year Surplus (Deficit)	3,961,858	2,335,190	10,746,694	(5,064,192)	(2,412,468)	8,615,313	(3,843,736)	17,289,834	834,537	(6,110,379)			26,352,650	2,635,265
Total Claims Payable	629,390,689	669,310,022	649,369,505	691,165,158	693,242,993	695,889,424	733,344,288	698,356,590	626,293,648	646,605,440			646,605,440	673,296,776
Total Fund Balance	1,461,512,071	1,463,847,260	1,474,593,953	1,469,529,761	1,467,117,293	1,475,732,606	1,471,888,870	1,489,178,704	1,490,013,242	1,483,902,863			1,483,902,863	1,474,731,662
Reserved Funds														
State Financial Performance Guarantee	1,135,173,000	1,146,059,000	1,166,267,000	1,181,553,000	1,195,372,000	1,208,212,000	1,221,224,000	1,191,261,000	1,175,457,000	1,173,987,000			1,173,987,000	1,179,456,500
Board Approved Capital and Infrastructure Purchases	100,733,349	100,103,601	98,688,437	97,620,158	94,941,438	93,782,664	92,028,380	90,442,990	89,322,236	88,490,275			88,490,275	94,615,353
Capital Assets	161,362,815	161,328,374	162,223,752	162,679,193	164,744,577	165,348,675	166,558,763	167,531,839	168,044,105	167,542,468			167,542,468	164,736,456
Strategic Use of Reserve-Board Approved	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	68,377,668	68,377,668	68,377,668	68,377,668			68,377,668	69,952,668
Unrestricted Fund Balance	(6,759,761)	(14,646,383)	(23,587,903)	(43,325,258)	(58,943,390)	(62,613,402)	(76,299,941)	(28,434,793)	(11,187,767)	(14,494,548)			(14,494,548)	(34,029,315)
Fund Balance as % of Reserved Funds	99.54%	99.01%	98.43%	97.14%	96.14%	95.93%	95.07%	98.13%	99.25%	99.03%			99.03%	97.74%
Current Ratio (including Required Reserves)	1.49:1	1.46:1	1.44:1	1.45:1	1.43:1	1.43:1	1.46:1	1.44:1	1.43:1	1.50:1			1.50:1	1.45:1
Medical Loss Ratio w/o Tax	94.55%	95.41%	93.23%	96.33%	95.36%	93.39%	95.82%	92.12%	94.86%	95.55%			94.66%	94.66%
Admin Ratio w/o Tax	4.70%	4.15%	4.82%	4.61%	5.10%	4.99%	4.91%	4.54%	4.99%	5.63%			4.84%	4.84%
Profit Margin Ratio	0.75%	0.44%	1.96%	-0.94%	-0.46%	1.62%	-0.72%	3.34%	0.16%	-1.17%			0.50%	0.50%

FINANCIAL INDICATORS	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD	Avg / Month As of Jun-25
Total Enrollment	898,490	898,153	897,450	895,408	895,235	905,698	901,907	904,947	906,317	904,513	903,817	910,264	10,822,199	901,850
Total Revenue	516,467,263	505,732,274	517,421,674	517,491,108	507,895,691	520,768,067	518,706,967	759,253,557	692,900,747	592,855,121	595,592,203	643,816,561	6,888,901,232	574,075,103
Total Healthcare Costs	455,570,291	455,587,935	449,203,390	445,671,531	422,571,150	440,227,707	443,280,032	430,197,038	480,694,520	490,255,409	527,157,036	443,488,949	5,483,904,985	456,992,082
Total Administrative Costs	17,164,116	20,965,109	20,303,694	22,663,983	19,787,655	21,565,508	23,537,967	22,873,201	21,628,246	26,832,114	23,265,462	26,309,568	266,896,625	22,241,385
Medi-Cal Hospital & Managed Care Taxes	46,566,563	46,437,851	46,436,856	46,083,262	46,460,193	46,509,845	46,696,106	298,302,026	105,449,368	66,370,265	66,176,548	66,663,236	928,152,119	77,346,010
Total Current Year Surplus (Deficit)	(2,833,707)	(17,258,621)	1,477,734	3,072,332	19,076,693	12,465,007	5,192,862	7,881,292	85,128,613	9,397,333	(21,006,843)	107,354,808	209,947,503	17,495,625
Total Claims Payable	884,509,979	911,448,691	890,651,592	852,864,933	830,533,762	775,002,932	770,859,204	759,273,827	639,166,969	601,722,478	648,998,299	613,302,418	613,302,418	764,861,257
Total Fund Balance	1,244,769,003	1,227,510,382	1,228,988,116	1,232,060,447	1,251,137,140	1,263,602,149	1,268,795,012	1,276,676,303	1,361,804,917	1,371,202,250	1,350,195,407	1,457,550,213	1,457,550,213	1,294,524,278
Reserved Funds														
State Financial Performance Guarantee	1,092,899,000	1,093,798,000	1,096,923,000	1,100,211,000	1,102,840,000	1,046,032,000	1,049,745,000	1,091,605,000	1,119,293,000	1,130,765,000	1,143,805,000	1,121,915,000	1,121,915,000	1,099,152,583
Board Approved Capital and Infrastructure Purchases	79,941,518	79,360,193	77,250,794	76,202,434	75,447,816	73,742,888	72,667,651	71,478,836	70,124,244	66,296,695	66,344,624	63,186,278	63,186,278	72,670,331
Capital Assets	134,500,819	148,731,129	150,227,245	152,420,562	152,556,243	152,888,655	154,088,260	154,631,556	155,340,379	157,165,923	157,852,579	160,862,612	160,862,612	152,605,497
Strategic Use of Reserve-Board Approved	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668
Unrestricted Fund Balance	(133,575,002)	(165,381,608)	(166,415,591)	(167,776,217)	(150,709,587)	(80,064,063)	(78,708,568)	(112,041,757)	(53,955,374)	(54,028,036)	(88,809,464)	40,583,655	40,583,655	(100,906,801)
Fund Balance as % of Reserved Funds	90.31%	88.13%	88.07%	88.01%	89.25%	94.04%	94.16%	91.93%	96.19%	96.21%	93.83%	102.86%	102.86%	92.77%
Current Ratio (including Required Reserves)	1.45:1	1.41:1	1.40:1	1.40:1	1.40:1	1.39:1	1.41:1	1.37:1	1.44:1	1.45:1	1.43:1	1.48:1	1.48:1	1.42:1
Medical Loss Ratio w/o Tax	96.95%	99.19%	95.38%	94.54%	91.58%	92.82%	93.91%	93.33%	81.83%	93.12%	99.57%	76.84%	92.00%	92.00%
Admin Ratio w/o Tax	3.65%	4.56%	4.31%	4.81%	4.29%	4.55%	4.99%	4.96%	3.68%	5.10%	4.39%	4.56%	4.48%	4.48%
Profit Margin Ratio	-0.60%	-3.76%	0.31%	0.65%	4.13%	2.63%	1.10%	1.71%	14.49%	1.78%	-3.97%	18.60%	3.52%	3.52%

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Membership and Financial Summary
For The Period Ending April 30, 2026

CURRENT MONTH	PRIOR MONTH	INC / DEC	MEMBERSHIP SUMMARY	CURRENT YTD AVG	PRIOR YTD AVG	VARIANCE
862,120	869,706	(7,586)	**Total Membership**	887,819	900,812	(12,993)

ACTUAL MONTH	BUDGET MONTH	$ VARIANCE MONTH	FINANCIAL SUMMARY	ACTUAL YTD	BUDGET YTD	$ VARIANCE YTD
584,419,840	630,257,112	(45,837,272)	**Total Revenue**	5,960,133,466	6,444,539,207	(484,405,741)
497,005,879	544,184,238	47,178,359	**Total Healthcare Costs**	5,024,545,294	5,518,132,386	493,587,092
29,267,043	34,870,547	5,603,504	**Total Administrative Costs**	256,945,784	319,243,543	62,297,759
64,257,297	66,501,448	2,244,151	**Medi-Cal Managed Care Tax**	652,289,738	665,908,987	13,619,249
(6,110,379)	**(15,299,121)**	**9,188,742**	**Total Current Year Surplus (Deficit)**	**26,352,650**	**(58,745,709)**	**85,098,359**

ACTUAL MONTH	BUDGET MONTH			ACTUAL YTD	BUDGET YTD	
95.55%	96.53%		**Medical Loss Ratio (HC Costs as a % of Rev, excluding Managed Care Tax)**	94.66%	95.49%	
5.63%	6.19%		**Admin Ratio (Admin Costs as a % of Rev, excluding Managed Care Tax)**	4.84%	5.52%	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of April 30, 2026

	April 2026	March 2026
A S S E T S		
Current Assets		
Cash & Cash Equivalents	**990,206,181**	**1,512,648,196**
Receivables		
Accrued Interest	384,800	1,172,500
State DHS - Cap Rec	1,599,416,471	1,499,298,122
Other Healthcare Receivable	47,450,036	43,089,039
Miscellaneous Receivable	6,264,075	6,232,740
Total Receivables	**1,653,515,382**	**1,549,792,401**
Other Current Assets		
Payroll Clearing	(2,843)	(1,463)
Prepaid Expenses	17,048,778	16,142,936
Total Other Current Assets	**17,045,935**	**16,141,473**
Total Current Assets	**2,660,767,498**	**3,078,582,070**
Non-Current Assets		
Fixed Assets		
Motor Vehicles	1,096,330	1,096,330
Furniture & Fixtures	7,701,728	7,701,728
Computer Equipment	22,832,149	21,552,145
Computer Software	9,060,595	9,048,571
Leasehold Improvements	124,288	124,288
Land	11,330,439	11,330,439
Building	79,474,549	79,474,549
Building Improvements	46,822,607	46,107,883
Accum Depr - Motor Vehicles	(578,014)	(562,987)
Accum Depr - Furniture	(6,786,618)	(6,767,303)
Accum Depr - Comp Equipment	(19,805,304)	(19,044,299)
Accum Depr - Comp Software	(9,015,479)	(8,989,896)
Accum Depr - Leasehold Improvements	(124,288)	(124,288)
Accum Depr - Building	(15,908,322)	(15,738,505)
Accum Depr - Bldg Improvements	(18,441,686)	(18,098,835)
Construction Work-In-Progress	59,759,494	60,934,285
Total Fixed Assets	**167,542,468**	**168,044,105**
Other Non-Current Assets		
Deposits	83,280	83,280
Board-Designated Reserves	1,262,177,275	1,264,479,236
Knox-Keene Reserves	300,000	300,000
Prepaid - Other Non-Current	9,073,573	9,354,099
Net Pension Asset	5,714,523	5,714,523
Deferred Outflows Of Resources	2,745,009	2,745,009
Net Subscription Asset	3,120,175	3,120,175
Total Other Non-Current Assets	**1,283,213,835**	**1,285,796,322**
Total Non-Current Assets	**1,450,756,303**	**1,453,840,427**
Total Assets	**4,111,523,801**	**4,532,422,497**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of April 30, 2026

	April 2026	March 2026
L I A B I L I T I E S & F U N D B A L A N C E		
Liabilities		
Current Liabilities		
Accounts Payable	251,861,655	378,497,815
Unearned Income	51,882,426	52,470,131
Suspense Account	11,252,121	15,600,034
Capitation Payable	7,720,702	6,840,525
State DHS - Cap Payable	32,633,113	32,633,113
Accrued Healthcare Costs	1,495,127,170	1,802,345,555
Claims Payable	291,787,634	165,123,996
Incurred But Not Reported-IBNR	354,817,806	461,169,652
Quality Improvement Programs	121,202,690	118,392,813
Total Current Liabilities	**2,618,285,317**	**3,033,073,634**
Non-Current Liabilities		
Deferred Inflows Of Resources	6,657,637	6,657,637
Net Subscription Liability	2,677,984	2,677,984
Total Non-Current Liabilities	**9,335,621**	**9,335,621**
Total Liabilities	**2,627,620,938**	**3,042,409,255**
Fund Balance		
Unrestricted Fund Balance	**(14,494,548)**	**(11,187,767)**
Reserved Funds		
State Financial Performance Guarantee	1,173,987,000	1,175,457,000
Board Approved Capital and Infrastructure Purchases	88,490,275	89,322,236
Capital Assets	167,542,468	168,044,105
Strategic Use of Reserve-Board Approved	68,377,668	68,377,668
Total Reserved Funds	**1,498,397,411**	**1,501,201,009**
Total Fund Balance	**1,483,902,863**	**1,490,013,242**
Total Liabilities And Fund Balance	**4,111,523,801**	**4,532,422,497**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Statement of Cash Flow

For The Period Ending April 30, 2026

	Current Month Activity	Year-To-Date Activity
CASH FLOWS FROM OPERATING ACTIVITIES:		
Cash Received From:		
Capitation from California Department of Health Care Services	475,336,121	6,101,950,102
Other Revenues	195,422	2,466,783
Cash Payments to Providers for Medi-Cal Members		
Capitation Payments	(20,595,795)	(206,868,712)
Medical Claims Payments	(761,978,387)	(4,741,739,886)
Drug Medi-Cal		
DMC Receipts from Counties	1,341,978	55,075,747
DMC Payments to Providers	(5,778,316)	(54,313,915)
Cash Payments to Vendors	(196,980,563)	(862,452,203)
Cash Payments to Employees	(23,869,035)	(207,284,917)
Net Cash (Used) Provided by Operating Activities	**(532,328,575)**	**86,832,999**
CASH FLOWS FROM CAPITAL FINANCING & RELATED ACTIVITIES:		
Purchases of Capital Assets	(1,357,776)	(14,502,501)
Net Cash (Used) by Capital Financial & Related Activities	**(1,357,776)**	**(14,502,501)**
CASH FLOWS FROM INVESTING ACTIVITIES:		
Board-Designated Reserve Transfers	2,301,961	(77,375,997)
Interest and Dividends on Investments	8,942,375	77,642,744
Net Cash Provided by Investing Activities	**11,244,336**	**266,747**
NET (DECREASE) INCREASE	**(522,442,015)**	**72,597,245**
CASH & CASH EQUIVALENTS, BEGINNING	**1,512,648,196**	**917,608,936**
CASH & CASH EQUIVALENTS, ENDING	**990,206,181**	**990,206,181**

RECONCILIATION OF TOTAL OPERATING LOSSTO NET CASH (USED) PROVIDED BY OPERATING ACTIVITIES

	Current Month Activity	Year-To-Date Activity
TOTAL OPERATING LOSS	**(14,265,054)**	**(50,711,394)**
DEPRECIATION	**1,333,597**	**6,670,489**
CHANGES IN ASSETS AND LIABILITIES:		
Other Receivables	(4,392,332)	11,086,089
California Department of Health Services Receivable	(100,118,349)	155,493,084
Other Assets	(98,121)	(1,570,246)
Accounts Payable and Accrued Expenses	(437,909,985)	(109,030,866)
Accrued Claims Payable	20,311,793	33,303,023
Quality Improvement Programs	2,809,876	41,592,820
Net Cash (Used) Provided by Operating Activities	**(532,328,575)**	**86,832,999**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Statement of Revenues and Expenses

For The Period Ending April 30, 2026

****The Notes to the Financial Statement are an Integral Part of this Statement****

ACTUAL MONTH	BUDGET MONTH	$ VARIANCE MONTH	ACTUAL MONTH PMPM	BUDGET MONTH PMPM		ACTUAL YTD	BUDGET YTD	$ VARIANCE YTD	ACTUAL YTD PMPM	BUDGET YTD PMPM
862,120	**862,120**	**-**			**TOTAL MEMBERSHIP**	**8,878,192**	**8,878,192**	**-**		
					REVENUE					
575,454,042	623,409,012	(47,954,970)	667.49	723.11	State Capitation Revenue	5,876,402,973	6,375,231,387	(498,828,414)	661.89	718.08
8,154,675	6,639,370	1,515,305	9.46	7.70	Interest Income	77,064,044	67,278,940	9,785,104	8.68	7.58
811,123	208,730	602,393	0.94	0.24	Other Revenue	6,666,450	2,028,880	4,637,570	0.75	0.23
584,419,840	**630,257,112**	**(45,837,272)**	**677.89**	**731.05**	**TOTAL REVENUE**	**5,960,133,466**	**6,444,539,207**	**(484,405,741)**	**671.32**	**725.89**
					HEALTHCARE COSTS					
					Physician Services					
9,255,567	9,391,885	136,318	10.74	10.89	Pcp Capitation	89,356,973	96,569,848	7,212,875	10.06	10.88
198,897	206,937	8,040	0.23	0.24	Specialty Capitation	2,100,799	2,085,035	(15,764)	0.24	0.23
85,231,308	84,108,780	(1,122,528)	98.86	97.56	Non-Capitated Physician Services	898,896,426	828,552,978	(70,343,448)	101.25	93.32
94,685,772	**93,707,602**	**(978,170)**	**109.83**	**108.69**	**Total Physician Services**	**990,354,198**	**927,207,861**	**(63,146,337)**	**111.55**	**104.43**
					Inpatient Hospital					
16,429,328	15,908,829	(520,499)	19.06	18.45	Hospital Capitation	168,862,736	166,402,911	(2,459,825)	19.02	18.74
110,709,015	112,369,857	1,660,842	128.41	130.34	Inpatient Hospital - Ffs	1,105,375,866	1,152,420,275	47,044,409	124.50	129.80
790,140	790,140	-	0.92	0.92	Hospital Stoploss	8,086,301	8,086,301	-	0.91	0.91
127,928,483	**129,068,826**	**1,140,343**	**148.39**	**149.71**	**Total Inpatient Hospital**	**1,282,324,903**	**1,326,909,487**	**44,584,584**	**144.43**	**149.45**
59,375,298	60,963,541	1,588,243	68.87	70.71	Long Term Care	608,306,175	613,127,547	4,821,372	68.52	69.06
					Ancillary Services					
1,275,282	1,297,813	22,531	1.48	1.51	Ancillary Services - Capitated	12,211,941	13,412,499	1,200,558	1.38	1.51
104,230,628	98,284,342	(5,946,286)	120.90	114.00	Ancillary Services - Non-Capitated	1,064,273,289	1,001,309,525	(62,963,764)	119.88	112.78
105,505,910	**99,582,155**	**(5,923,755)**	**122.38**	**115.51**	**Total Ancillary Services**	**1,076,485,230**	**1,014,722,024**	**(61,763,206)**	**121.26**	**114.29**
					Other Medical					
6,261,753	8,393,253	2,131,500	7.26	9.74	Quality Assurance	59,274,849	75,671,757	16,396,908	6.68	8.52
82,922,470	132,286,973	49,364,503	96.18	153.44	Healthcare Investment Funds	799,272,728	1,355,917,796	556,645,068	90.03	152.72
115,500	151,560	36,060	0.13	0.18	Advice Nurse	1,222,500	1,439,830	217,330	0.14	0.16
13,149,280	12,968,915	(180,365)	15.25	15.04	Transportation	134,840,996	130,672,369	(4,168,627)	15.19	14.72
102,449,003	**153,800,701**	**51,351,698**	**118.82**	**178.40**	**Total Other Medical**	**994,611,073**	**1,563,701,752**	**569,090,679**	**112.04**	**176.12**
7,061,413	7,061,413	-	8.19	8.19	Quality Improvement Programs	72,463,715	72,463,715	-	8.16	8.16
497,005,879	**544,184,238**	**47,178,359**	**576.48**	**631.21**	**TOTAL HEALTHCARE COSTS**	**5,024,545,294**	**5,518,132,386**	**493,587,092**	**565.96**	**621.51**
					ADMINISTRATIVE COSTS					
17,412,501	22,177,527	4,765,026	20.20	25.72	Employee	161,285,706	203,544,736	42,259,030	18.17	22.93
95,152	201,064	105,912	0.11	0.23	Travel And Meals	850,027	1,910,282	1,060,255	0.10	0.22
2,090,676	3,342,790	1,252,114	2.43	3.88	Occupancy	13,880,331	26,871,650	12,991,319	1.56	3.03
655,317	956,246	300,929	0.76	1.11	Operational	6,576,492	9,083,920	2,507,428	0.74	1.02
4,754,613	3,461,288	(1,293,325)	5.52	4.01	Professional Services	37,182,537	32,882,398	(4,300,139)	4.19	3.70
4,258,784	4,731,632	472,848	4.94	5.49	Computer And Data	37,170,691	44,950,557	7,779,866	4.19	5.06
29,267,043	**34,870,547**	**5,603,504**	**33.96**	**40.44**	**TOTAL ADMINISTRATIVE COSTS**	**256,945,784**	**319,243,543**	**62,297,759**	**28.95**	**35.96**
64,257,297	66,501,448	2,244,151	74.53	77.14	**Medi-Cal Managed Care Tax**	652,289,738	665,908,987	13,619,249	73.47	75.01
(6,110,379)	**(15,299,121)**	**9,188,742**	**(7.08)**	**(17.74)**	**TOTAL CURRENT YEAR SURPLUS (DEFICIT)**	**26,352,650**	**(58,745,709)**	**85,098,359**	**2.94**	**(6.59)**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
NOTES TO FINANCIAL STATEMENTS
April 30, 2026

1. **ORGANIZATION**

The Partnership HealthPlan of California (the HealthPlan) was formed as a health insurance organization and is legally a subdivision of the State of California but is not part of any city, county or state government system. The HealthPlan has quasi-independent political jurisdiction to contract with the State for managing Medi-Cal beneficiaries who reside in various Northern California counties. The HealthPlan is a combined public and private effort engaged principally in providing a more cost-effective method of healthcare. The HealthPlan began serving Medi-Cal eligible persons in Solano County in May 1994. That was followed by additional Northern California counties in March 1998, March 2001, October 2009, two counties in July 2011, and eight counties in September 2013. Beginning July 2018 and in accordance with direction from the Department of Health Care Services (DHCS), the HealthPlan consolidated its reporting from these fourteen counties into two regions, which are in alignment with the two DHCS rating regions. Beginning January 2024, the HealthPlan expanded into ten additional counties, which comprise a third region.

As a public agency, the HealthPlan is exempt from state and federal income tax.

2. **SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES**

ACCOUNTING POLICIES:
The accounting and reporting policies of the HealthPlan conform to Generally Accepted Accounting Principles and general practices within the healthcare industry.

PROPERTY AND EQUIPMENT:
Effective July 2015, property and equipment totaling $10,000 or more are recorded at cost; this includes assets acquired through capital leases and improvements that significantly add to the productive capacity or extend the useful life of the asset. Costs of maintenance and repairs are expensed as incurred. Depreciation for financial reporting purposes is provided on a straight-line method over the estimated useful life of the asset. The costs of major remodeling and improvements are capitalized as building or leasehold improvements. Leasehold improvements are amortized using the straight-line method over the shorter of the remaining term of the applicable lease or their estimated useful life. Building improvements are depreciated over their estimated useful life.

INVESTMENTS:
The HealthPlan investments can consist of U.S. Treasury Securities, Certificates of Deposits, Money Market and Mutual Funds, Government Pooled Funds, Agency Notes, Repurchase

Agreements, Shares of Beneficial Interest and Commercial Paper and are carried at fair value.

RESERVED FUNDS:
As of April 2026, the HealthPlan has Total Reserved Funds of $1.5 billion. This includes $68.4 million of funds set aside for Board approved Strategic Use of Reserve (SUR) initiatives; this also includes funding for the Wellness & Recovery program. The total SUR amount represents the net amount remaining for all SUR projects that have been approved to date and is periodically adjusted as projects are completed. Reserved Funds also includes $0.3 million of Knox-Keene Reserves.

RECLASSIFICATIONS:
Certain reclassifications of prior period balances have been made to conform with the current period presentations. Such reclassifications do not affect the total increase in net position or total current or noncurrent assets or liabilities.

3. STATE CAPITATION REVENUE

Medi-Cal capitation revenue is based on the monthly capitation rates, as provided for in the State contract, and the actual number of Medi-Cal eligible members. Capitation revenues are paid by the State on a monthly basis in arrears based on estimated membership. As such, capitation revenue includes an estimate for amounts receivable from or refundable to the State for projected changes in membership and trued up monthly through a State reconciliation process. These estimates are continually monitored and adjusted, as necessary, as experience develops or new information becomes known.

4. HEALTHCARE COST

The HealthPlan continues to develop completion factors to calculate estimated liability for claims Incurred But Not Reported. These factors are reviewed and adjusted as more historical data becomes available. Budgeted capitation revenues and healthcare costs are adjusted each month to reflect changes in enrollee counts.

5. QUALITY IMPROVEMENT PROGRAM

The HealthPlan maintains quality improvement contracts with acute care hospitals and primary care physicians. As of April 2026, the HealthPlan has accrued a Quality Improvement Program payout of $121.2 million.

6. ESTIMATES

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
NOTES TO FINANCIAL STATEMENTS
April 30, 2026

Due to the nature of the operations of the HealthPlan, it is necessary to estimate amounts for financial statement presentation. Substantial overstatement or understatement of these estimates would have a significant impact on the statements. The items estimated through various methodologies are:

- Value of Claims Incurred But Not Reported
- Quality Incentive Payouts
- Earned Capitation Revenues
- Total Number of Members
- Retro Capitation Expense for Certain Providers

7. COMMITMENTS AND CONTINGENCIES

In the ordinary course of business, the HealthPlan is party to claims and legal actions by enrollees, providers, and others. After consulting with legal counsel, the HealthPlan's Management is of the opinion that any liability which may ultimately be incurred as a result of claims or legal actions will not have a material effect on the financial position or results of the operations of the HealthPlan.

8. UNUSUAL OR INFREQUENT ITEMS REPORTED IN CURRENT MONTH'S FINANCIAL STATEMENTS

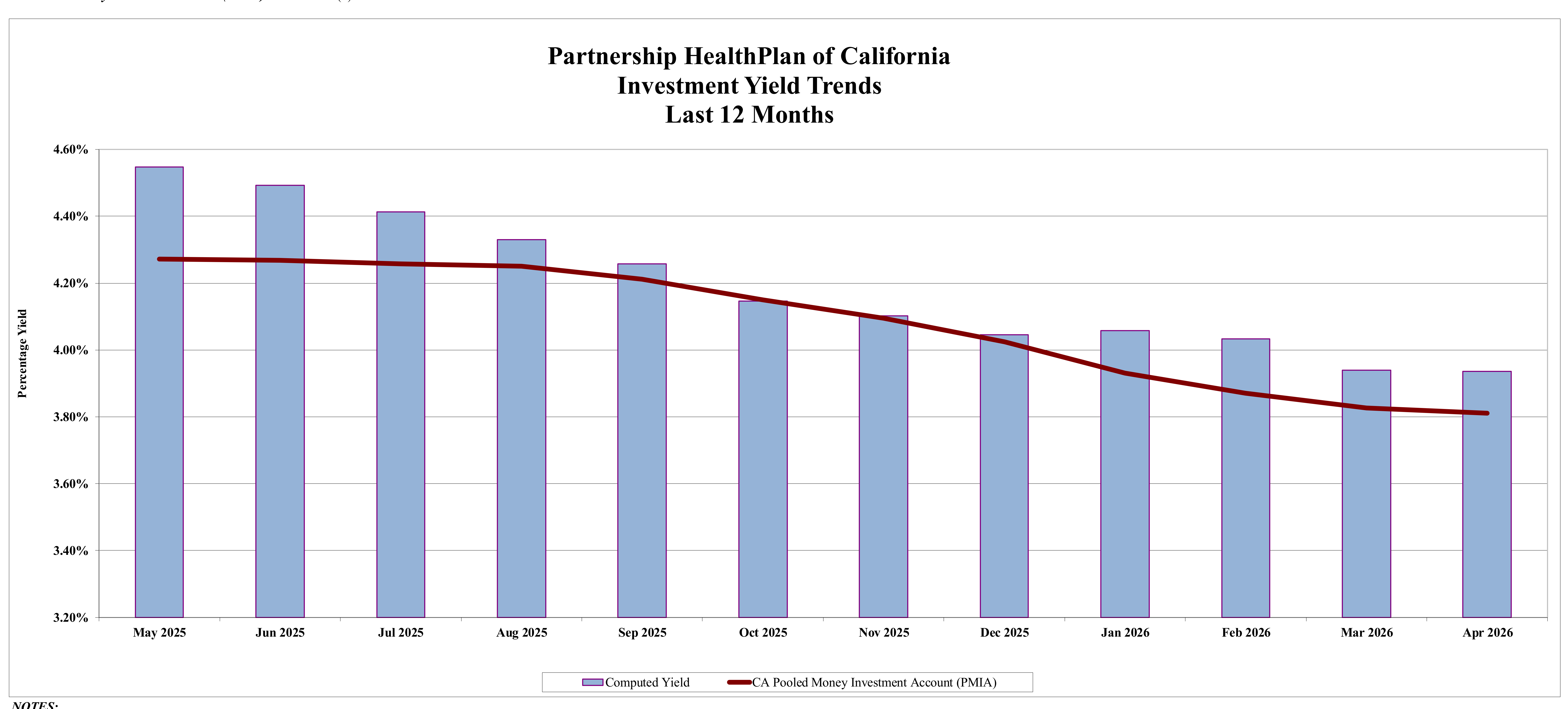
None noted.

Partnership HealthPlan of California
Investment Schedule
April 30, 2026

Name of Investment	Investment Type	Yield to Maturity	Trade Date	Maturity Date	Call Date	Face Value	Purchase Price	Market Value	Credit Rating Agency	Credit Rating
FUNDS HELD FOR INVESTMENT:										
Highmark Money Market	Cash & Cash Equiv	NA	Various	NA	NA	NA	$ 1,828,645	$ 1,828,645	NA	NR
Certificate of Deposit for Knox Keene	Cash & Cash Equiv	0.0405	1/31/2025	1/30/2030	NA	$ 300,000	$ 300,000	$ 300,000	NA	NR
FUNDS HELD FOR OPERATIONS:										
Merrill Lynch Institutional	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 81,337,228		
Merrill Lynch MMA - Checking	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 702,102		
US Bank - General, MMA, and Sweeps	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 2,046,756,502		
Government Investment Pools (LAIF)	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 75,000,000		
Government Investment Pools (County)	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 46,607,450		
West America Payroll	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 148,229		
Petty Cash	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 3,300		
GRAND TOTAL:								$ 2,252,683,456		

Partnership HealthPlan of California
Investment Yield Trends

PERIOD		May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026
Interest Income		7,671,506	7,390,920	7,568,557	7,456,341	7,941,176	8,116,523	6,918,278	7,880,097	8,365,738	6,897,186	7,765,472	8,154,675
Cash & Investments at Historical Cost	(1)	2,207,098,027	2,102,710,214	2,160,202,257	2,286,589,057	2,474,845,534	2,254,168,286	2,239,590,881	2,602,840,892	2,355,098,087	2,373,599,880	2,777,427,432	2,252,683,455
Computed Yield	(2)	4.55%	4.49%	4.41%	4.33%	4.26%	4.15%	4.10%	4.05%	4.06%	4.03%	3.94%	3.94%
CA Pooled Money Investment Account (PMIA)	(3)	4.27%	4.27%	4.26%	4.25%	4.21%	4.15%	4.10%	4.03%	3.93%	3.87%	3.83%	3.81%



NOTES:

(1) Investment balances include Restricted Cash and Board Designated Reserves

(2) Computed yield is calculated by dividing the past 12 months of interest by the average cash balance for the past 12 months.

(3) LAIF limits the amount a single government entity can deposit into LAIF; currently that amount is set at $75 million.

COO Board Report

Wendi Davis

June 2026

I am pleased to provide you with an update on the recent activities and initiatives undertaken by our operations teams over the past few months. Our focus remains on enhancing member and provider engagement, benefit and process improvement implementation and ensuring that our services are effectively aligned with the needs of our community.

Our operations teams have been actively collaborating with stakeholders and community partners to implement proactive measures that support our members in retaining their Medi-Cal coverage and familiarizing themselves with their benefits. Efforts are being made to offer easy to understand interpretations of new requirements that are currently in effect and also preparing members for anticipated guidelines due to go into effect in the near future. We have engaged in a variety of outreach initiatives, including webinars, in-person informative sessions, call campaigns, text notifications, and promotional efforts aimed at raising awareness about the need for members to take action. We are also providing resources for members to reach out for more assistance.

In addition, our team has leveraged the strengths of our Community Advisory Committee (CAC), which is comprised of nearly 40 member representatives from diverse communities across our 24-county footprint. The CAC members not only participate in regular meetings but also accompany our team members at community events, and membership informative sessions offering valuable insights from the members' perspective on various topics. Our Communication department solicited suggestions and recommendations on the changes being proposed with the Partnership public website and the team plans to share updates as the work continues. Information was shared with the CAC on several important issues, including the details of the Community Reinvestment APL including the program guidelines and project ideas, a review of cultural and linguistic services, and updates on our collaborative efforts with various counties regarding our CHA/CHIP programs. The insights gathered will inform our strategies to address service gaps and health disparities.

Our engagement with the provider network has been notably intensified as we prepare for our transition to a new claims processing system. Our team members have been proactively reaching out to share the outcomes of live provider claim submissions currently being tested within our new system. We provide individualized feedback on claim rejections, denials, and payment variances, along with detailed instructions to help providers mitigate any negative outcomes. A summarized claims scorecard based on projected future outcomes is regularly shared with providers to keep them informed of their claim performance. In cases where we do not receive responses, our teams are escalating these matters to senior leaders at each facility to ensure visibility and prompt resolution.

COO Board Report

Wendi Davis

June 2026

As our new claims system is set to offer enhanced functionality and accuracy, we anticipate that providers could notice differences in the results of their claim submissions compared to the traditional methods they have r. To facilitate received with our legacy system. We are offering training sessions and best practice recommendations through webinars, in-person workshops, and one-on-one visits to provider locations. These support efforts will extend beyond our go-live date to ensure that providers receive the assistance they require.

Partnership remains committed to being a steadfast presence in our communities, providing personalized support and training to those we serve. We understand the importance of fostering strong relationships with our members and partners, and we will continue to prioritize these efforts as we move forward.

Partnership Board Legislative Update

June 2026

Bills of Interest

AB 1682 (Hart) Health care coverage: scalp cooling

Requires a health plan, health insurer, and the Medi-Cal program, to provide coverage for scalp cooling, as prescribed by a health care provider in connection with chemotherapy for persons with cancer. Requires cost-sharing for scalp cooling to be no less favorable to an enrollee than cost-sharing for oncology supportive care services. Defines "scalp cooling" as the use of a medical device or system cleared by the federal Food and Drug Administration (FDA) applied to the scalp before, during, or after the administration of chemotherapy to reduce the incidence or severity of chemotherapy-induced alopecia (hair loss). The California Association of Health Plans (CAHP) is opposed.

AB 1811 (Rogers) Health professional shortage areas

This bill would define the term “health professional shortage area” to mean (1) an area determined by the Department of Health Care Access and Information to have a shortage of health professionals, (2) a health professional shortage area designated or recognized by the United States Department of Health and Human Services, or (3) an area designated or recognized as a health professional shortage area by the United States Department of Health and Human Services on January 1, 2025, regardless of whether that area remains designated or recognized by the US HHS as a health professional shortage area.

AB 1906 (Aguiar-Curry) Health care coverage: cervical cancer home test kits

Requires a health plan, health insurer, and the Medi-Cal program to cover cervical cancer screening home kits at zero cost sharing, upon referral of a patient's health care provider. CAHP is opposed.

AB 1979 (Bonta) Health care services: artificial intelligence

Requires a health facility, clinic, physician's office, or office of a group practice to ensure that no clinical decision is based solely on the output of a clinical decision support system (CDSS) and that a licensed health care professional exercises independent professional judgment when reviewing and approving a clinical decision that is based on the output of a CDSS. Specifies that this bill does not prohibit the use of artificial intelligence (AI) for documentation and communication that does not involve the application of professional judgment, including automated messages to inform patients of updates to their health records. Clarifies, for the purposes of the Confidentiality of Medical Information Act (CMIA) that a business that offers a healthcare chatbot to a consumer is a provider of health care subject to the requirements of the CMIA. CAHP is opposed.

AB 2160 (Rodriguez) Medi-Cal: Lactation Service

This bill directs the DHCS to issue updated guidance by July 1, 2027, clarifying Medi-Cal coverage for lactation services to improve access to lactation supports and breast pumps for low-income beneficiaries. The guidance must define a continuum of services—including lactation health education, basic lactation support, and clinical lactation consultation—and be developed with stakeholder input on the draft. Implementation is conditional on

availability of federal financial participation. Partnership has already deployed many of these provisions, but LHPC is opposed unless amended.

AB 2348 (Bonta) Medi-Cal: Community Supports (CS)
The bill would authorize MCPs to continue to cover CSs approved by DHCS as cost effective and medically appropriate. Under the bill, continued coverage would commence on January 1, 2027, would be conditioned on the availability of federal financial participation, and would be set forth as part of a CalAIM successor program. The bill would require DHCS to publish quarterly report including CS utilization data. The bill would require DHCS to provide ongoing technical assistance to MCPs and providers of CS to enhance the ability to effectively provide these services. The bill would require DHCS to produce a model Evidence of Coverage document that contains comprehensive and detailed instructions on model eligibility and coverage policies, and to develop related policies for each community support provided. The bill would require DHCS to solicit and accept feedback in developing the Evidence of Coverage document. Would also require MCPs to track and report to DHCS the number and percentage of their providers that are community providers and would define "community provider" for these purposes. LHPC is opposed unless amended and is seeking significant amendments.

AB 2551 (Elhawary) Behavioral health care coverage
Requires health plans regulated by the Department of Managed Health Care and subject to Knox Keene licensing, to collect data and report on the number of enrollees and insureds seeking out-of-network behavioral health (BH) care. Expands existing licensing board reporting requirements to include whether a licensee and registrant contracts with a health plan or health insurer to provide services. CAHP is opposed to this bill, stating that it would require new annual surveys and reporting on out-of-network BH care, adding to existing oversight requirements, network adequacy standards, timely access rules, and ongoing reporting.

AB 2575 (Ortega) Health care services: artificial intelligence
Requires a health facility, clinic, physician's office, or office of a group practice that uses or deploys a clinical decision support system (CDSS) for patient care to disclose required information to any licensed health care professional. Requires the disclosure to include a notice that a worker providing direct patient care is authorized to override the output of a CDSS if an override is appropriate for the patient, or as necessary to meet the applicable standard of care or to comply with the law. Prohibits an employer from retaliating or discriminating against a worker providing patient care based solely on the worker's override of the output of a CDSS. Authorizes a worker who is subject to retaliation or discrimination in violation of this bill to file a complaint with the Labor Commissioner against an employer. Prohibits a defendant who developed, modified, selected, or deployed a CDSS that is alleged to have harmed a plaintiff from asserting a defense that the failure of a licensed health care professional to override an output of the CDSS is a superseding cause severing the defendant's liability for the alleged harm.

AB 2613 (Sharp-Collins) Health care service plans: provider contract termination: notice
For health plans regulated by the Department of Managed Health Care and subject to Knox Keene licensing, this bill requires a health plan to send written notice via text message or email, in addition to U.S. mail, to an affected enrollee at least 60 days before the termination date of a contract between the health plan and a provider group or a general acute care hospital. If, after sending the notice, the health plan reaches an

agreement to continue the contract with the provider group or hospital, this bill requires the health plan to notify the enrollee within 60 days by U.S. mail and either text message or email. LHPC is opposed unless amended.

AB 2756 (Ahrens) Medi-Cal: vision services: performance measures
This bill would require the DHCS, by January 1, 2028, to establish a list of performance measures (PMs) to ensure that the vision services under the Medi-Cal program meet quality and access criteria. The bill would require that the performance measures be designed to evaluate utilization, access, and availability of Medi-Cal vision services. It would also require certain information related to providers and exams be included within the PMs. The bill would require DHCS to include trended data and other state performance and quality measures. The bill would require DHCS to report on each PM only to the extent that it has existing data sources from which to calculate the applicable measure and specify a timeline for the posting PMs on DHCS' website. The bill would also require DHCS to establish benchmarks for each PM and to annually prepare a summary report on complaints and grievances. Local Health Plans of California (LHPC) is opposed unless amended.

SB 874 (Weber Pierson) Behavioral health treatment (BHT) workgroup.
This bill would require DHCS to ensure that certain individuals providing BHT services under Medi-Cal undergo background checks before 7/1/2027. DHCS would be required to convene a stakeholder workgroup made up of BHT providers, MCPs, and consumers with autism to review the implementation of BHT services in Medi-Cal and advise on clinical guidelines for the provision of BHT services, and treatment plan requirement.

SB 1002 (Niello) Out-of-state physicians and surgeons: telehealth: license exemption
Proposes allowing out-of-state physicians to practice telehealth without a California license for patients with life-threatening conditions, including those in remission. It removes the clinical trial participation requirement for such patients, enabling continued care with previously established physicians regardless of trial eligibility.

SB 1049 (Weber Pierson) Health care claims reimbursement
For health plans regulated by the Department of Managed Health Care and subject to Knox Keene licensing, this bill provides a 90-day opportunity for a health care provider to submit a corrected claim if a health plan or insurer denies a claim or sends a notice of overpayment based on a defect that may be remedied by submitting a corrected claim. CAHP is opposed, and LHPC is opposed unless amended.

H.R.1 Implementation Bills

AB 2161 (Bonta) Medi-Cal: redeterminations and work or community engagement
During county redeterminations, AB 2161 would expand the form delivery mechanisms to include the telephone, online, or commonly available electronic means, including specified methods of signatures, and to adopt regulations by July 1, 2028. The bill would require DHCS, before verifying an individual's application, to ensure and confirm that systems are programmed to maintain coverage with minimal data request to a beneficiary. *For beneficiaries who cannot be deemed compliant via ex parte review, the bill requires counties to request a Medi-Cal managed care plan to provide any data that will verify that a beneficiary is exempted or meets the requirements before requesting information directly from the beneficiary*. AB 2161 would not apply every 6-month redeterminations on *"individuals whose Medicaid eligibility is not specifically required by federal law."* LHPC is opposed unless amended.

AB 2201 (Boerner) Medi-Cal: eligibility redetermination
During annual and semi-annual redeterminations, this bill would require the county to verify countable income and assets without requesting additional verification information or documentation if any of specified sets of conditions are met, relating to certain financial data sources. Implementation would be subject to an appropriation by the Legislature.

AB 2208 (Stefani) Medi-Cal: cost sharing, retroactivity, and accessibility
This bill would preserve the ability of Medi-Cal enrollees to apply for up to three months of retroactive Medi-Cal coverage despite changes included in H.R.1. The bill would implement $.01 cost-sharing for non-emergency services, for specified Medi-Cal populations; and, makes a number of changes to improve the usability of smart phones and devices for the state's Medi-Cal application, and conforms the application process to new eligibility requirements under federal law.

AB 2368 (Bonta) Indigent health care: information and planning
Requires DHCS, by July 1, 2027, to establish an internet website where the public can access specified information on safety-net health care services in the state, including: all eligibility requirements; cost of services; telephone number to reach the appropriate county program administrator; a hyperlink or URL for each county internet website related to safety-net services or medically indigent programs; and any other information or resources that will assist an individual seeking information about accessing medically indigent health care services. Requires each county to prepare and submit to DHCS a plan to operate programs to provide health care to medically indigent individuals.

SB 1202 (Weber Pierson) Medi-Cal: dashboard and outreach
This bill would require DHCS to establish a public facing dashboard that provides data on applications, enrollment, redeterminations, disenrollments, and terminations, stratified by county and demographic data including age, race, ethnicity, language, and gender related to the impact of H.R.1 on Medi-Cal eligibility and enrollment. The bill would require the dashboard to track and report on the specific data for work or community engagement requirements and exemptions. The bill would require DHCS to operationalize the dashboard and to post the information on a monthly basis in a downloadable format. The bill would require DHCS to undertake efforts to conduct outreach about work requirements, more frequent redeterminations, and changes to retroactive eligibility to impacted Medi-Cal beneficiaries, and to conduct listening sessions. Outreach and education would be coordinated across public social services programs to help minimize barriers to administrative disenrollments and require counties to make a good faith effort to collaborate with CBOs.

Requires a Medi-Cal managed care plan to establish and conduct an outreach and education plan for its enrollees about work or community engagement guidelines. Requires such a plan to address specified issues, including beneficiary rights, local resources, and information on maintaining Medi-Cal eligibility. Requires such a plan to be informed by stakeholder input, best practices issued by DHCS, and the Medi-Cal managed care plan's Population Needs Assessment, and to meet cultural and linguistic appropriateness standards. LHPC is opposed unless amended.

Public Health Bills

AB 2667 (Hadwick) Vape products: household hazardous waste: advertising
Requires the Department of Toxic Substances Control (DTSC) to evaluate opportunities for the safe management of vape pens confiscated from students at a school. Authorizes household hazard waste (HHW) facilities to mechanically disassemble vapes so that those facilities may separately process the components of the vapes. Prohibits anyone from selling, marketing, advertising, or distributing a vape product if the vape product imitates a food marketed to minors, such as candy; if the vape imitates school supplies commonly used by minors; uses branding that is known to appeal to minors; or, if the vape is constructed into clothing or accessories that could be marketed to minors.

AB 2346 (Wilson) Vehicles: electric bicycles and speed limits.
Sets speed limits for electric bicycles (e-bikes) and bicycle paths, requires certain disclosures when selling an e-bike, and requires all e-bikes to have a speedometer and integrated lights. The bill, 1) prohibits a person under the age of 16 from riding an electric bicycle at a speed greater than 15 miles per hour (mph). 2) Authorizes local authorities to set speed limits on bicycle paths of 20 or 15 mph and on multiuse trails at 20, 15 or 10 mph. 3) Sets a prima facia speed limit of 10 mph on sidewalks and specifies that a violation of this provision does not result in a negligent operator point. 4) Requires manufacturers and distributors of electric bikes to apply a permanent label to each electric bike specifying the classification number, top assisted speed, and motor wattage of the electric bicycle, in Arial font in at least 9-point type. The California Medical Association is sponsoring this bill.

News Updates June 2026

Partnership Press Releases:

Your Partner in Health: Finding the Facts on Childhood Immunizations
Partnership HealthPlan of California – Teresa Frankovich, MD
June 9, 2026
This may be the most challenging time in history for parents to make informed decisions about their child's immunizations.

Partnership Announces Winners of 2026 Member Scholarships
Partnership HealthPlan of California
June 1, 2026
Partnership HealthPlan of California is proud to announce the winners of the 2026 Member Scholarship Program, which supports Medi-Cal recipients pursuing careers in health care, social service, and public service.

Nourish & Flourish Brings Free Health Services to the Redding Farmers Market
Partnership HealthPlan of California
May 27, 2026
Partnership HealthPlan of California is bringing Nourish & Flourish to the Redding Farmers Market on Saturday, May 30, 2026, from 7:30 a.m. to noon at 777 Cypress Ave., Redding.

Partnership Welcomes the Inaugural Cohort of the Partnership Clinic Leadership Academy
Partnership HealthPlan of California and Healthforce Center at UCSF
May 12, 2026
Partnership HealthPlan of California has selected 34 participants for the inaugural cohort of the Partnership Clinic Leadership Academy.

Partnership Mentioned:

Ideas & Opinions – Dr. Teresa Frankovich: Finding the facts on childhood immunizations
The Union
June 10, 2026
This may be the most challenging time in history for parents to make informed decisions about their child's immunizations.

Business briefs | Partnership announces scholarships
The Times-Standard
June 7, 2026
Partnership HealthPlan of California is proud to announce the winners of the 2026 Member Scholarship Program, which supports Medi-Cal recipients pursuing careers in healthcare, social service, and public service.

News Updates
June 2026

Napa's Cope Family Center names Coats and Guerrero to board
Napa Valley Register
June 2, 2026
His career spans two decades in public accounting and nonprofit financial oversight, and he currently serves as the Director of Internal Audit for Partnership HealthPlan of California.

Adult Day Health Care of Mad River marks 40th year
Times Standard
May 26, 2026
Adult Day Health Care of Mad River also has a contract with Partnership Health Plan to provide respite services in the center for those who are covered by this Medi-Cal plan.

Partnership names members of 1st Leadership Academy
Daily Republic
May 14, 2026
Partnership HealthPlan of California has selected 34 participants for the inaugural Partnership Clinic Leadership Academy.

How this local health plan CEO navigates challenges of providing care
North Bay Business Journal / Press Democrat
April 26, 2026
Sonja Bjork remains upbeat even though overseeing a health plan that administers Medi-Cal benefits to nearly 900,000 people in Northern California is getting increasingly difficult.

- *Reprinted in **Ukiah Daily Journal,** April 28, 2026:* **How this local health plan CEO navigates challenges of providing care**

Napa's CHI hosts Cinco De Mayo party, honors Robles
Napa Valley Register
April 30, 2026
Siempre es Hoy! is sponsored by The Doctors Company, Gasser Foundation, Mechanics Bank, Partnership HealthPlan, Ag Health Benefits Alliance, Dr. Karen Smith, and Honoree Oscar Robles.

Chief Medical Officer Report

June 24, 2026

Kermit Jones, MD JD Deputy CMO

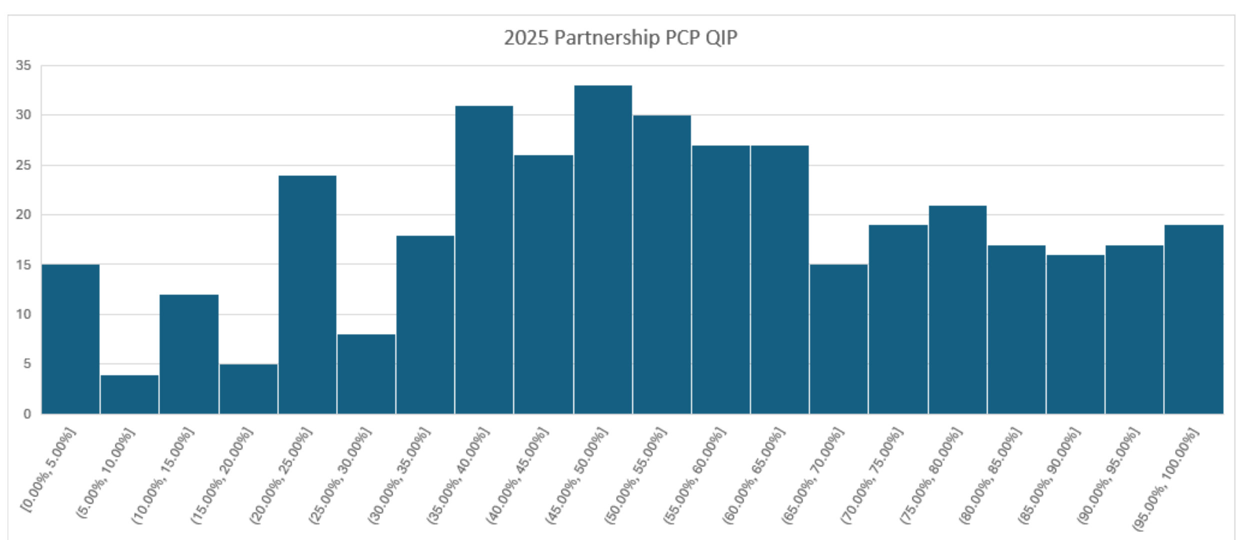
1. **Primary Care QIP: Summary of Measurement year 2025 results.**

In calendar year 2025, a total of 380 PCP sites belonging to 125 parent organizations participated in the PCP QIP.

The weighted average (mean) of the score was 61.4% (up from 58.9% in 2024). The non-weighted mean was 54.0% and the median score was 48%.

- Weighted average effective Payment in PMPM (normalized for new factor 6 method): $6.73 PMPM (down slightly from $6.78 in 2024)
- Total payment: $55,700,067.59
- Up from $51,836,240.27; total increase year over year: $3,863,827.32

The distribution of points ranged from 0% to 100%, as noted on the histogram below:



High performers (those with scores >90%) are listed here:

<u>Tribal Health Centers</u>

1. Lake County Tribal Health (Bevins Ct.) 100%

<u>FQHCs</u>

2. Marin Community Clinics
   i. 3110 Kerner 98%
   ii. 3260 Kerner 99%
   iii. Novato 98%

iv. North Novato 98%
v. Larkspur 97%
vi. Greenbrae 93%
vii. Downtown 90%

3. Communicare+Ole
    i. Calistoga 100%
    ii. Fairfield 96%
    iii. East Fairfield 93%
    iv. Pear Tree Lane 92%
    v. St. Helena 91%
4. Anderson Valley CHC 94%
5. La Clinica
    i. Vallejo 98%
    ii. North Vallejo 95%
6. Petaluma Health Center (Petaluma Site) 94%
7. Winters Healthcare Foundation 93%
8. Shasta Community Health Centers (Enterprise) 93%

Medical Groups (Hospital Affiliated)

9. Dignity
    i. Redding (1755 Court) 98%
    ii. Redding (2336 Court) 95%
10. Northbay Health
    i. Hilborn 92%
11. St. Joseph's Heritage Foundation
    i. Queen of the Valley (Trancas) 100%
    ii. Annadel (Windsor) 98%
    iii. Queen of the Valley (Villa Lane) 96%
    iv. Annadel (Petaluma) 95%
    v. Annadel (510 Doyle Park) 94%
    vi. Providence Medical Group (Montgomery Dr.) 94%
    vii. Humbolt Medical Specialists 94%
    viii. Providence Medical Group (500 Doyle Park) 94%

Rural Health Center

12. Modoc Medical Center (Canby) 100%

Private Medical Groups

1. Sonoma Plaza Pediatrics 100%
2. Pediatric Medical Associates
    a. Capital Pediatrics (Land Park) 97%
    b. Harvest Peds (Napa) 92%

We will post the PCP QIP results for all health centers in about 2 months. Prior to that, Sonja will send to Partnership Board members the summary scores for the PCPs in the county they represent.

2. Quality Related Topics Covered at Future Board Meetings

1. **August, 2026**
    a. **At 9 a.m. before Board meeting: Recognition breakfast for top primary care QIP performers for 2025**
    b. HEDIS results (Measurement year 2025);
2. **October, 2026**
    a. Annual Educational session;
    b. Review of annual quality program document (including update of quality strategic plan)
3. December, 2026
    a. Report on 25-26 Hospital QIP results
    b. Report on CG CAHPS results for PCPs.
4. February, 2027
    a. At 9:30 am before Board meeting: recognition for top hospital QIP performers for 2025-26
5. April, 2027
    a. In person strategic planning retreat
6. June, 2027
    a. Announcement of High performers of QIPs

Health Services Board Report
February 25, 2026

Katherine Barresi, RN, BSN, PHN, NE-BC, CCM
Chief Health Services Officer

Care Coordination

RSST / Medi-Cal Connect Pilots

Partnership continues to make significant progress in advancing statewide transformation efforts through launch of DHCS' new statewide data and analytics platform Medi-Cal Connect. The Medi-Cal Connect platform was created by DHCS to support the Population Health Management (PHM) initiative under CalAIM. A core component of the platform is the Risk Segmentation, Segmentation and Tiering (RSST) tool which identifies which Medi-Cal members are at higher risk and need more support.

Care Coordination has led a cross-departmental initiative to proactively prepare for the implementation of DHCS's RSST requirements under Medi-Cal Connect. This internal project brought together key teams across the organization to better understand RSST data outputs, assess operational implications, and design engagement strategies tailored to identified member risk tiers. Care Coordination partnered with internal stakeholders to design, pilot, and study engagement strategies for 1,700 members identified as high-risk in the RSST. These strategies include targeted outreach such as mailed letters, outbound calling campaigns, and text messaging to engage members in a timely and person-centered manner.

DHCS is expected to release a revised PHM Policy Guide at the end of July, which will contain guidance to Partnership on required activities for high-risk members. This work positions Partnership to implement a more proactive, data-driven approach to care coordination, strengthen member engagement, and ensure compliance with DHCS expectations while advancing equitable health outcomes.

Targeted Autism Spectrum Disorder (ASD) Training

The Care Coordination department advanced staff competency through targeted autism spectrum disorder (ASD) training, reinforcing clinical importance of understanding Autism as a lifelong condition and applying evidence-based approaches such as high-quality Applied Behavioral Analysis (ABA)/ Behavioral Health Therapy (BHT). This training strengthens Care Coordination's ability to improve member outcomes through better care coordination, timely access to services, and family-centered, culturally responsive practices. This initiative also reflects Partnership's commitment to high-quality

ABA/BHT services by supporting strong program oversight, including care coordination activities, member experience monitoring, and collaboration with utilization and quality teams to ensure effective and appropriate care delivery.

In June, Partnership responded to a request from the U.S. Department of Health and Human Services Office of Inspector General for information and utilization data related to non-specialty mental health services, including ABA/BHT. Health Services leaders and staff worked with the compliance team to prepare for and submit timely and accurate responses to the Office of Inspector General. This effort reflects Partnership's strong commitment to regulatory compliance, transparency, and accountability, while reinforcing its ongoing focus on delivering high-quality, timely ABA/BHT services.

Utilization Management

Treatment Authorization Request (TAR) Volumes & Timeliness

During Q1 of 2026, the Utilization Management (UM) reliably and consistently managed a high-volume of Treatment Authorization Requests (TARs) averaging a department total of approximately 27,000 TARs per month across Acute Inpatient, Outpatient, and LTSS service categories. The department absorbed significant TAR volume growth, especially in March, without degradation in timeliness or quality, indicating strong operational controls and favorable fiscal implications. Overall, UM performance in Q1 protected Partnership's revenue, reduced downstream cost risk, and avoided regulatory penalties, while also signaling areas of future cost pressure related to sustained volume growth. For Q1, the department successfully achieved:

- Acute Inpatient: ~99.4% timely completion
- Outpatient: ~99.4% timely completion
- LTSS: ~98.73% timely completion

Hospice Quality Network

In collaboration with the Chief Medical Officer (CMO), Provider Relations and Care Coordination, the Utilization Management department has led and supported targeted efforts to develop Partnership's Hospice Quality Network. This work includes better defining quality expectations, assessing current hospice provider performance, and identifying opportunities to standardize care delivery across the network. UM has partnered with internal stakeholders to tighten the oversight processes and workflows, including enhanced review of authorizations, configuring new flags in the UM systems, monitoring of utilization patterns, and collaborating with Care Coordination to ensure members are connected and receiving services from high quality providers to meet their end-of-life care needs.

These efforts support more consistent, high-quality hospice care for members that is reflective of Partnership's commitment to ensuring compassionate, person-centered end-of-life care while building a high-performing hospice network grounded in quality, accountability, and continuous improvement.

Interoperability

Following the release of the DHCS All Plan Letter (APL) 26-008 on Interoperability, Partnership has initiated cross-departmental project to develop an organization-wide strategic plan for Interoperability implementation. A cornerstone of the federal rule by CMS, which was also outlined by DHCS APL 26-008, is the requirement that Partnership implement the Prior Authorization API. The Prior Authorization API represents more than just a technical or compliance requirement for the health plan, but a business and operational transformation opportunity. Through this requirement, Partnership's UM systems will have the opportunity to connect and communicate directly with provider systems for authorizations; easing administrative burden for both areas of healthcare delivery while potentially supporting patients in getting to care quicker. The UM department along with IT and Compliance will be key stakeholders as Partnership evaluates and positions itself for Interoperability.

Behavioral Health & Youth Services

Behavioral Health Access Team

Partnership continues to excel in supporting members seeking behavioral health care services through the Behavioral Health Access team. In Q1, the Behavioral Health Access Line (BHAL) answered 6,387 inbound calls, representing an 8% increase over Q4 2025. Notably, 52% of members seeking services were directly scheduled for appointments during the call, significantly enhancing the member experience and in alignment with high-quality health care.

Outbound engagement also increased substantially, with 20,703 outbound calls completed in Q1—a 28% increase from Q4 2025. This growth was driven by a new mid-February initiative to conduct daily outreach to members following emergency department visits for behavioral health conditions.

These efforts reflect continued improvements in access, timely connection to care, and proactive member engagement.

Data Sharing and Collaboration with County Behavioral Health Plans

In partnering closely with our IT department, the Behavioral Health department has worked to successfully submit Partnership's 2024–2025 encounter data to county partners via CalMHSA to support HEDIS reporting requirements. Ongoing processes have been established to continue providing high-quality data submissions that represent high-quality health care.

Data sharing efforts remain in place with all counties Behavioral Health Plans (BHPs) where MOUs are executed. The Behavioral Health leadership continues to explore and evaluate opportunities for bidirectional data sharing with county BHPs to strengthen collaboration and optimize data exchange across partners on behalf of members and shared goals.

Enhanced Health Services

ECM/CS Referrals & Treatment Authorization Request (TAR) Volumes

The EHS Department maintained strong operational performance in Q1 2026, managing sustained high volumes of Treatment Authorization Requests (TARs) and referrals. TAR activity remained significant, averaging approximately 9,300 per month, with a total of 28,170 TARs processed across ECM and Community Supports services. ECM and housing-related services accounted for a substantial share of volume, reflecting continued demand for complex care coordination and social support services. Referral volume also increased in Q1, averaging approximately 6,300 referrals per month—an increase of 1,000 per month compared to the prior quarter. Together, these trends highlight the ongoing demand placed on EHS clinical and administrative teams to support timely evaluation, triage, and coordination of services, while demonstrating the department's continued ability to effectively manage high-volume operations.

Quality Monitoring & Oversight for Enhanced Care Management (ECM) and Community Supports (CS) Provider Network

The EHS Department continues to advance quality monitoring and oversight for ECM and CS provider network. A comprehensive ECM/CS Quality Monitoring & Oversight framework has been in place outlining Partnership's approach to evaluating provider performance and ensuring compliance with program requirements. Part of the Quality Monitoring and Oversight framework includes an audit of ECM and CS provider performance by clinical staff in the EHS department. In Q1 and Q2 of this year, a total of 26 ECM and/or CS providers were audited, demonstrating proactive oversight of the provider network. Part of the audit includes Partnership clinical staff reviewing care plans and quality

of documentation to ensure providers are in alignment with policies and services. The department presents findings to providers, and providers who score less than 79% do not pass the audit and are placed on a Performance Improvement Plan.

As part of the DHCS Medical Audit findings this year and Partnership's commitment to continuous process improvement the EHS clinical team refined and implemented a standardized ECM care plan. Partnership's ECM providers are now required to use this standardized care plan, or submit copies of their ECM care plans, demonstrating alignment with ECM core service requirements.

Health Equity

Discrimination Grievances

In Q1 2026, the Health Equity (HE) Department processed 85 discrimination grievances, with 15 cases (17.6%) determined to be "likely." This rate is consistent with the 2025 annual average, where approximately 15% of grievances met the "likely" threshold for discrimination. Most grievances were associated with the disability category, with Transportation services continuing to represent the highest source of reported concerns. The Health Equity team is leveraging this information for feedback to providers and is aligning efforts with Partnership's Transportation teams and Grievance & Appeals departments to address these areas of concern.

Tribal Health Activities

Partnership's Tribal Health Liaison, Sunshine Jackson, has made significant progress in strengthening partnerships by conducting in-person engagement with over 10 Tribal Health Providers and programs. Recently, Ms. Jackson and Partnership's Regional Director Rebecca Stark, were invited to the Grindstone Reservation in Elk Creek, CA and to meet with the Tribal Chairman and their team. As part of their meeting, they were given a tour of the reservation and saw first-hand the beauty and challenges this very rural Tribe navigates each day.

Another cornerstone of Partnership's Tribal Health activities is our Tribal Perinatal Program. We are pleased to share that two more new Tribal Health Programs have signed up for this initiative. Through the Tribal Perinatal Program Partnership provides direct support to Tribes in improving the care and outcomes of tribal members with perinatal and/or postpartum needs. The group focuses on benefits such as ECM, CHW and doula benefits, as well as discussing data, quality measures, and trauma-informed care training. The Tribal Health Liaison has also partnered closely with Partnership's Population Health Management department to host a Tribal Maternal Photoshoot on the Hoopa

Valley Indian Reservation to bring resources, health information and coordination to those members and communities.

Collectively, these efforts and many others have enhanced trust with our tribal members, providers and community partners to drive strong member engagement, improve access to care, and address health disparities in culturally sensitive and responsive way. Partnership continues to receive positive feedback regarding these efforts, and the team is proud to be making an impact in the lives of members while fulfilling Partnership's vision and mission.