PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE MEETING NOTICE

FROM: Leslie Erickson, Program Coordinator II, Quality & Performance Improvement (QI)
DATE: Sept. 11, 2025
SUBJECT: Quality/Utilization Advisory Committee (Q/UAC) Meeting

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

Meeting Time/Date: 7:30 – 8:55 a.m., Wednesday, Sept. 17, 2025
Meeting Locations:

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

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

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

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

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

cc:
Andrews, Leigha, Regional Director, Southwest
Beltran-Nampraseut, Athena, CPhT, Program Manager II (PCP QIP), QI
Bjork, Sonja, JD, Chief Executive Officer
Blake, Jill, Regional Director, Auburn
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brunkal, Monika, RPh, Associate Director of Population Health
Campbell, Anna, Policy Analyst, Utilization Management
Davis, Wendi, Chief Operations Officer
Devan, James, Manager of Performance Improvement, QI (NR)
Durst, Jennifer, Sr Mgr of Performance Improvement, QI (SE/SW)
Escobar, Nicole, S, Mgr of Behavioral Health, Behavioral Health
Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
Gual, Kristine, Director of Quality Measurement, QI
Harrell, Bria, Project Manager I, Configuration
Innes, Latrice, Manager of Grievance & Appeals Compliance
Isola, Brandy, Mgt of Performance Improvement, QI (Chico/Auburn)
Jarrett-Lee, Kevin, RN, Associate Director, UM
Kerlin, Mary, Senior Director of Provider Relations
Klakken, Vicki, Regional Director, Northwest
Kubota, Marshall, MD, Associate Medical Director
McCune, Amy, MPH, MS, Manager of Quality Incentive Programs, QI
Morris, Matthew, MD, Regional Medical Director, Auburn
Nakatani-Phipps, Stephanie, Manager of Provider Relations Reps
Power, Kathryn, Regional Director, Southeast
Quichocho, Sue, Manager of Quality Improvement, QI
Sharp, Tim, Regional Director, Northeast
Smith, Christine, Community Health Needs Liaison, Pop Health
Spencer, Ben, Project Coordinator I, Health Equity
Stark, Rebecca, Regional Director, Chico

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

Date: Sept. 17, 2025 **Time: 7:30 – 8:55 a.m.**

Locations: Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano Room
2525 Airpark Drive, Redding, CA 96002 | Trinity Alps Conference Room
495 Tesconi Circle, Santa Rosa, CA 95401 | Santa Rosa Huddle Room
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Partnership Staff only may join by Web-ex:
https://partnershiphp.webex.com/meet/quac Meeting # 809 114 256

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

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

Welcome / Introductions / Public welcome at cited locations

	Item	Lead	Time	Page #
I.	**Call to Order – Welcome/Introductions/Announcements/Approval/Acceptance of Minutes**			
1	*Approval of* • Aug. 20 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Mark Netherda, MD	7:30	5 – 18
2	*Acknowledgment and acceptance of draft minutes of the* • Aug. 12 Internal Quality Improvement (IQI) Committee • July 30 Over/Under Utilization Workgroup • Aug. 7 Population Needs Assessment (PNA) Committee – *see also CHA/CHIP paper under FYI*			19 – 42
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Isacc Brown, MHA/MBA	7:37	43 – 53
2	HealthPlan Update	Mark Netherda, MD	7:45	--
III.	**Old Business – None**			
IV.	**New Business – Consent Calendar**			
	Consent Calendar	All	7:52	54
	G&A PULSE Report, Issue 18, September 2025 – *direct questions to Latrice Innes*			55 – 68
	1st/2nd Qtrs 2025 UM/Pharmacy IRR / Timeliness – *direct questions to Tony Hightower, CPhT, and Andrea Ocampo, Pharm.D*			69 – 78
Health Srvcs	**Utilization Management Policies**			
	MCUG3118 – Prenatal & Perinatal Care			79 – 95
	MCUP3140 – Palliative Care: Pediatric Program for Members Under the Age of 21			97 – 110
V.	**New Business – Discussion Policies**			
	Synopsis of Changes		--	111 – 112
HS	**Utilization Management Policies**			
	MCUG3007 – Authorization of Ambulatory Procedures and Services	Tony Hightower, CPhT	8:00	113 – 135

	Item	Lead	Time	Page #
	MCUP3013 – Durable Medical Equipment (DME) Authorization		8:05	137 – 151
	MCUP3119 – Sterilization Consent Protocol		8:10	153 – 158
	MPUD3001 – Utilization Management Program Description		8:15	159 – 198
Non-HS	**Grievance & Appeals Policy**			
	CGA024 – Medi-Cal Member Grievance System	Kory Watkins, MBA-HM	8:20	199 – 217
VI.	**Presentations**			
1	2024 Primary Care Provider Quality Incentive Program (PCP QIP) Evaluation	Athena Beltran-Nampraseut, CPhT	8:25	219 – 242
VII. FYI	HEDIS® MY 2024 / RY 2025 NCQA Health Plan Accreditation (HPA) Summary of Performance – *refer any questions to Kristine Gual*			243 – 308
	5-Star QI Strategy Plan / Tactical Plan Update – *refer any questions to Isaac Brown*			309 – 326
	Community Health Assessment / Community Health Improvement Plan (CHA/CHIP) August Update – *refer questions to DrPh. DeLorean Ruffin*			327 – 342
	Adjournment scheduled for 8:55 a.m. Q/UAC next meets 7:30 a.m. Wednesday, Oct. 15, 2025			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

Quality and Utilization Advisory Committee (Q/UAC)
Wednesday, Aug. 20, 2025 / 7:30 – 8:56 a.m. Napa/Solano Room, 1st Floor, Fairfield

August is HEDIS® and QI Trilogy Month

Voting Members Present:	Brandy Lane, Consumer Member	Michael Strain, PHC Consumer Member
Sara Choudhry, MD	Phuong Luu, MD	Chris Swales, MD
Steven Gwiazdowski, MD, FAAP	Brian Montenegro, MD	Randolph Thomas, MD
Emma Hackett, MD, FACOG	Meagan Mulligan, FNP-BC	Jennifer Wilson, MD

Voting Members Absent: John Murphy, MD; Robert Quon, MD, FACP

Partnership *Ex-Officio* Members Present:

Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI
Brown, Isaac, MBA/MHA, Interim Senior Director of Q & P Improvement
Cox, Bradley, DO, Regional Medical Director (Northeast)
Esget, Heather, RN, BSN, ACM, Director of Utilization Management
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management
Glickstein, Mark, MD, Associate Medical Director
Hightower, Tony, CPhT, Associate Director, UM Regulations
Jalloh, Mohamed "Moe", Pharm.D, Dir. of Health Equity (Health Equity Officer)
Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Katz, Dave, MD, Associate Medical Director
Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair
Netherda, Mark, MD, Medical Director for Quality – Vice Chair
Newman, Rachel, RN, BSN, Mgr, Clinical Compliance – Quality Inspections
O'Connell, Lisa, Director, Enhanced Health Services
Randhawa, Manleen, Senior Health Educator, Population Health
Ribordy, Jeff, MD, Regional Medical Director (Northwest)
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Thornton, Aaron, MD, Associate Medical Director
Townsend, Colleen, MD, Regional Medical Director (Southeast)
Ward, Lisa, MD, Regional Medical Director (Southwest)

Partnership *Ex-Officio* Members Absent:

Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
Bontrager, Mark, Senior Director of Behavioral Health
Cotter, James, MD, Associate Medical Director
DeVido, Jeff, Behavioral Health Clinical Director
Guillory, Ledra, Senior Manager of Provider Relations Representatives
Leung, Stan, Pharm.D, Director of Pharmacy Services
Spiller, Bettina, MD, Associate Medical Director
Watkins, Kory, MBA-HM, Director, Grievance & Appeals

Guests:

Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brunkal, Monika, Associate Director, Population Health
Campbell, Anna, Health Policy Analyst, Utilization Management
Chiang, Yuen, Program Manager 1, Utilization Management
Conner, Maria, Improvement Advisor, QI (Auburn)
Cunningham, Aryana, Policy Analyst, Care Coordination
Devan, James, Manager of Performance Improvement (Redding)
Durst, Jennifer, Senior Manager of Performance Improvement, QI (Santa Rosa)
Erickson, Leslie, Program Coordinator II, QI (scribe)
Forehand, Jenn, County Child Welfare Liaison, Behavioral Health (Redding)
Isola, Brandy, Manager of Performance Improvement, QI (Chico)
Jamali, Shahrzad, Improvement Advisor, QI (Chico)
Jarrett-Lee, Kevin, Associate Director of Utilization Management (Auburn)
Kim, Amanda, Improvement Advisor, QI (Redding)
Kubota, Marshall, MD, Associate Medical Director
Matthews, Richard "Doug," MD, Regional Medical Director (Chico)
Morris, Matthew, MD, Regional Medical Director (Auburn)
Nakatani-Phipps, Stephanie, Lead Senior Provider Relations Rep, PR
Quichocho, Sue, Manager of Quality Measurement, QI
Robertello, Kimberly, PhD, Sr. Medicare QI Program Manager, QI
Romero, Liz, Improvement Advisor, QI (Redding)

Frankovich, Terry, MD, Associate Medical Director
Garcia-Hernandez, Margarita, PhD, Director of Health Analytics, Finance
Gaul, Kristine, PMO, CPHQ, Director of Quality Measurement, QI
Innes, Latrice, Manager of Grievance & Appeals Compliance, G&A
Smith, Christine, Community Health Needs Liaison, Population Health
Spencer, Ben, Project Coordinator I, Health Equity
YoungStone, Kelly, RN, Director of Care Coordination

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *none made* Introductions Approval of Minutes	Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 7:30 a.m. Organization-wide Internet issues delayed quorum, which was established before Isaac Brown finished his QI update. Attending Q/UAC for the first time as part of their new Partnership employee on-boarding: • Yuen Chiang, Program Manager I, Utilization Management • Jenn Forehand, County Child Welfare Liaison, Behavioral Health (Redding) The June 18, 2025 Q/UAC Minutes were approved as presented without comment. *Acknowledgment and acceptance of draft meeting minutes of the* • June 10 Internal Quality Improvement (IQI) Committee • May 8 Substance Use Internal Quality Improvement (SUIQI) Committee • May 27 Quality Improvement & Health Equity Committee (QIHEC) • July 22 QIHEC	Motion to **approve the Q/UAC minutes:** Steven Gwiazdowski, MD Second: Brian Montenegro, MD *Approved unanimously* Motion to **accept the other minutes:** Steven Gwiazdowski, MD Second: Brian Montenegro, MD *Approved unanimously*
II. Standing Updates		
1. Quality Improvement (QI) Department Update *Isaac Brown, Interim Senior Director of Quality and Performance Improvement, QI*	• Regarding the Primary Care Provider Quality Incentive Program **(PCP QIP)**, our payments were distributed in June, and top performers are listed in the packet. • **The 2025-26 Hospital QIP (HQIP) Measurement Set**, as approved by Partnership's Physician Advisory Committee (PAC) in April, is now in full effect as of 07/01/2025 through 6/30/2026. In January 2025, there was much discussion in quality committees about how the QIP team was applying lessons learned from its annual evaluation of FY 2023-2024 Hospital QIP to measure development for FY 2025-2026. o As an update to this discussion, it is important to note that FY 2025-2026 includes a new Vaccines for Children (VFC) Program Enrollment measure incentivizing birthing hospitals' enrollment in the California Department of Public Health program. This CDPH program provides vaccines to hospitals at a lower cost for the Medi-Cal population. Three of the 17 birthing hospitals in the HQIP are currently enrolled, and two more are in the contracting process. The measurement set includes links to the VFC program website that explains the program requirements and enrollment process. Troy Foster, HQIP Program Manager, will connect with hospital quality directors throughout the year to monitor and encourage enrollment status. o Additionally, in FY 2025-2026 Partnership continues to encourage its hospitals to engage in advancing health equity by including a health equity measure in the HQIP that now aligns with the Centers for Medicare & Medicaid Services (CMS). This HQIP measure requires hospitals with ≥ 25 Licensed General Acute (LGA) beds to submit a copy of their most recent CMS program attestation for the Hospital Commitment. This measure challenges hospitals to commit to health equity in	*For information only. There were no questions.*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	measurable ways as points are only earned through attestations demonstrating fulfillment of all five domains set forth by CMS. • We saw some **improvements in our Consumer Assessment of Healthcare Providers and Systems (CAHPS®) scores** this past year, and we are projecting an achievement of 2.5 stars on the Child's CAHPS® survey results. This reflects a .5 star improvement in patient experience rating as compared to MY 2023. o Also, this year we are doing something a little bit different, Previously, we had tried to do a drill down survey, which was to help us get at some more detailed insights. Some good learnings came from that. We still have some benefit literacy issues: people were asking about dental, vision, transportation, etc., and that was causing some lower scores, so this year, we will be refining our drill down survey for the following year. • We have been working on some pilots related to bringing in **locum tenens**. We had our first pilot this past year. We have now kicked off a second phase of the pilot with Open Door, Western Sierra Medical, Ampla Health, and Chesters Community Health, and hope to be able to share afterwards a local playbook with the network using the learnings that we have got from those sites, which are focused on well-child visits and other preventative visits during these important summer months. • Finally, we were able to receive our **National Committee for Quality Assurance (NCQA) Health Equity Accreditation (HEA)** just recently, and that is a big cause for celebration here in the organization. You may hear various updates throughout different meetings.	
2. HealthPlan Update *Robert Moore, MD Chief Medical Officer*	• Nancy Steffen has left Partnership to move to the Portland area. We are sad to see her go. Isaac Brown is now the acting head of the Quality Improvement department. We don't anticipate any issues as we work on the permanent hiring process. • HR1 has passed in Wasington with long implications: o First, there will be an immediate reduction in provider tax revenue. The billions added back in for rural hospitals may not be a substantial relief – the cuts are about three times larger than the monies actually allocated – and some small hospitals may face closure in the near future. o Work requirements will take effect in 2027. Each community will need to work with members who would be at risk to lose Medi-Cal coverage. We learned after the Covid pandemic that counties who put in the effort to aid in redeterminations had higher rates of member retention than did the counties that made less effort. o Other implications have not yet filtered down from the State. We are exercising fiscal caution as we wait. However, we cannot unilaterally stop programs, especially those contracted services, because there is a risk of it going away. • Our Hospital Quality Symposium in July was well attended and well received. Our Behavioral Health Clinical Director Jeff DeVido, MD, gave a talk on the large increase in nitrous oxide over related B12 deficiency hospitalizations, the history and biochemistry of that. It was an excellent talk, and it is available on our website.	*For information only. There were no questions.*
III. Old Business – None		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
IV. New Business – Consent Calendar (Committee Members as Applicable)		
	PQI/PPC 1st and 2nd Qtrs 2025 with Data Analysis – *direct questions to Robert Bides, RN*	Nothing was pulled from the Consent Calendar, and no questions were asked. Motion to **approve slate as presented:** Steven Gwiazdowski, MD Second: Brian Montenegro, MD *Approved unanimously* Next Steps: Sept. 10 Physician Advisory Committee (PAC)
Health Services Department Policies	Care Coordination MPCP2007 – Complex Case Management – *previously MCCP2007* MCCP2032 – CalAIM Enhanced Care Management (ECM) – **ARCHIVE** *effective 09/10/25* Enhanced Health Services MCAP7002 – CalAIM Enhanced Care Management (ECM) – *previously MCCP2032* Quality Improvement MPQP1048 – Reporting Communicable Diseases Utilization Management MCUP3053 – Acute Inpatient Administrative Days – **ARCHIVE** *effective 09/10/25* MCUP3114 – Physical, Occupational and Speech Therapies MCUP3133 – Wheelchair Mobility, Seating and Positional Components MCUP3141 – Delegation of Inpatient Utilization Management MPUP3006 – Appropriate Service & Coverage (Over/Under Utilization) MPUP3042 – Technology Assessment – *previously MCUP3042* MPUP3138 – External Independent Medical Review – *previously MCUP3138*	
Non – HS Department Policies	Member Services MP301 – Assisting Providers with Missed Appointments MP316 – Provider Request to Discharge Member & Assistance with Inappropriate Member Behavior Network Services MPNET101 – Wellness and Recovery Access Standards and Monitoring	
V. New Business – Discussion Policies		
Policy Owner: Health Equity – *Presenter: Mohamed Jalloh, Pharm.D, Director of Health Equity (Health Equity Officer)*		
MCED6001 – Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description	This policy is updated to fulfill Department of Health Care Services related corrective action plans and Community Reinvestment Requirements All Plan Letter (APL) 25-004. Updated clear designation of QIHETP leadership/committee roles, to ensure programs are fully implemented and maintained. For each identified role, the qualifications of staff presently fulfilling each role is detailed in an appendix to the Quality Improvement Program Description being presented today. The definition of the Community Reinvestment Management program is updated and a note added to explain the funding requirements per APL 25-004. Also, it is updated to clarify relationship between Partnership HealthPlan and Local Health Jurisdictions (LHJ) and Behavioral Health Teams. Finally, the update clarifies community engagement requirements and reinvestment plan timelines.	*There were no questions*. Motion to **approve as presented:** Steven Gwiazdowski, MD Second: Jennifer Wilson, MD *Approved unanimously* Next Steps: Sept. 10 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Community – Access – Respect – Engagement Services (CARES) training coverage is explained. Access to staff for members and practitioners seeking information about the utilization management process and the authorization of care is explained. 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 sensory impairment for population groups as determined by contract. Dr. Jalloh noted changes were made with DHCS' guidance. We will be looking at CARES completion rates and community reinvestment plans Partnership must make/report. Elements of how those reinvestment requirements are calculated, and annual reporting requirements are laid out. Changes in the job descriptions for key QIHETP participants are now in this program description.	Dr. Jalloh noted that Diversity Equity and Inclusion (DEI) and Transgender Inclusion (TGI) training completion rates will be presented in the Evaluation. The Evaluation will be part of the Health Equity Grand Analysis scheduled for Oct. 7 IQI and Oct. 15 Q/UAC.
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations*		
MCUG3024 – Inpatient Utilization Management	This policy has been **updated to include information regarding acute inpatient administrative days that was previously located in policy, MCUP3053, which is now archived**. Additionally, a new Attachment document has been added to this policy to describe the information required for a post-discharge appeal for Inpatient Admissions. **Section I:** Policy numbers were updated and two Related Policies were added: F. MCUG3038 - Review Guidelines for Member Placement in LTC Facilities G. MCAP7003 - CalAIM Community Supports (CS) **Section III.A.** Definition was added for Acute Inpatient Administrative Days. **Section III.E.** Definition of Inpatient Admission locations was expanded to include Subacute Care Facilities. Also, each type of location was defined. **Section IV.** Attachment A was added: "Provider Dispute Resolution (PDR) Request: Post Discharge Appeal for Inpatient Admission." **Section VI.B.** This section on Criteria was simplified and the reader was referred instead to further information in policy MPUP3139 Criteria and Guidelines for Utilization Management. **Section VI.E.5.j.** Paragraph was added regarding Peer to Peer request requirements for inpatient admissions. **Section VI.E.5.k.** Paragraph was added regarding requirements for post-discharge provider dispute request for inpatient admission. **Section VI.G.** This new policy section was added to incorporate the information regarding Acute Inpatient Administrative Days that was previously located in policy MCUP3053, which is now archived. **Section VI.H.** This section regarding Inpatient Psychiatric Admissions was updated to clarify that acute inpatient administrative days do not apply when a Partnership Medi-Cal Member is pending evaluation on a psychiatric hold or awaiting placement at a mental health facility. Specialty mental health services are not a Partnership responsibility	Motion to **approve with verbalized changes to the new Attachment A:** Steven Gwiazdowski, MD Second: Brian Montenegro, MD *Approved unanimously* Next Steps: Sept. 10 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.I.2. Language was added in the Case Review Conference section to specify that these meetings now often include facility care management staff (e.g. case managers, discharge planners). **Section VI.K.** This section on Communication Services was simplified, and the reader was referred instead to further information in policy MCUP3064 Communication Services. **Section VI.L.** This section on Delegation Oversight and Monitoring was simplified, and the reader was referred instead to further information in policy MCUP3141 Delegation of Inpatient Utilization Management. Tony noted that some language regarding communication services as well as the delegation of inpatient utilization management was removed. The reader is directed to refer to other policies. Tony stated that we expanded on our requirements for peer-to-peer process for inpatient admissions by creating **Attachment A**, **a new form** now entitled "Provider Dispute *Resolution* (DPR) Request Post Discharge for Inpatient Services." UM Policy Analyst Anna Campbell read out further requested changes to the attachment that were not reflected in today's packet. **The word "appeal" is replaced with "resolution" in the title and with "review" in the body. Further, "appeal" is eliminated from the signature information of the person filing the form.** Dr. Gwiazdowski questioned the rationale for these changes. Tony noted that these situations are more of a dispute between the provider and Partnership and do not necessarily rise to the level of being an appeal on behalf of the member. Dr. Moore added that NCQA has specific requirements around "appeals," and they do not apply here because this is a post-service provider dispute: it's not an appeal of a service that the patient has not yet received or is currently receiving. Moreover, there are different regulatory requirements for appeals.	
VI. Presentations		
HEDIS® MY 2024 / RY 2025 Summary of Performance – *Kristine Gual, PMP, CPHQ, Director of Quality Measurement, QI*		
	Kristine went through the significant changes to reporting populations in MY2024 and noted that the Healthcare Effectiveness Data Information Set (HEDIS®) companion pieces, the Managed Care Accountability Set (MCAS) and NCQA Health Plan Accreditation (HPA) summaries of performance would be posted to Partnership's public website by the end of August. Prior to MY2024, when Partnership had just 14 "legacy" counties, reporting was done according to four geographical regions. Reporting is now, for the first time, plan-wide for all 24 counties in MY2024, during which time total membership grew 36.7%, despite the ~80,000 member loss of Kaiser patients. Furthermore, DHCS is also interested in each county's performance on each of the 18 MCAS measures to which we are held accountable. Today's presentation focused on plan-wide data. The 18 MCAS measures – nine of which are "quality withhold" measures subject to sanction – continue from MY2023, and it is DHCS's expectation that we will meet or exceed the 50th percentile of the national Quality Compass® Medicaid Benchmark for each measure. A maximum of 10 points is awarded per measure based on these benchmarks. The resulting composite core from DHCS is known as the Quality Factor Score (QFS), which is also used to rank Partnership among all managed care plans (MCPs) throughout California. Sanctions may apply where we may fail to meet the 50th percentile minimum performance level (MPL). We hope to learn	The MCAS white paper is included in today's meeting packet and is rich in data on regional- and county-level rates. *Meeting Postscript:* MCAS and the HPA Projected Star Rating is now posted on the public website at MY2024 MCAS Annual Summary of Performance and MY2024 NCQA HPA Annual

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	by the end of August DHCS's sanction methodology. (Q/UAC voter Stephen Gwiazdowski, MD, noted later that it is a disincentive to expand if we are not given "dispensation" to allow these new counties time to adjust to "our culture and infrastructure." Kristine then clarified that sanctions will only apply to the 14 legacy counties. Isaac Brown added that in our PCP QIP we "ease in" these new providers on "our benchmarks and cut points.") In a year-over-year comparison of our MCAS composite scoring, Partnership fared better in MY2024 (56.10%) than in MY2023 (51.88%) but not as well as in MY2022 (59.99%) when we had 15, rather than 18, measures. (DHCS extended a one-year grace period in MY2023 when we and all other MCPs went from 15 to 18 measures.) "When you add new measures, it takes time to get your arms around them," Kristine said. "Now that our measure set is stable in 2024, we are coming back from that." The HEDIS® table of the 18 MCAS measures is now in development on Tableau. Kristine noted that our highest plan-wide performance relative to the national Quality Compass® Medicaid Benchmark came in our Prenatal and Postpartum Care – postpartum care measure (90%). We realized somewhere between the 50th and 90th percentiles on 10 measures. We might expect some sanctions on the seven measures scoring under the 50th percentile MPL. We are very proud of our dramatic improvements in the two Well-Child Visits measures. Historically, we have not performed well here, in part because of data incompleteness issues. However, this year our HEDIS® team received auditor permission to do a "chart chase," that is, conduct medical record reviews. The results improved our WCV in the first 15 months of life from under the 10th percentile to 75th percentile. Similarly, WCV in the first 30 months went from 37.5% last measurement year to 62.5% in MY2024. "This is unheard if growth in quality," Kristine said, adding that performance is now aligned with our PCP QIP measure performance. Our providers have done a "fantastic job" of picking up the torch and doing advocacy on our blood lead screening for children, Kristine said. They, together with our "very robust" point-of-care device distribution program have raised us from the 25th percentile to the 75th in MY 2024. Three multi-year measures – Breast Cancer Screening, Cervical Cancer Screening, and Childhood Immunization Status – each improved to the 50th percentile MPL despite data incompleteness in the 10 new counties. In response to a question from Isaac, Kristine now that the self-swab cervical cancer screening test is FDA-approved, we will be able to count these rates toward that measure. Kristine also noted that Partnership's Immunization rate improved even though the national trend is going downward. We continued to do well on the three hybrid measures – Controlling High Blood Pressure, Glycemic Status Assessment for Patients with Diabetes (GSD), and Immunizations for Adolescents; however, we are watching the GSD and the Prenatal and Postpartum Timeliness of Prenatal Care too as we saw some erosion in our performance there. (Those national benchmarks themselves moved this year.) Kristine has confidence in the data we are now receiving for three measures that did not meet the 50th percentile MPL – Asthma Medication Ratio (AMR), Chlamydia Screening in Women (CHL), and Child and Adolescent Well-Care Visits. Pharmacy's interventions through more than a dozen academic detailing sessions with various hospitals has helped with the AMR, which is being retired from the measure set next year. The CHL is new to the PCP QIP and may be helped therein this coming year, although in some counties there is not enough "critical mass" of members receiving these services. Q/UAC voter and pediatrician Randolph Thomas, MD, noted that it can present difficulties to a provider to suggest to parents that their 15-year-old girl be screened and not say the same regarding their 16-year-old boy. He suggested we might do even better if we screened all adolescents, not just females. Southeast Regional Medical Director	Summary of Performance, respectively. Providers are encouraged to look at their county-level rates for each measure.

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	Colleen Townsend, MD, (and the medical advisor to our cervical cancer screening pilot last year) didn't disagree; however, she noted that the measure is drawn on the Centers for Disease Control (CDC) and the California Department of Public Health (CDPH) guidelines, which recognize that there is a risk of pelvic inflammatory disease and infertility in females. Deputy Chief Medical Officer Kermit Jones, MD, JD, said he agreed with Dr. Thomas, adding that he totally understood the scientific and epidemiological rationales, but that political and behavioral aspects are other things altogether: we may need to think about messaging in new ways to achieve our goals. Q/UAC voter and Yuba/Sutter County Public Health Officer Phuong Luu, MD, commented that it would be better to consider a group of screenings – chlamydia, gonorrhea, and syphilis – in all persons under the age of 25 who are sexually active. Kristine said this exemplifies where a measure itself may not actually get at what we want to achieve but instead is the minimum. Dr. Moore agreed, saying "the blood pressure guidelines are too high and the A1C target population is too extreme," adding that it might seem that if you are not achieving to a standard, you are not providing optimum care. "It's really important in cases where NCQA or HEDIS tries to shoot for the optimum, you end up getting overshooting and you get negative consequences," Dr. Moore explained. "You need to let clinical judgment drive each individual patient but let the quality measures be something that we don't risk causing an unintended negative consequence by overshooting." Dr. Townsend added that as we integrate CHL into the PCP QIP we are intentionally looking at how to provide education around the measure and also put it in the context of the broader discussion around sexual and reproductive health, creating an opportunity to discuss this area of health care services in a different manner than we have done previously. The Child and Adolescent Well Care is a large volume measure that gained 1.42%, representing tens of thousands of children who received care, Kristine said. Q/UAC voter and neonatologist Steven Gwiazdowski, MD, said he imagined that the drop off in care as children age might be happening to all MCPs. Dr. Moore responded that this measure is most sensitive to access: to get every single child in for a preventive visit every year would require a large number of appointment and there is a shortage of primary care providers in our regions. Four measures – Developmental Screening in the First Three Years of Life (DEV), Follow-up After Emergency Department Visit for Substance Use (FUA-30), Follow-up After Emergency Department Visit for Mental Illness (FUM-30) and Topical Fluoride for Children – for which we are dependent on DHCS for data, did poorly, in large part because of data incompleteness issues. Coding was an issue for providers on the Topical Fluoride, but we devised a workaround, which has been of help. Coding was also an issue for DEV, may improve next year as it becomes a hybrid measure and our HEDIS® team will be allowed to "chart chase." We have been tracking and advocating to get complete data sets and Kristine said she imagines that we will appeal if we are sanctioned this year. We are really working on improvements through our Health Information exchange (HIE), SacValley MedShare. Q/UAC voter and neonatologist Brian Montenegro, MD, followed Dr. Gwiazdowski's questions on coding by recalling that once specific classes on codes had been available, and he wondered whether there might be an education piece to mitigate these issues. Dr. Moore responded that "it's complicated. In general, since 90% of our Federally Qualified Health Centers (FQHCs), rural health centers and tribal health centers get a fixed rate no matter what they do in a visit, the coding is de-emphasized. However, interestingly, developmental screening is one of a small handful of measures that, at the request of the health centers, is being reimbursed fee for service on top of their PPS rate. Unfortunately, that has only had a small impact and is a good example of a failed experiment: if you have one code by which you get paid and all the rest you don't, then it is not enough to change the system."	

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	Kristine went on to explain NCQA's methodology for assigning a "Star rating" via Health Plan Accreditation (HPA). Our Star rating is a "reputational goal" to which no sanctions are attached. It is a combination of the Patient Experience as drawn from Partnership's choice to use either the Adult or the Child CAHPS survey (we chose to use the Child), our HEDIS® scores across Prevention and Population and Treatment domains in clinical measures. A half point bonus is added if the Plan is HPA accredited, which Partnership is. We had projected ourselves at 3.5 Stars; however, last week NCQA told us we were being rated at 3 Stars. "This was a tough one," Kristine said. "There were measures where the benchmarks increased, so we missed 3.5 stars by eight one thousandths of a point. I want to celebrate that we saw some significant improvement in our CAHPS scores for child and adult. It is a testament to the great care people are receiving throughout our network and the work that we are doing to capture that feedback. But we did see that we took a significant drop on our HEDIS domains. The population movement we saw this year had an impact. The 10 new counties did not come from legacy plans that were NCQA accredited, so these were new measures for them, and they had their own data incompleteness issues. Finally, there was the Dignity interruption as the beginning of MY2024 and that had an impact on the continuity of care." Kristine encouraged everyone to look at their counties rates and think what could be done to prioritize these measures. "Fall is a great time to really lean into chronic condition management," she said. "Make sure that people are adhering to their medications, that they are getting their screenings, and take advantage of our Pharmacy team's academic detailing at your health center."	
Close-out Summary of FY 2024-025 QI Work Plan – *Isaac Brown,, MPH/MBA, Interim Senior Director, Quality & Performance Improvement*		
	The QI Work Plan is designed to track progress on key QI activities and initiatives throughout the year. Approved by our Board of Directors and quality committees, it includes progress updates on planned activities and objectives for improving quality of clinical care, safety of clinical care, quality of service and members' experience. This update includes progress on activities included in the FY 2024-2025 QI Work Plan from July 1, 2024 to June 30, 2025. Fifty-five of the 67 goals are marked as "met." Most of the 12 unmet (some "terminated") goals are largely thus because delays in the implementation of Health Rules Payor as our new core claims system has in turn pushed back the go-live implementation of our new Medicare product, Partnership Advantage, by one year to Jan. 1, 2027. • The Dual Eligible Special Needs Plan (D-SNP) Strategy Work Group was formed and met with representatives from across the organization. All Medicare D-SNP measures were reviewed including those in Part C, Part D and Display measures, along with DHCS D-SNP measures for which Partnership will be accountable. Each measure was reviewed to identify measure ownership, data collection and intervention/actions. This information was documented for all measures and is available for other projects to identify business needs by department. • A new PCP Incentive Program for organizations contracting to serve Partnership Advantage members has been developed and gained executive approval. The approved proposal included program goals and principles, member and provider eligibility criteria, the measure set, scoring methodology, and payment mechanisms. • External vendors and internal IT resource capacity were both explored to identify a system solution for performance tracking of the D-SNP PCP QIP program. A vendor with experience delivering provider-based measure performance solutions was identified as the preferred option and recommended to Partnership's Project Review Board (PRB) in May 2025. The recommendation was accepted, and contracting was underway at the June 30 close of the fiscal year.	*There were no questions.* The Work Plan spreadsheet was included in the meeting packet under FYI. There was **a singular motion to approve the Closeout of the FY 2024-2025 QI Work Plan together with each document of the QI Trilogy**: Brian Montenegro, MD Second: Jennifer Wilson, MD Isaac thanked everyone who worked throughout the year on these documents.

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

1. Pediatrics
    - Expanded promotion of Healthy Babies Growing Together Program to include Partnership's Provider Network and specific messaging on an expanded $100 member incentive offering for timely completion of childhood immunizations required by HEDIS® measure, CIS-10
    - Launched a new Human Papillomavirus (HPV) 2nd Dose Reminder Program Pilot to affect HEDIS® immunization measure performance under IMA-2
    - Launched a new provider educational webinar on Developmental Screening in the First Three Years of Life (DEV) in preparation for more focused DEV measure improvement work in the provider network
    - Extended the PCP QIP Unit of Service (UOS) group well care visit measures to include members eligible under either the Well Child Visits in the First 15 Months (W15) or Well Child Visits for ages 15-30 months (W30) measure
    - Conducted Topical Fluoride for Children (TFL-CH) data investigation to identify and better address known data source gaps in related MCAS measure reporting
    - Completed a Child and Adolescent Well Care Visits (WCV) Disparity Sprint Campaign focused on improving well child visit completion in 4Q 2024 among disparate populations identified by DHCS from MY2022 MCAS Annual HEDIS® reporting.

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	○ Continued work on the DHCS-mandated Performance Improvement Project (PIP) to improve W15 completion rates in African American members in Solano County, while looking for spread opportunities in other areas of Partnership's service region. 2. Behavioral Health ○ As part of the DHCS-mandated Non-Clinical PIP, implemented a pilot to track and improve the follow up care for patients with mental health (FUM) and substance abuse disorder (FUA) after emergency department (ED) discharge aiming to increase the percentage of PCP notifications for a provider partner's assigned members. ○ Executed the DHCS-mandated IHI Behavioral Health Collaborative Project in partnership with Nevada County ○ Engaged County Departments of Behavioral Health (DBH) to utilize Sac Valley Med Share Data Exchange for follow-up after mental illness (FUM) data ○ Facilitated collaboration amongst several departments, including Behavior Health, Care Coordination, Population Health, Pharmacy, Health Equity's Tribal Health Liaison, and Quality Improvement. This collaborative group monitored and evaluated interventions aiming to improve FUM and FUA measures scores. ○ Increased embedded Community Health Workers (CHWs) in hospital Emergency Departments 3. Management of Chronic Diseases ○ Monitored, evaluated, and improved the use of the Diabetes management program offered by TeleMed2U ○ Implemented a pilot of a comprehensive, service-intensive diabetes management program ○ Brought the blood pressure control strategies into alignment with best practices of at least one primary care practice ○ Implemented a retinal eye exam grant to support providers in improving the rate of diabetic members receiving an annual retinal eye exam ○ Implemented improvements to the Cologuard bulk ordering program to better serve a broader group of Primary Care providers 4. Women's Health ○ Facilitated integration of cervical cancer screening HPV Self Swab across our network to affect the corresponding measure (CCS) rate ○ Identified three practices in counties with Chlamydia Screening in Women (CHL) rates below the MPL and conducted 1-on-1 provider education ○ Promoted incentives for "Increasing Screening Mammogram Capacity" in the Hospital Quality Incentive Program (H-QIP) ○ Elevated promotion of the Growing Together Program's increased incentive to impact postpartum rates ○ Identified counties with race/ethnicity disparities for post-partum visits and supported connection to Enhanced Care Management (ECM) Birth Equity (BE) providers to support members accessing post-partum care 5. Elder Care ○ Identified all D-SNP measures which fall within the QMSI workgroups by work group domain for further focus in D-SNP implementation planning. • The Performance Improvement (PI) team collaborated with the far northern consortia to bring QI awareness and education to providers serving members in Partnership's Redding and Eureka regions through several activities and forums. • Four (4) new Eastern Region providers were added to the Joint Leadership Initiative (JLI) series. • Improvement Academy offered six virtual trainings in 2025 highlighting priority MCAS measures including Pediatric Preventative Care for Ages 0 - 30 Months, Pediatric Preventative Care for Ages 3 - 17 years, Chronic Disease and Colorectal Cancer Screening, Perinatal Care and Chlamydia Screening, Breast and Cervical Cancer Screenings, and Diabetes Control. Improving Member Outcomes webinar attendance ranged from 53 to 90 attendees, with each session representing 28 to 45 unique organizations. Of	

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	attendees who completed the post-session evaluations for all six webinars, 99% selected "strongly agree" or "agree" when asked if the webinar was relevant and useful. • Improvement Academy hosted three "ABCs of Quality Improvement" in-person trainings with 100% of survey respondents, representing 37 unique provider organizations, reporting being extremely satisfied/satisfied with this course. • The Healthy Kids Growing Together Program conducted two (2) cohorts focused on contacting any 3 -6 year old who has never had a well-child visit in a set timeframe and offered an incentive to complete a well-child visit within 90 days prior to their 4th, 5th, and 6th birthday. More than 2,600 children participated and received member incentives. • The PCP QIP Breast Cancer 50th percentile benchmark has been met in the legacy Southeast, Southwest, and Northeast regions. This improvement was largely influenced by 77 Mobile Mammography event days, resulting in 2,162 completed breast cancer screenings. o 15 Mobile Mammography event days were held at Tribal Health Centers. o 14 Mobile Mammography event days were held at Enhanced Provider Engagement (EPE) provider organizations.	
QI Trilogy Summary – *Isaac Brown*		
Annually, the Quality and Performance Improvement Team updates three documents that reflect past, present, and future work related to quality improvement at Partnership HealthPlan of California (Partnership). Each document accounts for activities on a fiscal year cycle: 1. Quality Improvement Program Description 2. Quality Improvement Program Evaluation 3. Quality Improvement Work Plan Each document is a regulatory and an NCQA Accreditation requirement. The Quality Improvement Project Management team, together with the Senior Director of Quality and Performance Improvement and Director of Quality Management, serves as the QI Trilogy Document Team. The team led the preparation of the documents for August review by Partnership's quality committees, September review at the Physician Advisory Committee (PAC), and final approval by the Board of Commissioners in October. The QI Trilogy documents will be submitted to the State after Board approval and shared with Partnership members via the website and upon request. The **QI Program Description** (PD) is a summary of the QI program with content including the structure, processes, and intra and interdepartmental work that supports quality improvement efforts at Partnership. (A comprehensive synopsis of major changes was provided on p. 558 of this meeting packet.) The PD contains the following components per the NCQA accreditation standards (QI 1A): • The QI program structure • The behavioral healthcare aspects of the program • Involvement of a designated physician in the QI program • Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program • Oversight of QI functions of the organization by the QI Committee The Partnership fiscal year 2025-2026 document reflects revisions completed through interdepartmental review and collaboration, particularly in the following areas: 1. Clearer designation of leadership roles carrying authority and responsibility to ensure the program is fully implemented and maintained. For each identified role, the qualifications of staff presently fulfilling each role are detailed in an appendix. 2. Due to the delayed implementation of Partnership Advantage, Partnership's D-SNP language was updated to reflect implementation in 2027. Increased programmatic details specific to the D-SNP implementation will be included in the next annual update, including the launch of a dedicated Quality D-SNP Sub-Committee and expansion of the CAHPS® survey administration to include the D-SNP population.		

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3. Revisions made to a few of Partnership's Value Based Payment Programs, which include the sunsetting of the Specialist Quality Incentive Program and measurement focus in the Enhanced Care Management Quality Incentive Program.
4. Changes in the Site Review team's scope, such as the inclusion of monitoring Mobile/Street medicine and workflow changes due to the sunsetting of DHCS' Comprehensive Perinatal Service Program (CPSP) and launch of Partnership Health Perinatal Service Program.
5. Partnership continues to devote coaching resources designed to align with the priorities and needs of organization performing below the MPL to build capacity for quality improvement work.

The **QI Evaluation** is designed to assess performance on work outlined in the QI Program Description and the QI Work Plan. Per NCQA requirements (QI 1C), the evaluation must include the following:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service
- Trending of measures of performance in the quality and safety of clinical care and quality of service
- Evaluation of the overall effectiveness of the QI program and of its progress toward influencing network wide safe clinical practices

The Evaluation includes work directly completed by the QI department and other departmental partners within Partnership. In preparing the 2024-2025 evaluation, the following items were given greater consideration.

1. Continued analysis of the QI program structure and how the roles defined within the QI department and senior leadership/physician roles fulfill it.
2. Enhanced trend analysis and implementation of interventions for measurements related to clinical quality, member safety, and member experience outcomes, reflecting the most recent 12-month period compared to the prior year
3. Continued assessment of barriers in quality improvement with corresponding health plan adaptations to member and provider engagement strategies and tactics
4. Assessment of resources and organization of quality and performance improvement activities to accommodate the growing scope and complexity of quality measurement and reporting under both DHCS and NCQA accreditation. In FY 2024-2025, of particular focus was the preparation for the implementation of Partnership's D-SNP, evaluation of achieving at least a 3.5 STAR health plan rating as an NCQA accredited health plan, and preparation for NCQA Health Equity Accreditation (HEA) requirements.

The **QI Work Plan** outlines major activities for the QI department and organization as a whole that advance quality and performance improvement. The main areas of the Work Plan are designed to monitor and increase accountability per the NCQA technical specifications (QI 1B):

- Yearly planned QI activities and objectives for improving:
  – Quality of clinical care
  – Safety of clinical care
  – Quality of service
  – Members' experience
- Time frame for each activity's completion
- Staff members responsible for each activity
- Monitoring of previously identified issues
- Evaluation of the QI program

The document and requests for semi-annual and annual updates also provide a better accounting of the following:

1. Continued improvement to clearly identify and align Work Plan activities with organizational goals and desired outcomes.
2. Enhancement of document to identify whether a goal is new or continued to better track Monitoring of Previous Conditions, which is an NCQA requirement.

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Annually, the process for completing the Trilogy documents is assessed for improvement. In developing the 2025-2026 Work Plan, QI leadership worked to proactively identify new and adapted projects and programs based on the closeout of the 2024-2025 Work Plan. This led to greater dialog amongst sponsors, business owners and contributors on lessons learned, which correlates to the accomplishments and challenges cited in the 2024-2025 QI Evaluation. Ultimately, this refined approach aided the work plan change process and led to sound goal setting and deliverable identification in the 2025-2026 Work Plan.		
VII. FYI Attachment and Adjournment		
FYI: 2024-2025 QI Program Work Plan Final – *refer questions to Isaac Brown*		
Q/UAC adjourned at 8:56 a.m. Q/UAC next meets at 7:30 a.m. Wednesday, Sept. 17, 2025		

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

Signature of Approval: _____ Date: _____

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, Aug. 12, 2025 / 1:34 – 3:14 PM

Members Present:	Jones, Kermit, MD, JD, Deputy CMO & Medical Director for Medicare Services
Andrews, Leigha, MBA, Regional Director (Southwest)	Klakken, Vicki, Regional Director (Northwest)
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer	Kubota, Marshall, MD, Associate Medical Director
Bides, Robert, RN, BSN, Manager of Member Safety – Quality Investigations, QI	Leung, Stan, Pharm.D, Director of Pharmacy Services
Bjork, Sonja, JD, Chief Executive Officer	Matthews, Richard "Doug," MD, Regional Medical Director (Chico)
Bontrager, Mark, Sr. Director of Behavioral Health, Behavioral Health	Moore, Robert, MD, MPH, MBA, Chief Medical Officer, Committee Chair
Brown, Isaac, MHA/MBA, Interim Sr. Dir. of Q & P Improvement	Netherda, Mark, MD, Medical Director for Quality, Committee Vice-Chair
Brundage O'Connell, Lisa, MHA, Director of Enhanced Health Services	Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
Brunkal, Monika, RPh, Assoc. Dir., Population Health	Randhawa, Manleen, Senior Health Educator, Population Health
Campbell, Anna, Policy Analyst, Utilization Management	Ruffin, DeLorean, DrPH, MPH, Director of Population Health
DeVido, Jeff, MD, Behavioral Health Clinical Director	Stone, Kelly, RN, Director of Care Coordination, Care Coordination
Hightower, Tony, CPhT, Associate Director, UM Regulations	Villasenor, Edna, Senior Director, Member Services and G&A
Innes, Latrice, Manager of Grievance & Appeals Compliance	Ward, Lisa, MD, Regional Medical Director (Southwest)
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer	
Members Absent:	Gast, Brigid, MSN, BS, RN, NEA-BC, Sr. Director, Care Management
Ayala, Priscila, Director of Network Services	Kerlin, Mary, Senior Director, Provider Relations
Davis, Wendi, Chief Operating Officer	Sharp, Tim, Regional Director (Northeast)
Esget, Heather, RN, BSN, ACM, Director of Utilization Management	Townsend, Colleen, MD, Regional Medical Director (Southeast)
Garcia-Hernandez, Margarita, PhD, Director of Health Analytics	Turnipseed, Amy, Senior Director of External and Regulatory Affairs
Guests:	Kubota, Marshall, MD, Associate Medical Director
Akintan, Folo, MBBS/MD MPH MBA, Epidemiologist, Population Health	Kung, Jen, Senior Health Data Analyst II, Finance
Arrazola, Kelcie, Lead Trainer, Provider Relations	Lee, Donna, Manager of Claims, Claims
Bikila, Dejene, Manager of Data Science, Finance	Moraghebi, Roudabeh, Manager of Health Analysts, Finance
Boyle, Shannon, RN, Manager, Care Coordination Regulatory Performance	Morris, Matthew, MD, Regional Medical Director (Auburn)
Chebolu, Radha, Senior Health Data Analyst II, Finance	Nguyen, Tom, Manager of Health Analysts, Finance
Chiang, Yuen, Program Manager I, Utilization Management	O'Malley, Sarah, Sr Mgr of Behavioral Health Access, BH
Clark, Kristen, Manager, Quality & Training, Member Services	Rathnayake, Russ, Senior Health Data Analyst I, Finance
Conner, Maria, Improvement Advisor, QI (Auburn)	Romero, Liz, MPH, MCHES, Improvement Advisor, QI (Northeast)
Devan, James, Manager of Performance Improvement, QI (Northeast)	Salehi, Tiphanie, Sr. Health Data Analyst I, Finance
Durst, Jennifer, Sr Manager of Performance Improvement, QI (Southwest)	Seale, J'aime, PR Lead, Network Services
Erickson, Leslie, Program Coordinator II, QI (scribe)	Shorter, Ayana, Supervisor of Credentialing, Network Services
Flourney, Candi, Project Manager II, QI	Sivasankar, Shivani, Sr Data Scientist, Health Analytics, Finance
Garnick, Hayley, Supervisor of Behavioral Health Access, BH	Spencer, Ben, Project Coordinator I, Health Equity
Gual, Kristine, PMO, CPHQ, Director of Quality Measurement, QI	Spiller, Bettina, Associate Medical Director
Harris, Vander, Senior Health Data Analyst I, Finance	Stark, Rebecca, Regional Director (Chico)
Hugais, Anwar, Project Manager I (NCQA), QI	Thomas, Penny, Senior Health Data Analyst I, Finance
Isola, Brandy, Manager of Performance Improvement, QI (Chico/Auburn)	Trosky, Renee, Manager of Provider Relations Compliance
Jamali, Shahrzad, Improvement Advisor, QI (Chico)	Vaisenberg, Liat, Associate Director of Health Analytics, Finance
Jensen, Annika, RN, Assoc. Dir., Clinical Integration, Care Coordination	Williams, Mahkeeva, Supervisor of Behavioral Health Access, BH
Kim, Amanda, Senior Project Manager, QI	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

I. Call to Order
• Introductions
• Approval / Acceptance of Minutes
	Chief Medical Officer/Committee Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 1:34 p.m.
	• Several new staff attended IQI for the first time:
	  ○ Yuen Chiang, Program Manager I, Utilization Management
	  ○ Hayley Garnick, Supervisor of Behavioral Health Access, Behavioral Health
	  ○ Sarah O'Malley, Supervisor of Behavioral Health Access, Behavioral Health
	• Approval of the June IQI Minutes
	• Acceptance of the draft minutes of the
	  ○ May 8 Substance Use Internal Quality Improvement (SUIQI)
		Motion to **approve IQI Minutes**: Mark Netherda, MD
		Second: Isaac Brown, MHA/MBA
		
		Motion to **accept other minutes**: Katherine Barresi, RN
		Second: Stan Leung, Pharm.D

II. Old Business - None		
III. New Business Consent Calendar (Committee Members as applicable)		
PQI / PPC 1st and 2nd Qtrs 2025 with Data Analysis – *direct questions to Robert Bides, RN* **Health Services Policies** <u>Care Coordination</u> MPCP2007 – Complex Case Management – *previously MCCP2007* MCCP2032 – CalAIM Enhanced Care Management (ECM) – **ARCHIVE** *effective 09/10/25* <u>Enhanced Health Services</u> MCAP7002 – CalAIM Enhanced Care Management (ECM) – *previously MCCP2032* <u>Pharmacy</u> MCRP4066 – AB1114 Benefit Implementation and Oversight <u>Quality Improvement</u> MPQP1048 – Reporting Communicable Diseases <u>Utilization Management</u> MCUP3053 – Acute Inpatient Administrative Days – **ARCHIVE** *effective 09/10/25* MCUP3114 – Physical, Occupational and Speech Therapies MCUP3133 – Wheelchair Mobility, Seating and Positional Components MCUP3141 – Delegation of Inpatient Utilization Management MPUP3006 – Appropriate Service & Coverage (Over/Under Utilization) MPUP3042 – Technology Assessment – *previously MCUP3042* MPUP3138 – External Independent Medical Review – *previously MCUP3138* **Non-Health Services Policies** <u>Member Services</u> MC334 – American Indian Rights and Protections MP301 – Assisting Providers with Missed Appointments MP316 – Provider Request to Discharge Member & Assistance with Inappropriate Member Behavior	Motion to **approve slate without MPQP1048**: Lisa O'Connell, MPH Second: Mark Netherda, MD Motion to **approve MPQP1048 as amended**: Lisa O'Connell, MPH Second: Anna Campbell <u>Next Steps</u>: Health Services policies but for MCRP4066 go to Aug. 20 Quality/Utilization Advisory Committee (Q/UAC) and to Sept. 10 Physician Advisory Committee (PAC) as do MP301, MP316, and MPNET101. MCRP4066 goes to Oct. 9 Pharmacy & Therapeutics Committee and Nov. 12 PAC MC334 now finals in Member Services The Credentialing slate but for MPNET101 goes to the Sept. 10 Credentials Committee for final approvals

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Network Services MPCR12 – Credentialing of Individual and Private Duty Nurses Under EPSDT MPCR15 – Doula Credentialing and Re-credentialing Criteria MPCP100 – Credential and Re-credential Decision Making Process MPCR200 – Credentials Committee and CMP Credentialing Program Responsibilities MPCR602 – Reporting Actions to Authorities MPNET101 – Wellness and Recovery Access Standards and Monitoring Mark Netherda, MD, **pulled MPQP1048 to add two Related Policies**: Care Coordination's MCCP2035 – Local Health Department (LHD) Coordination and Utilization Management's MPUP3047 – Tuberculosis Related Treatment. There was no discussion, and **the policy was approved as amended.**		
IV. New Business – Discussion Policies		
Policy Owner: Enhanced Health Services – *Lisa O'Connell, MPH, Director of Enhanced Health Services*		
MCAP7003 – CalAIM Community Supports (CS)	**This policy was pulled from the packet Aug. 4 for more internal work on medically tailored meals/groceries criteria.**	*This policy will likely come back to committees in October.*
Policy Owner: Health Equity – *Presenter: Mohamed Jalloh, Pharm.D, Director of Health Equity (Health Equity Officer)*		
MCED6001 – Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description	This policy is updated to fulfill Department of Health Care Services related corrective action plans and Community Reinvestment Requirements All Plan Letter (APL) 25-004. Updated clear designation of QIHETP leadership/committee roles, to ensure programs are fully implemented and maintained. For each identified role, the qualifications of staff presently fulfilling each role is detailed in an appendix to the Quality Improvement Program Description being presented today. The definition of the Community Reinvestment Management program is updated and a note added to explain the funding requirements per APL 25-004. Also, it is updated to clarify relationship between Partnership HealthPlan and Local Health Jurisdictions (LHJ) and Behavioral Health Teams. Finally, the update clarifies community engagement requirements and reinvestment plan timelines. Community – Access – Respect – Engagement Services (CARES) training coverage is explained. Access to staff for members and practitioners seeking information about the utilization management process and the authorization of care is explained. 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 sensory impairment for population groups as determined by contract. Dr. Jalloh noted changes were made with DHCS' guidance. We will be looking at CARES completion rates and community reinvestment plans Partnership needs to make and report.	*There were no questions.* Motion to **approve as presented**: Isaac Brown Second: Mark Netherda, MD Next Steps: Aug. 20 Q/UAC Sept. 10 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations*		
MCUG3024 – Inpatient Utilization Management	This policy has been **updated to include information regarding acute inpatient administrative days that was previously located in policy, MCUP3053, which is now archived**. Additionally, a new Attachment document has been added to this policy to describe the information required for a post-discharge appeal for Inpatient Admissions. **Section I:** Policy numbers were updated and two Related Policies were added: F. MCUG3038 - Review Guidelines for Member Placement in LTC Facilities G. MCAP7003 - CalAIM Community Supports (CS) **Section III.A.** Definition was added for Acute Inpatient Administrative Days. **Section III.E.** Definition of Inpatient Admission locations was expanded to include Subacute Care Facilities. Also, each type of location was defined. **Section IV.** Attachment A was added: "Provider Dispute Resolution (PDR) Request: Post Discharge Appeal for Inpatient Admission." **Section VI.B.** This section on Criteria was simplified and the reader was referred instead to further information in policy MPUP3139 Criteria and Guidelines for Utilization Management. **Section VI.E.5.j.** Paragraph was added regarding Peer to Peer request requirements for inpatient admissions. **Section VI.E.5.k.** Paragraph was added regarding requirements for post-discharge provider dispute request for inpatient admission. **Section VI.G.** This new policy section was added to incorporate the information regarding Acute Inpatient Administrative Days that was previously located in policy MCUP3053, which is now archived. **Section VI.H.** This section regarding Inpatient Psychiatric Admissions was updated to clarify that acute inpatient administrative days do not apply when a Partnership Medi-Cal Member is pending evaluation on a psychiatric hold or awaiting placement at a mental health facility. Specialty mental health services are not a Partnership responsibility **Section VI.I.2**. Language was added in the Case Review Conference section to specify that these meetings now often include facility care management staff (e.g. case managers, discharge planners). **Section VI.K.** This section on Communication Services was simplified and the reader was referred instead to further information in policy MCUP3064 Communication Services. **Section VI.L.** This section on Delegation Oversight and Monitoring was simplified and the reader was referred instead to further information in policy MCUP3141 Delegation of Inpatient Utilization Management. Tony went through the synopsis. Associate Medical Director Marshall Kubota, MD, asked if VI.G.2 was an exhaustive list of facilities providing lower levels of care. He suggested that if it is, the policy should say that so there is no question whether congregate living is a lower level of care. Discussion ensued between doctors Kubota and Moore, CEO Sonja Bjork, Chief Health Services Officer Katherine Barresi, and Policy Analyst Anna Campbell. **VI.G.2 is amended** as follows: **Inpatient acute facilities must provide documentation to demonstrate that active inquiries are being made to potential facilities for the appropriate level of care as determined by medical necessity. The Member's record must reflect the outreach efforts to achieve placement at a SNF, Subacute facility, or ICF.**	Motion to **approve as amended**: Katherine Barrsi, RN Second: Mark Netherda, MD Next Steps: Aug. 20 Q/UAC Sept. 10 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
V. Presentations		
QI Update – *Isaac Brown, MPH/MBA, Interim Senior Director, Quality Improvement and Performance*		
• We are in the middle of our Primary Care Provider Quality Incentive Program (PCP QIP) season. The June disbursement of approximately $52M is the largest to date. • The 2025-26 Hospital QIP (HQIP) Measurement Set, as approved by Partnership's Physician Advisory Committee (PAC) in April, is now in full effect as of 07/01/2025 through 6/30/2026. In January 2025, there was much discussion in quality committees about how the QIP team was applying lessons learned from its annual evaluation of FY 2023-2024 Hospital QIP to measure development for FY 2025-2026. • As an update to this discussion, it is important to note that FY 2025-2026 includes a new Vaccines for Children (VFC) Program Enrollment measure incentivizing birthing hospitals' enrollment in the California Department of Public Health program. This CDPH program provides vaccines to hospitals at a lower cost for the Medi-Cal population. Three of the 17 birthing hospitals in the HQIP are currently enrolled, and two more are in the contracting process. The measurement set includes links to the VFC program website that explains the program requirements and enrollment process. Troy Foster, HQIP Program Manager, will connect with hospital quality directors throughout the year to monitor and encourage enrollment status. • Additionally in FY 2025-2026, Partnership continues to encourage its hospitals to engage in advancing health equity by including a health equity measure in the HQIP that now aligns with the Centers for Medicare & Medicaid Services (CMS). This HQIP measure requires hospitals with ≥ 25 Licensed General Acute (LGA) beds to submit a copy of their most recent CMS program attestation for the Hospital Commitment. This measure challenges hospitals to commit to health equity in measurable ways as points are only earned through attestations demonstrating fulfillment of all five domains set forth by CMS. • It is nice to see Consumer Assessment of Healthcare Providers and Systems (CAHPS®) scores heading in the right direction. The Plan's Patient Experience rating is projected to achieve 2.5 with the submission of the Child CAHPS® results. This reflects a notable .5 STAR improvement compared to the Measurement Year (MY) 2023 Patient Experience rating. • The CAHPS® team is working closely with our certified vendor, Press Ganey, to finalize a multi-phase project. Phase One centers on the design and refinement of survey questions to ensure relevance and ease of understanding. Phase Two – developing standardized reporting formats and data presentation tool – is targeted to begin his November. • We are now in the middle of our second locum tenens pilot, now known as the Preventative Care Bridge Project. We are pushing well-child visits through several providers, each of whom are using locums for three months. We intend to develop a practical locum toolkit that providers may integrate into their practices. • Partnership had a call Aug. 4 with National Committee for Quality Assurance (NCQA) personnel regarding our Health Equity Accreditation (HEA). We are now providing our final responses on NCQA's preliminary report.		*For information only.* Dr. Moore thanked everyone who worked on our successful effort to become HEA accredited.
HEDIS® MY 2024 / RY 2025 Summary of Performance – *Kristine Gual, PMP, CPHQ, Director of Quality Measurement, QI*		
Kristine went through the changes to reporting populations in MY2024 and noted that the Healthcare Effectiveness Data Information Set (HEDIS®) companion pieces, the Managed Care Accountability Set (MCAS) and NCQA Health Plan Accreditation (HPA) summaries of performance would be posted to Partnership's public website by the end of August. Prior to MY2024, when Partnership had just 14 "legacy" counties, reporting was done according to four geographical regions. Reporting is now plan-wide for all 24 counties in MY2024, during which time total membership grew 36.7%. Furthermore, DHCS is also interested in each county's performance on each of the 18 MCAS measures to which we are held accountable. Today's presentation focused on plan-wide data.		The MCAS Summary of Performance will be included in the Aug. 20 Q/UAC packet. The HPA Summary of Performance is pending. Both white papers should be available on the public website by the end of this month.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	The 18 MCAS measures continue from MY2023, and it is DHCS's expectation that we will meet or exceed the 50th percentile of the national Quality Compass® Medicaid Benchmark for each measure. A maximum of 10 points is awarded per measure based on these benchmarks. The resulting composite core from DHCS is known as the Quality Factor Score (QFS). Sanctions may apply where we may fail to meet the 50th percentile minimum performance level (MPL). We hope to learn by the end of August DHCS's sanction methodology: would they be applied by county or group of counties? In a year-over-year comparison of our MCAS composite scoring, Partnership fared better in MY2024 (56.10%) than in MY2023 (51.88%) but not as well as in MY2022 (59.99%) when we had 15, rather than 18, measures. DHCS extended a one-year grace period in MY2023 when we and all other Managed Care Plans (MCPs) in California went from 15 to 18 measures. DHCS will not be doing the same for MY2025, and Deputy Chief Medical Officer and Medical Director for Medicare Services Kermit Jones, MD, JD, asked why. Dr. Moore replied that DHCS had a change in leadership this year and did not tell us why there will be no grace despite this being a multi-year precedent. The HEDIS® table of the 18 MCAS measures is now in development on Tableau. Kristine noted that our highest plan-wide performance relative to the national Quality Compass® Medicaid Benchmark came in our Prenatal and Postpartum Care – postpartum care measure (90%). We might expect some sanctions, perhaps at the geographic level, on the seven measures scoring under the 50th percentile MPL. We are very proud of our dramatic improvements in the two Well-Child Visits measures. Historically, we have not performed well here, in part because of data incompleteness issues. However, this year our HEDIS® team received auditor permission to do a "chart chase," that is, conduct medical record reviews. The results improved our WCV in the first 15 months of life from under the 10th percentile to 75th percentile. Similarly, WCV in the first 30 months went from 37.5% last measurement year to 62.5% in MY2024. Blood lead screening in children increased from the 25th percentile to the 75th percentile, in part likely because we brought focus to it by incentivizing it in the PCP QIP. Three multi-year measures – Breast Cancer Screening, Cervical Cancer Screening, and Childhood Immunization Status – each improved to the 50th percentile MPL despite data incompleteness in the 10 new counties. We continued to do well on the three hybrid measures – Controlling High Blood Pressure, Glycemic Status Assessment for Patients with Diabetes (GSD), and Immunizations for Adolescents; however, the GSD and the Prenatal and Postpartum Timeliness of Prenatal Care too are now on our "watch list" because those national benchmarks themselves moved this year. Kristine said she has confidence in the data we are now receiving for three measures that did not meet the 50th percentile MPL – Asthma Medication Ratio (AMR), Chlamydia Screening in Women (CHL), and Child and Adolescent Well-Care Visits. The CHL is new to the PCP QIP and may be helped therein this coming year. Pharmacy's interventions through more than a dozen academic detailing sessions with various hospitals has helped with the AMR. Director of Pharmacy Services Stan Leung, Pharm.D, remarked that continuing to drive the message to use "smart therapy" will show results. (Dr. Moore added that Partnership must continue to "evangelize" this even though we have just five months before this measure will be retired.) Four measures, including two behavioral health measures, for which we are dependent on DHCS for data, did poorly, in large part because of data incompleteness issues. Coding was an issue for providers on the Topical Fluoride in Children, but we devised a workaround, which has been of help. Coding was also an issue for providers in meeting Developmental Screening in the First Three Years of Life; however, DEV may improve next year as it becomes a hybrid measure. Further, we experience big delays in receiving behavioral health data from Carelon, our network providers, and our county health departments. DHCS declined to sanction us last year because of these data incompleteness issues; we do not know if they will sanction us for MY2024.	*Meeting Postscript:* NCQA contacted Partnership earlier than expected to convey our HPA Star rating. Refer to the Aug. 20 Q/UAC minutes for a more extensive discussion on how their rating is different than what we projected at IQI.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Kristine went on to explain NCQA's methodology for assigning a "Star rating" via Health Plan Accreditation (HPA). It is a combination of the Patient Experience as drawn from Partnership's choice to use either the Adult or the Child CAHPS survey, our HEDIS® scores across Prevention and Population and Treatment domains in clinical measures. A half point bonus is added if the Plan is HPA accredited, which Partnership is. We rated 3.5 stars (on a five star scale) last year and are projecting we will again be at 3.5 for MY2024. (See *Meeting Postscript*.) This year Partnership elected to use the Child CAHPS survey. Kristine lauded Anthony Sackett, Andrea Thomas, and team for their hard work on the surveys, in which we estimated a half point improvement in both the Child and Adult experiences. Marshall Kubota, MD, questioned how, if we have done better, we could still be at 3.5 stars. A conversation ensued on NCQA's rounding methodology.	
Closeout Summary of FY 2024-2025 QI Work Plan – *Isaac Brown, MPH/MBA, Interim Senior Director of Quality & Performance Improvement*		
	The QI Work Plan is designed to track progress on key QI activities and initiatives throughout the year. Approved by our Board of Directors and quality committees, it includes progress updates on planned activities and objectives for improving quality of clinical care, safety of clinical care, quality of service and members' experience. This update includes progress on activities included in the FY 2024-2025 QI Work Plan from July 1, 2024 to June 30, 2025. Fifty-five of the 67 goals are marked as "met." Most of the 12 unmet (some "terminated") goals are largely thus because delays in the implementation of Health Rules Payor as our new core claims system has in turn pushed back the go-live implementation of our new Medicare product, Partnership Advantage, by one year to Jan. 1, 2027. • The Dual Eligible Special Needs Plan (D-SNP) Strategy Work Group was formed and met with representatives from across the organization. All Medicare D-SNP measures were reviewed including those in Part C, Part D and Display measures, along with DHCS D-SNP measures for which Partnership will be accountable. Each measure was reviewed to identify measure ownership, data collection and intervention/actions. This information was documented for all measures and is available for other projects to identify business needs by department. • A new PCP Incentive Program for organizations contracting to serve Partnership Advantage members has been developed and gained executive approval. The approved proposal included program goals and principles, member and provider eligibility criteria, the measure set, scoring methodology, and payment mechanisms. • External vendors and internal IT resource capacity were both explored to identify a system solution for performance tracking of the D-SNP PCP QIP program. A vendor with experience delivering provider-based measure performance solutions was identified as the preferred option and recommended to Partnership's Project Review Board (PRB) in May 2025. The recommendation was accepted, and contracting was underway at the June 30 close of the fiscal year. • A CAHPS D-SNP programmatic work plan and timeline have been developed with framework informed by research into survey methodologies and conversation with other local health plans in California. Ongoing coordination with the identified survey vendor and CAHPS team will help further implementation planning. • The Member Safety Quality Investigation team reviewed and saw no changes would be needed to Partnership's current Peer Review Committee (PRC) policy or to the current Potential Quality Investigation (PQI) process to accommodate D-SNP. • The Investigation team completed UAT testing and upgraded its PQI process tool to Sugar, Version 14. This tool is used to maintain PQI cases end-to-end through the process and for storage. • The Member Safety Inspections Team piloted a "Quality Management Overview" document that is completed prior to each scheduled site review. Each Overview details recent QI interactions, status check on sites, and updates on HEDIS®, QIP, and Performance Improvement programs and initiatives. These details are reviewed with the site's staff during the completion of the	*There were no questions.* The Work Plan spreadsheet was included in the meeting packet under FYI. There was **a singular motion to approve the Closeout of the FY 2024-2025 QI Work Plan together with each document of the QI Trilogy**: Mark Netherda, MD Second: Richard "Doug" Matthews, MD Isaac thanked everyone who worked throughout the year on these documents. Dr. Moore added his thanks too.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

Medical Record Review (MRR). Post review surveys of Site Review nurses revealed mixed feedback. Most nurses found sharing this additional quality information beneficial to conducting the site review. A few warm hand offs to the PI and QIP teams also resulted.

- The Inspections Team developed provider training materials to reflect Child Health and Disability Program (CHDP) requirements. The delivery of these training materials is now the responsibility of managed care plans. Training topics include vision, hearing, fluoride varnish application, anthropometric screenings and information on vaccines for children (VFC). These materials have been distributed to the provider network with issuance of certificates upon staff completion.
- The PCP QIP team reviewed its existing Data Validation framework to identify areas for improvement, based on learnings over the past year. The team added a dedicated Non-Clinical Measure Preliminary Period for providers to review and validate their final data before Partnership completes scoring and payment. The team also detailed the existing eReports clinical validation period and updated the process for verifying Health Information Exchange (HIE) connections by provider organization. A designated QIP Workgroup developed provider education materials to inform and influence Member Experience improvement activities.
- The Quality Measure Score Improvement (QMSI) initiative successfully engaged five measure-specific workgroups. Each workgroup monitored and reviewed measure performance, as data was available, identified and completed score improvement activities for all stated deliverables by the end of the fiscal year. Highlights include:

  1. Pediatrics
     - Expanded promotion of Healthy Babies Growing Together Program to include Partnership's Provider Network and specific messaging on an expanded $100 member incentive offering for timely completion of childhood immunizations required by HEDIS® measure, CIS-10
     - Launched a new Human Papillomavirus (HPV) 2nd Dose Reminder Program Pilot to affect HEDIS® immunization measure performance under IMA-2
     - Launched a new provider educational webinar on Developmental Screening in the First Three Years of Life (DEV) in preparation for more focused DEV measure improvement work in the provider network
     - Extended the PCP QIP Unit of Service (UOS) group well care visit measures to include members eligible under either the Well Child Visits in the First 15 Months (W15) or Well Child Visits for ages 15-30 months (W30) measure
     - Conducted Topical Fluoride for Children (TFL-CH) data investigation to identify and better address known data source gaps in related MCAS measure reporting
     - Completed a Child and Adolescent Well Care Visits (WCV) Disparity Sprint Campaign focused on improving well child visit completion in 4Q 2024 among disparate populations identified by DHCS from MY2022 MCAS Annual HEDIS® reporting.
     - Continued work on the DHCS-mandated Performance Improvement Project (PIP) to improve W15 completion rates in African American members in Solano County, while looking for spread opportunities in other areas of Partnership's service region.

  2. Behavioral Health
     - As part of the DHCS-mandated Non-Clinical PIP, implemented a pilot to track and improve the follow up care for patients with mental health (FUM) and substance abuse disorder (FUA) after emergency department (ED) discharge aiming to increase the percentage of PCP notifications for a provider partner's assigned members.
     - Executed the DHCS-mandated IHI Behavioral Health Collaborative Project in partnership with Nevada County
     - Engaged County Departments of Behavioral Health (DBH) to utilize Sac Valley Med Share Data Exchange for follow-up after mental illness (FUM) data
     - Facilitated collaboration amongst several departments, including Behavior Health, Care Coordination, Population Health, Pharmacy, Health Equity's Tribal Health Liaison, and Quality Improvement. This collaborative group monitored and evaluated interventions aiming to improve FUM and FUA measures scores.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	○ Increased embedded Community Health Workers (CHWs) in hospital Emergency Departments 3. Management of Chronic Diseases ○ Monitored, evaluated, and improved the use of the Diabetes management program offered by TeleMed2U ○ Implemented a pilot of a comprehensive, service-intensive diabetes management program ○ Brought the blood pressure control strategies into alignment with best practices of at least one primary care practice ○ Implemented a retinal eye exam grant to support providers in improving the rate of diabetic members receiving an annual retinal eye exam ○ Implemented improvements to the Cologuard bulk ordering program to better serve a broader group of Primary Care providers 4. Women's Health ○ Facilitated integration of cervical cancer screening HPV Self Swab across our network to affect the corresponding measure (CCS) rate ○ Identified three practices in counties with Chlamydia Screening in Women (CHL) rates below the MPL and conducted 1-on-1 provider education ○ Promoted incentives for "Increasing Screening Mammogram Capacity" in the Hospital Quality Incentive Program (H-QIP) ○ Elevated promotion of the Growing Together Program's increased incentive to impact postpartum rates ○ Identified counties with race/ethnicity disparities for post-partum visits and supported connection to Enhanced Care Management (ECM) Birth Equity (BE) providers to support members accessing post-partum care 5. Elder Care ○ Identified all D-SNP measures which fall within the QMSI workgroups by work group domain for further focus in D-SNP implementation planning. • The Performance Improvement (PI) team collaborated with the far northern consortia to bring QI awareness and education to providers serving members in Partnership's Redding and Eureka regions through several activities and forums. • Four (4) new Eastern Region providers were added to the Joint Leadership Initiative (JLI) series. • Improvement Academy offered six virtual trainings in 2025 highlighting priority MCAS measures including Pediatric Preventative Care for Ages 0 - 30 Months, Pediatric Preventative Care for Ages 3 - 17 years, Chronic Disease and Colorectal Cancer Screening, Perinatal Care and Chlamydia Screening, Breast and Cervical Cancer Screenings, and Diabetes Control. Improving Member Outcomes webinar attendance ranged from 53 to 90 attendees, with each session representing 28 to 45 unique organizations. Of attendees who completed the post-session evaluations for all six webinars, 99% selected "strongly agree" or "agree" when asked if the webinar was relevant and useful. • Improvement Academy hosted three "ABCs of Quality Improvement" in-person trainings with 100% of survey respondents, representing 37 unique provider organizations, reporting being extremely satisfied/satisfied with this course. • The Healthy Kids Growing Together Program conducted two (2) cohorts focused on contacting any 3 -6 year old who has never had a well-child visit in a set timeframe and offered an incentive to complete a well-child visit within 90 days prior to their 4th, 5th, and 6th birthday. More than 2,600 children participated and received member incentives. • The PCP QIP Breast Cancer 50th percentile benchmark has been met in the legacy Southeast, Southwest, and Northeast regions. This improvement was largely influenced by 77 Mobile Mammography event days, resulting in 2,162 completed breast cancer screenings. ○ 15 Mobile Mammography event days were held at Tribal Health Centers. ○ 14 Mobile Mammography event days were held at Enhanced Provider Engagement (EPE) provider organizations.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

QI Trilogy Summary – *Isaac Brown*

Annually, the Quality and Performance Improvement Team updates three documents that reflect past, present, and future work related to quality improvement at Partnership HealthPlan of California (Partnership). Each document accounts for activities on a fiscal year cycle:
1. Quality Improvement Program Description
2. Quality Improvement Program Evaluation
3. Quality Improvement Work Plan

Each document is a regulatory and an NCQA Accreditation requirement. The Quality Improvement Project Management team, together with the Senior Director of Quality and Performance Improvement and Director of Quality Management, serves as the QI Trilogy Document Team. The team led the preparation of the documents for August review by Partnership's quality committees, September review at the Physician Advisory Committee (PAC), and final approval by the Board of Commissioners in October. The QI Trilogy documents will be submitted to the State after Board approval and shared with Partnership members via the website and upon request.

The **QI Program Description** (PD) is a summary of the QI program with content including the structure, processes, and intra and interdepartmental work that supports quality improvement efforts at Partnership. (A comprehensive synopsis of major changes was provided on p. 499 of this meeting packet.) The PD contains the following components per the NCQA accreditation standards (QI 1A):
- The QI program structure
- The behavioral healthcare aspects of the program
- Involvement of a designated physician in the QI program
- Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program
- Oversight of QI functions of the organization by the QI Committee

The Partnership fiscal year 2025-2026 document reflects revisions completed through interdepartmental review and collaboration, particularly in the following areas:
1. Clearer designation of leadership roles carrying authority and responsibility to ensure the program is fully implemented and maintained. For each identified role, the qualifications of staff presently fulfilling each role are detailed in an appendix.
2. Due to the delayed implementation of Partnership Advantage, Partnership's D-SNP language was updated to reflect implementation in 2027. Increased programmatic details specific to the D-SNP implementation will be included in the next annual update, including the launch of a dedicated Quality D-SNP Sub-Committee and expansion of the CAHPS® survey administration to include the D-SNP population.
3. Revisions made to a few of Partnership's Value Based Payment Programs, which include the sunsetting of the Specialist Quality Incentive Program and measurement focus in the Enhanced Care Management Quality Incentive Program.
4. Changes in the Site Review team's scope, such as the inclusion of monitoring Mobile/Street medicine and workflow changes due to the sunsetting of DHCS' Comprehensive Perinatal Service Program (CPSP) and launch of Partnership Health Perinatal Service Program.
5. Partnership continues to devote coaching resources designed to align with the priorities and needs of organization performing below the MPL to build capacity for quality improvement work.

The **QI Evaluation** is designed to assess performance on work outlined in the QI Program Description and the QI Work Plan. Per NCQA requirements (QI 1C), the evaluation must include the following:
- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service
- Trending of measures of performance in the quality and safety of clinical care and quality of service
- Evaluation of the overall effectiveness of the QI program and of its progress toward influencing network wide safe clinical practices

The Evaluation includes work directly completed by the QI department and other departmental partners within Partnership. In preparing the 2024-2025 evaluation, the following items were given greater consideration.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

1. Continued analysis of the QI program structure and how the roles defined within the QI department and senior leadership/physician roles fulfill it.
2. Enhanced trend analysis and implementation of interventions for measurements related to clinical quality, member safety, and member experience outcomes, reflecting the most recent 12-month period compared to the prior year
3. Continued assessment of barriers in quality improvement with corresponding health plan adaptations to member and provider engagement strategies and tactics
4. Assessment of resources and organization of quality and performance improvement activities to accommodate the growing scope and complexity of quality measurement and reporting under both DHCS and NCQA accreditation. In FY 2024-2025, of particular focus was the preparation for the implementation of Partnership's D-SNP, evaluation of achieving at least a 3.5 STAR health plan rating as an NCQA accredited health plan, and preparation for NCQA Health Equity Accreditation (HEA) requirements.

The **QI Work Plan** outlines major activities for the QI department and organization as a whole that advance quality and performance improvement. The main areas of the Work Plan are designed to monitor and increase accountability per the NCQA technical specifications (QI 1B):

- Yearly planned QI activities and objectives for improving:
  - – Quality of clinical care
  - – Safety of clinical care
  - – Quality of service
  - – Members' experience
- Time frame for each activity's completion
- Staff members responsible for each activity
- Monitoring of previously identified issues
- Evaluation of the QI program

The document and requests for semi-annual and annual updates also provide a better accounting of the following:

1. Continued improvement to clearly identify and align Work Plan activities with organizational goals and desired outcomes.
2. Enhancement of document to identify whether a goal is new or continued to better track Monitoring of Previous Conditions, which is an NCQA requirement.

Annually, the process for completing the Trilogy documents is assessed for improvement. In developing the 2025-2026 Work Plan, QI leadership worked to proactively identify new and adapted projects and programs based on the closeout of the 2024-2025 Work Plan. This led to greater dialog amongst sponsors, business owners and contributors on lessons learned, which correlates to the accomplishments and challenges cited in the 2024-2025 QI Evaluation. Ultimately, this refined approach aided the work plan change process and led to sound goal setting and deliverable identification in the 2025-2026 Work Plan.

FYI: 2024-2025 QI Program Work Plan Final – Excel spreadsheet – *direct any questions to Isaac Brown, MPA/MBH*

VI. Adjournment

Dr. Moore adjourned the meeting at 3:14 p.m. IQI will meet next Tuesday, Sept. 9, 2025.

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

Approval Signature: *Date:*

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

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Over/Under Utilization Workgroup

Meeting Name: Over/Under Utilization Workgroup

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

Date: July 30th, 2025

Time: 3:00pm – 4:00pm

Location: Board Room

Owner: Dr. Ribordy

Coordinator: Radha Chebolu (Health Analytics)

Attendees:

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

Action Items	Presenter	Due	Revise / Approve Date
Approve Minutes from 04/30/2025		07/30/2025	

Topic	Notes
1) Introductions & Objective of Meeting *Speaker:* Dr. Jeff Ribordy	Identify potential concerns for over/under utilization within the PHC network
2) Review & approve minutes from last meeting *Speaker:* Dr. Jeff Ribordy	
Underutilization Analysis Discussion Topics	
1) PCP Visit Report Owner*:* HA	In 2025, so far, Colusa, Del Norte, and Glenn counties are leading in PCP visit rates, exceeding the target, while the counties - Placer, Lassen, and Solano have seen the lowest visit rates. Overall, the PCP visit rates are trending up compared to prior quarter. Sister health plans in Southern California experienced lower rates due to the ongoing political environment that led to member hesitation to access care. Plumas County has highest number of PCPs per capita, but its visit rates remain low. Low rates are usually due to poor access or billing issues. While Ampla Health is generally doing well, the Chico location is underperforming with low visit rates.
2) TAR trend report *Speaker:* HA	Discuss Findings In 2024, Partnership received almost 750k authorizations of all types (approved, denied, in process, etc.) except voided, and from all classes (inpatient, outpatient, referral, etc.) which is a 56% increase from 2023. The annualized rate per 1,000 members has only increased by 3.5% from 2023. For authorizations that turned into paid claims, the total paid amount was $2.7 billion in 2024, a 56% increase from 2023. In annualized rate per 1,000, this is a 3% increase from 2023. In 2025, the number of authorizations is quite similar to 2024, except in March 2025, where the number of authorizations have increased by 6% from 2024. In 2024, Outpatient Hospital services generated the highest number of authorizations with 79.58 authorizations per 1,000 members per year. Among the RAFs, Ophthalmology is the specialty with the second highest number of authorizations received in 2024. In terms of total paid amount, inpatient Hospital and inpatient Skilled Nursing Facility are the 2 specialties with the largest total paid amount in 2024.
3) Chlamydia Screening *Speaker:* Dr. Moore	Discuss Findings From HEDIS data 2023 year: a. Northeast i. Anderson clinic outperformed all the

	clinics ii. Churn creek doing well in 2025 a. Northwest i. Open door doing more universal screening in 2024 b. Southeast i. Winters healthcare had unusually low visit rate ii. Pediatricians have a harder time with this measure c. Southwest i. Marin community clinic is performing universal screenings ii. Rate improvements at Santa Rosa clinic are expected to be slower
4) Underutilization of Well Child Visits *Speaker:* QI	Discuss Findings *Measure Definition:* The percentage of continuously enrolled Medi-Cal members who turned 15 months old during the measurement year and who had six (6) or more well-child visits with a PCP during their first 15 months of life. For measurement year 2024 (MY2024), Partnership HealthPlan of California's (Partnership) performance on the Well Child Visits Birth – 15 Months (W30-6) measure relative to NCQA national Medicaid benchmarks was at or above the 50th national percentile in 3 of the five sub regions, and 10 out of 24 Partnership counties. The Department of Health Care Services (DHCS) has established the 50th national percentile as the minimum performance level (MPL). In May 2023 DHCS announced that beginning in 2024, all Managed Care Plans would be subject to withholds of a percentage of revenue, which would be paid to the plan for meeting MPL's for 10 prioritized HEDIS measures. Well Child Visits Birth – 15 Months is one of the prioritized "Withhold Measures" and Partnership is committed to prioritizing improving performance on this measure along with all other Withhold Measures. The following are Partnership's interventions to increase W30-6 rates: - Continued Focus from Pediatric Workgroup (QMSI) - Preventative Care Reports for W30-6 - Healthy Kids/Growing Together Program - CMS Well Child Visit Affinity Group - DHCS Assigned W30-6 Equity PIP - SQIP-I Workgroup - Training through Accelerated Learning and Regional Meetings
5) Transportation services report *Speaker:* HA	For June 2025, there were 88,161 total trips across all counties. Shasta had the most at 13,600, while Sierra had the fewest at 38. Out of 909,331 eligible members, 10,617 used

	transportation services, for an average utilization rate of 1.17 percent. Shasta led with 2.23 percent utilization, and Yuba was lowest at 0.64 percent. Members who used the service averaged 8.3 trips each, with Glenn highest at 11.1 and Modoc lowest at 3.1. The overall trip rate was 97 per 1,000 members, with Shasta again highest at 209 and Plumas lowest at 31. For context, January 2025 saw 101,945 trips, 1.15 percent utilization, 9.8 trips per user, and a trip rate of 113 per 1,000 members. Utilization rate slightly increased compared to June, but overall volume and trip frequency per member were lower. **Ethnicity:** Percent utilization was highest among Black or African American and American Indian or Alaska Native members, and lowest among Hispanic or Latino and Asian members. American Indian members had the highest average trips per utilizer, while Black members had the lowest. For trip rate per 1,000 members, American Indian members ranked highest and Hispanic or Latino members lowest. **Language:** Tagalog speaking members had the highest percent utilization, though they accounted for a small share of total trips. Russian speaking members had the lowest percent utilization. Russian speakers had the highest average trips per utilizer, and Spanish speakers had the lowest. For trip rate per 1,000 members, Tagalog speakers were highest, while Spanish and Russian speakers were lowest. **Age:** Members age 65 and older had the highest percent utilization, while those age 0 to 20 had the lowest. The 21 to 64 age group had the highest average trips per utilizer. For trip rate per 1,000 members, the 65 and older group had the highest rate overall. From January to July 2025, most trips were between 1 and 10 miles, making up 46.5 percent of all transportation. Trips over 50 miles made up 15.1 percent but were not evenly spread across counties. Seven counties had over 40 percent of their trips exceed 50 miles, with Del Norte leading at 74.2 percent of its 17,000 trips falling into that category. In

	contrast, Marin County had only 0.8 percent of its nearly 15,000 trips go over 50 miles. Most transports in 2025 were completed using NMT vehicles, with 76 percent of those provided by taxis. NEMT trips, used for members needing mobility assistance, made up 20.6 percent of total volume, and 90 percent of those were completed using wheelchair vans. From January to July 2025, the top ten service types by trip volume made up 81.3 percent of all trips. Drug Rehabilitation was the most common, alone accounting for 40.3 percent. In contrast, the least used service types totaled fewer than 100 trips combined. So far in 2025, 116 different transport servicers have completed member trips. The top ten accounted for over 40 percent of total volume, with Lyft delivering nearly twice as many trips as the second most used provider. The least used servicers combined for only 210 trips this year.
Overutilization Analysis Discussion Topics	
Future Agenda Items	PCP visit rates will continue to be monitored
Next Meeting Date: TBD	

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MEETING MINUTES

Meeting Name: Population Needs Assessment Committee

Date: August 7, 2025 **Time**: 4 - 5 p.m.

Location: Marin Conference Room; Webex

Attendees: Isaac Brown

Virtual Attendees: DeLorean Ruffin, DrPH; Denise Rivera; Folo Akintan; Greg Allen Friedman; Jeff Ribordy, MD; Jill Blake; Leigha Andrews; Lilian Merino; Lisa O'Connell; Mark Bontrager; Marshall Kubota, MD; Matthew Morris, MD; Richard Matthews, MD; Robert Moore, MD; Sydni Aguirre; Tim Sharp; Vicky Klakken; Wendy Starr

Absent: Aaron Maxwell; Amanda Smith; Christine Smith; Colleen Townsend, MD; Hannah O'Leary; Katherine Barresi, RN; Kathryn Power; Liat Vaisenberg; Margarita Hernandez; Matt Hintereder; Mohamed Jalloh, PharmD; Monika Brunkal, RPh; Nancy Steffen; Priscila Ayala; Rebecca Stark; Wendi Davis; Yolanda Latham

Agenda Topic	Minutes	Action Items
1. CHA/CHIP updates *Time: 30 minutes* *Speaker: CHNL Team*	A PowerPoint presentation was shared (attached to these minutes). Each region's Community Health Needs Liaison (CHNL) spoke for their counties. For more details, please reference the PowerPoint. Status of Goals: • Slide 3, Goal Status: To date, 13 goals have been approved, 4 are pending, 4 are drafted, 3 counties have an idea for a goal, and 2 counties have no goals. ○ Note that Sutter and Yuba counties both have goals drafted and ideas for goals, and are counted twice.	

Agenda Topic	Minutes	Action Items
	Updated Goal for Approval: • Slides 5-6, Colusa Goal: Increase access to prenatal care among Partnership members in Colusa County. *SMART Objective:* Colusa County will increase PPC- Timeliness of Prenatal Care rate from 75.28% to meet the 50th percentile benchmark of 84.55% by August 30, 2026. ○ This goal was reviewed in April, and has been updated based on feedback. ○ Strategy 1: Collaborative Partnerships with Local Prenatal Care Providers ○ Strategy 2: Provider Mapping ▪ Partnership can pull data to see where members delivered. Note that a survey of members who haven't delivered is a somewhat hypothetical one. Members in Colusa are typically delivering at Woodland Memorial Hospital, Adventist Health and Rideout, or Enloe Health. Prenatal care is limited in Colusa – recently an OBGYN from Rideout visits, and there may be 2 family doctors who could do prenatal visits. For prenatal care, members may be going to Chico, Marysville, or elsewhere. ▪ For the resource guide, it'd be good to add info about Partnership's Transportation benefit, because of the resources in surrounding communities. ○ Strategy 3: Community Engagement ▪ Question: based on understanding of why people weren't getting visits, is this initiative sufficient to make up that 10 point gap? Answer: the Strategy 2 survey may help with this. Still, the county felt all strategies were achievable. New Goals for Approval: • Slides 8-9, Plumas Goal: Reduction in opioid overdose related emergencies. *SMART Objective:* Plumas County will decrease the number of annual opioid overdose related emergency department visits from 32 to 16 by December 31, 2026. ○ Strategy 1: Identification and Tracking of Increases in Opioid Overdose-Related Emergency Department (ED) Visits ▪ Comment: tracking overdoses more accurately may result in an increase to the numbers. • According to QI, the numbers are low. A suggestion the team received was to use a claims count instead of member count. Plumas data from	• Dr. Moore moves to approve • Dr. Matthews seconds Colusa's goal is approved as written.

Agenda Topic	Minutes	Action Items

	2024 SUD claims and opioids with a service location of "ER" was retrieved from Tableau.
	• Comment: surprised the county can't get this data from their ERs directly. That data would have everyone as well, not just Partnership members. Public Health should have that data. There must be a reason they can't get data from ERs, and we should find out what that is.
	  ○ Note: there are 3 small ERs in the county.
	• Data may be available from the National Syndrome and Surveillance Program (https://www.cdc.gov/nssp/php/about/index.html). Data comes in very quickly there (after ~24 hours). Someone at the county should have access to it.
	  ○ This may be related to the Hospital Quality Institute. Not all counties are participating, but Plumas is.
	○ Strategy 2: Implement an Anonymous SMS System for Real-Time Opioid Overdose Alerts
	  ▪ Partnership had little input on this, the county wanted it.
	  ▪ Comment: the texting system could be used to alert people when a batch of drugs has been contaminated, and tell them to throw away their drugs.
	  ▪ Comment: it would be good to do surveys afterward to see how effective texts were.
	  ▪ Resources related to this work were shared: https://bridgetotreatment.org/addiction-treatment/ca-bridge/ https://www.odmap.org/ https://www.odmap.org/AgencyAccess/RequestForm
	  ▪ Comment: texting is a good mechanism, but best not to overuse it.
	  ▪ The harm reduction program has patients with phone numbers entered, Plumas may start by texting that group first.
	  ▪ Comment: When they do syringe exchange or Narcan distribution, it's an opportunity to get people to sign up for this anonymous texting system.
	○ Strategy 3: Harm Reduction Outreach and Community Engagement
	  ▪ Q: there will be naloxone distribution at these events? A: yes.
	
	• Slides 10-11, Sierra Goal: Improve mental health and reduce tobacco use from 9th to 11th grade high school students in Sierra County.
	SMART Objectives:
		Sydni will ask the county about getting overdose data from ERs.
		
		Plumas' goal will be taken back for edits and review based on feedback, and discussed further with our LHJ contact.

Agenda Topic	Minutes	Action Items
	1. By December 31, 2026, reduce the percentage of 11th grade students in Sierra County who experience chronic sadness or hopeless feelings from 36% (2023-2024 CHKS) to 25% using the 2025-2026 CHKS. 2. By December 31, 2026, decrease the percentage of 11th grade students current use of vape products in Sierra County from 13% (2023-2024 CHKS) to 10% using the 2025-2026 CHKS. ○ Strategy 1: Peer Advocate Training ▪ The baseline for the 11th graders will be a look back at when the same students were in 9th grade. They will use the 2026 County Healthy Kids survey. ▪ Comment: Sierra's student population is very low, and they have no sports teams. This county faces challenges that larger ones don't. But with their small size, there's more opportunity to make change. ▪ Comment: since it's not legal for high schoolers to buy vapes, and the number of vendors is small, it might be effective to address this from the sellers' side. • Comment: there is evidence to show that one can decrease nicotine products by looking into distributors. There are usually a low number of them. An intervention involves hiring people who look underage, who attempt to buy nicotine (sting operations). Instead of it being done with law enforcement though, they can have a restorative justice approach. Distributors are warned, but not reported to the police. This approach has worked well on reservations. • Comment: many Sierra residents shop in Reno, [making the number of possible distributors higher]. ▪ Question: are health educators equipped to educate on this topic? Maybe Behavioral Health should be involved. Answer: the CHNL team has been in contact with Monika Brunkal and Manleen Randhawa (Sr. Health Educator) about content they would provide. ▪ Comment: Dr. Moore would like to see a program that aims for the whole class rather than individuals, because there are so few individuals in this case. ▪ Comment: Sierra County just applied to become a formal Mental Health Plan, they are not a heavy deliverer of services currently. ▪ Comment: The results from the peer advocates may be most apparent in the people who were trained.	• Dr. Moore moves to approve • Dr. Kubota seconds Sierra's goal is approved as written.

Agenda Topic	Minutes	Action Items
	○ Strategy 2: Peer-led Lunchtime Events ○ Strategy 3: Resource Mobilization Campaign • Slides 12-13, Marin Goal: To improve preventative care measures for children ages 0-5 years of age in the Marin County Community Health Worker Hub by leveraging Community Health Worker Medi-Cal reimbursement benefit. *SMART Objective:* By December 31, 2026, Partnership Health Plan, Kaiser Permanente and Marin County Public Health will support implementation of the Marin County First 5 CHW Hub in serving 30 families and assessing impact of CHW services on early childhood preventive services (comparing year over year [MY24 to MY25] performance in (W30 2 & 6T, WCV) in Marin County and cross sectoral analysis among the total Medi-Cal population vs. the CHW served cohort of families. ○ Strategy 1: Establish a high-quality, financially sustainable CHW Hub that serves children 0–5-year-olds and their families ○ Strategy 2: Provide professional development and continuous learning opportunities for CHWs and CHW Network Administrators ▪ Question: how does this benefit the families? Answer: Marin is adamant about focusing on CHWs. First, starting a hub, evaluating work with families, and how that changes metrics for childhood immunizations. Second, making it sustainable, and making sure billing infrastructure is in place. • Comment: While Strategy 1 helps the community, Strategy 2 appears to about helping the Public Health dept. improve. To better show how it will help the community, recommend including indicators for improvement that Marin will look for in the families being studied. • Comment: the key is to make sure they have patient-centered outcomes, not just process outcomes. The strategies seem to assume many health workers will lead to [success], but that's not necessarily true. They need to be tracking outcomes. ▪ This is not being classified as a pilot. It will measure how CHW benefits are going to support the CHW hub Marin wants to improve.	Marin's Goal Strategy 1 & 2 will be taken back for edits and review based on feedback, and discussed further with our LHJ contact.
2. CHA/CHIP Grant Funding Update	• Sierra County has been approved for funding. • Lassen and Humboldt have submitted applications, currently under review. • Other counties have not applied as of this time.	

Agenda Topic	Minutes	Action Items
Time: 5 minutes *Speaker: DeLorean Ruffin, CHNL Team*	• PHM will be reminding the counties about the $100,000 LHJ grant. That communication will make sure all parties are up to date with the same talking points. Once Communications releases the final version of the Grant Addendum Announcement, it'll be circulated to Kathryn Power, and disseminated to Regional Leads and other relevant staff.	
3. Next steps *Time: 5 minutes* *Speaker: All*	• If attending a CHA/CHIP-relevant meeting, don't forget to send the CHA/CHIP team your notes at chachip@partnershiphp.org.	

PARTNERSHIP HEALTHPLAN of CALIFORNIA

QI Department Update
September 2025
Prepared by Isaac Brown, MPH/MBA
Interim Senior Director, Quality and Performance Improvement

Quality Improvement Programs (QIPs)

PROGRAM	UPDATE
Primary Care Provider Quality Incentive Program (PCP QIP)	• Measure development season for 2026 is on-going through September. In September we will be holding our yearly public comment period for the entire provider network. This will give PCPs the chance to weigh in on any proposed changes/retirements or additions we are planning for 2026 prior to committee presentation.
Palliative Care Quality Incentive Program (Palliative Care QIP)	• Measure development season for 2026 is on-going through September. • 2025 mid-year change to Measure III. Retirement of Completion of Standardized Palliative Care Quality Collaborative (PCQC) Assessments & Use of PCQC Tool to the implementation of a Palliative Care Survey (2025 only).
Perinatal Quality Incentive Program (PQIP)	• Fiscal Year (FY) 2024-2025 final data have been received and final refresh to the Perinatal QIP dashboard is in progress. • FY24-25 prelims and payment preparation are underway
Enhanced Care Management quality incentive program (ECM QIP)	• Q2 2025 payment data is being prepped for September prelims and payment • Measure development season for 2026 is on-going through September.
Hospital Quality Incentive Program (HQIP)	• Fiscal Year (FY) 2024-2025 final submissions should be turned into the HQIP inbox by August 31st. • FY24-25 payment preparation is underway

Quality Data Tools

TOOL	UPDATE
Partnership Quality Dashboard (PQD)	• 2025 PQD development is underway. Publication is set to happen by the end of September as communicated to the provider network • 2025 PQD Kick Off webinar is being planned with registration link and date/time communicated to the network from the QIP team in the next week
eReports	• 2026 eReports planning is in its preparation stages

Performance Improvement (PI)

ACTIVITY	UPDATE
State Mandated Work: *Performance Improvement Project (PIP) & Plan-To-Do-Study-Act (PDSA) Cycle*	• The second-year non-clinical PIP, aimed at improving the percentage of provider notifications for members with SMH diagnoses within 7 days of an emergency department (ED) visit, was submitted on August 7th. Partnership will respond to any feedback or comments from Health Services Advisory Group (HSAG).

Quality Measure Score Improvement	• **Behavioral Health:** • The 2025–2027 DMC-ODS non-clinical PIP for Humboldt, Lassen, Modoc, Shasta, Siskiyou, and Solano counties was submitted to HSAG on July 14, 2025, as required by DHCS. The project targets increasing peer support services after emergency substance use visits. HSAG will validate by 10/03/2015. • The 2025-2026 non-clinical PIP with Open Door was submitted to HSAG on 08/07/2025. The project targets to improve the percentage of provider notifications for members with SMH diagnoses following or within 7 days of emergency department (ED) visit. • **Chronic Disease:** Partnership will be sharing several resources in the upcoming quarterly regional quality meeting, including a guidebook for increasing colorectal cancer screening in rural communities from American Cancer Society. • **Women's Health and Perinatal:** No updates. • **Pediatrics:** Partnership continues to monitor dental fluoride utilization across its footprint, specifically for dental practices using the Z29.3 ICD code. Partnership is offering support and technical assistance to practices that either have not begun implementing this code or have had issues implementing. Partnership's Dental Liaison has connected with dental leadership across the footprint to address questions and troubleshoot issues.

Improvement Academy	• For Fiscal Year 2025-26, the Improvement Academy will host three (3) ABCs of QI in-person trainings.
	  ○ 01/28/2026 – Fairfield
	  ○ 03/19/2026 – Redding
	  ○ 05/14/2026 – Auburn
	• The Improving Measure Outcomes webinar series focused on targeted Managed Care Accountability Set (MCAS) measures will take place February – April 2026.

Joint Leadership Initiative (JLI)	• No updates for Redding and Eureka Regions. • No updates for Santa Rosa and Fairfield Regions. • First Joint Leadership Initiative Meetings for the Chico and Auburn meetings for 2025 start in October.
Regional Improvement Meetings	• The Eureka and Redding Q3 regional quality meetings will be held on 09/09/2025 and 09/30/2025 respectively. Partnership's QI team will be sharing MY2024 HEDIS rates for the state MCAS and Health Plan Accreditation (HPA) projects, as well as some relevant updates for priority quality measures. • The Santa Rosa office will begin a new series of Regional Quality Meetings for Marin & Sonoma Counties beginning in October 2025. At the request of the provider orgs, there will be two series': one for Medium to Large practices and a separate series for Small practices • The first Regional Quality Improvement meetings for the Auburn and Chico regions took place at the end of July. Year-end 2024 PCP QIP data by county was shared and measure best practices were interspersed with the data. The PI Manager

	asked for comments regarding barriers and other best practices throughout the meeting. o Chico Region: There were 23 individuals representing 9 Parent Organizations in attendance at the Chico meeting. This represents 50% of the 18 parent organizations with more than 1,000 members assigned in the Chico region. A feedback survey was completed by 6 of the 23 in attendance (RR = 26%). o Auburn Region: There were 13 attendees from 6 parent organizations in attendance at the Auburn meeting. This represents 55% of the 11 parent organizations with more than 1,000 members assigned in the Auburn region. A feedback survey was completed by 3 of the 13 in attendance (RR = 23%).

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

QI PROGRAM & PROJECT MANAGEMENT

ACTIVITY	UPDATE
CAHPS SURVEY PROGRAM - MEDI-CAL PRODUCT LINE AND FY 25/26 ORG GOALS	**CAHPS® Regulated Measurement Year (MY) 2024 / Report Year (RY) 2025 Survey - Closed** • Partnership's survey vendor, Press Ganey, presented the regulated CAHPS® survey results for Measurement Year (MY) 2024 / Report Year (RY) 2025 (Adult and Child) to internal stakeholders. • The MY 2024 / RY 2025 Child CAHPS® survey was formally submitted as part of NCQA's accreditation process to determine Health Plan Rating (HPR). The projected HPR for MY 2024 is 3.0 Stars; final ratings are expected to be available on NCQA's website in late September. **Fiscal Year 2025/2026 Organizational Goal 5: Member Experience (MX)** • Organizational goal activities are underway, led by several cross-department champions. • Org. Goal milestone updates for Q1 goal quarter will be posted internally on the OpEx|PMO internal goal dashboard in October (*Partnership4Me, under Smart Links).* **Additional Updates** • The Member Experience Grand Analysis (ME 7) is under review by QI leadership and Partnership's NCQA consultant. The analysis will begin making its way through the formal Committee approval process, in November.
EXACT SCIENCES: PROMOTING COLORECTAL CANCER SCREENINGS	**Colorectal Cancer Web Page** The new provider facing webpage is now available on Partnership's website to support colorectal cancer screening efforts. The page includes a variety of internal and external resources, including:

	• Educational videos on Cologuard for providers to share with their patients, developed by the Population Health Team • Information on how to order FIT tests • Links to materials for providers and patients The Cologuard overview outlines all available screening options and includes guidance on how to effectively address care gaps. For more information about Colorectal Cancer Screening opportunities and resources visit https://www.partnershiphp.org/Providers/Quality/Pages/Cologuard.aspx **Bulk Order Offering** All providers are eligible to participate in bulk ordering Cologuard at any time during the year. To confirm eligibility, providers contact Exact Sciences directly at PHC@exactsciences.com Enrollment in a "Program" and/or pre-approval from Partnership is not required. **Partnership Facilitated Order** Partnership continues to facilitate multi-patient orders where orders are submitted on behalf of providers to Exact Sciences. Facilitated orders removes the two hundred (200) patient minimum barrier that some providers face when wanting to place a bulk order directly with Exact Sciences. ○ The current facilitated order accepted submissions from Monday, 07/21/2025 through Monday, 08/18/2025 with the Cologuard kits having a tentative shipping date of Monday, 09/29/2025 and aligned with QIP's timeline for addressing 2025 and 2026 PCP QIP Measures. ○ Next facilitated order is scheduled to launch on Monday, 01/19/2026 and will align with Colorectal Cancer Awareness Month in March.
EQUITY & PRACTICE TRANSFORMATION PROJECT	***Program Overview*** *The DHCS Equity and Practice Transformation (EPT) Program is a statewide initiative aimed at advancing health equity while reducing COVID-19 driven care disparities. The funding is divided between three (3) programs; the Initial Planning Incentives Payments (IPIP), the Provider Directed Payment Program (PDPP), and the Statewide Learning Collaborative (SLC).* **PDPP Participation and Deliverables** • All twenty-seven (27) provider organizations invited by DHCS to participate in the PDPP accepted by the 01/26/2024 deadline. Partnership had the third most accepted applications of all managed care plans with a 49% acceptance rate vs 29% state-wide. • According to updated deliverable submission requirements and as part of their continued participation, practices that were unable to submit their required 2024 deliverables by the original 11/01/2024 deadline. • By May 2026, practices should complete the Year 3 PhmCAT and successfully submit the following deliverables:

- Milestone 3: Empanelment Policy & Procedure
- Milestone 4.2: Data Governance Policy & Procedure
- Milestone 6: Data Implementation Plan
- Milestone 8: Disparity Reduction Plan
- At least one Model of Care deliverable (Milestones 8 – 12 and 15 – 16)

- The EPT PM Team sent personalized emails to EPT practices summarizing the eligible milestone deliverables they can submit in the November 1 submission cycle and offered deliverable achievement support.

EPT MCP Reporting Requirements

- In addition to funneling EPT payment from DHCS to EPT practices, MCPs are required to submit data on all HEDIS-like measures at the practice level on all Medi-Cal members. This reporting requirement will be used for practice payment calculation and is intended to align with the forthcoming APL from DHCS for directed payment programs that will specify responsibility to produce primary care site-level quality metrics regularly. The EPT MCP Reporting requirements have changed to be compliant with the new draft APL and the CaTS. MCPs are asked to provide raw data (claims, pharmacy, lab, member roster, and ECDS data) to PHLC for ingestion into their HEDIS vendor, Innovacer.
- Most MCPs were concerned with this updated approach due to the integrity of the CaTS/HEDIS-like rates, data privacy and security concerns, complexity of developing data files for the scope of PHLC's measure set and requiring a Data Sharing Agreement (DSA) between PHLC and not Innovacer.
- The PM team has been working with the Director of Quality Measurement on ensuring PHLC's updated reporting request is compliant.

<u>Revised EPT Payment Methodology</u>

- PHLC recently confirmed DHCS will be modifying the EPT payment schedule for May 2026 payments.
- The change in the EPT payment schedule will cause a delay in the distribution of May 2025 EPT Payments. MCPs will receive funds in December 2025 as opposed to September 2025. Practices will then be paid in January 2026 instead of October 2025.

Statewide Learning Collaborative

- The Statewide Learning Collaborative (SLC) is meant to support practices awarded PDPP funding in the implementation of practice transformation activities, sharing and spread of best practices, practice coaching activities, and achievement of quality and equity goals stated in their PDPP applications. Participation in the SLC is a requirement for all participants in the PDPP.

Preventive Care Bridge Project (Formerly: Locum Pilot Initiative)	***Overview of the Preventive Care Bridge Project*** *The Preventive Care Bridge Project was developed as a short-term solution to provide access to clinicians with the goal of improving HEDIS® performance in preventative care, specifically well-child visits and cervical cancer screenings. This offering was designed as a limited grant program; whereby select provider organizations are granted funds to hire a Locum Tenens Provider.* **Pilot 2 Implementation**: Four providers have submitted applications and were awarded up to $96,000 • Ampla Health • Western Sierra Medical Clinic • Shasta Community Health • Open Door Community Health Locum providers are in place at all sites and initial observations include: • Providers report no-show rates are lower than expected • **WSMC** reports noticeable increase in WCV measure rates, attributed to the locum; Peds backlog is substantial, no outreach has been necessary. • **Open Door** experienced a slowdown in their mid-late July scheduling, despite outreach efforts. Response rates are now increasing. • **Shasta** utilized an existing locum for this work to reduce onboarding and ramp-up period. They are encountering barriers with the locum's schedule; new strategies are being considered. • **Ampla** experienced credentialing-related delays. Onboarding is now taking place and outreach efforts have begun.

Provider Org	Total Visits	PHC Members	WCV	CCS	No-show Rate	Avg. Visit/Day
WSMC *Start: June 30*	333	244	266	0	15.7%	13
Open Door *Start: July 14*	128	128	106	20	15.8%	8
Shasta *Start: July 28*	109	106	89	20	21%	11
Ampla *Start: Aug 18*						

<table>
<tr>
<td>Mobile Mammography Program</td>
<td>

Upcoming Event Days for FY 25/26 Q1 (July – September)

<table>
<tr><th colspan="4">Upcoming Event Days
07/01/2025 – 09/30/2025</th></tr>
<tr><th>Region</th><th># of Provider Organizations</th><th># of Provider Sites</th><th># of Event Days</th></tr>
<tr><td>Auburn</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Chico</td><td>1</td><td>2</td><td>2</td></tr>
<tr><td>Eureka</td><td>3</td><td>9</td><td>9</td></tr>
<tr><td>Fairfield</td><td>2</td><td>4</td><td>4</td></tr>
<tr><td>Redding</td><td>2</td><td>3</td><td>4</td></tr>
<tr><td>Santa Rosa</td><td>2</td><td>2</td><td>2</td></tr>
<tr><td>Plan Wide</td><td>10</td><td>20</td><td>21</td></tr>
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Scheduling for Mobile Mammography event days for FY 25/26 Q2 (October – December 2025) is currently in progress.

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<td>Partnering for Pediatric Lead Prevention Program</td>
<td>No further update at this time.</td>
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<tr>
<td>QI Trilogy Program</td>
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All Trilogy documents (FY2025/26 QI Program Description; FY2024/25 QI Evaluation; and FY2025/26 QI Work Plan), together with the FY2024/25 QI Work Plan are making their way through the formal approval process. They were presented at the August Internal Quality Improvement (IQI) Committee and Quality/Utilization Advisory Committee (Q/UAC) meetings and will be on the Physician Advisory Committee (PAC) Sept. 10. The Board of Commissioners will see the documents Oct. 22.

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<tr>
<td>QI Project Toolkit & Training Program</td>
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The Quality Improvement (QI) Project Toolkit and Training Program is designed to help provider organizations and community partners strengthen their skills to lead and manage QI initiatives by offering training and use of standardized tools, templates, and best practices. The program features a 6-session webinar series delivered over 12 weeks, covering all phases of the project life cycle and focusing on applying those methods to real-world QI efforts.

Current Status

Curriculum development is undergoing final edits
Dedicated Toolkit Hub webpage launched on the Improvement Academy website
Pilot cohort (20 participants) scheduled to begin in September 2025
Full program launch planned for Q1 CY2026

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ACTIVITY	UPDATE
DUAL-ELIGIBLE SPECIAL NEEDS PLAN (D-SNP)	• The QI department is continuing its collaboration with Wakely (part of HMA) to develop a HEDIS® visualization dashboard and a Stars analytics tool. • "Capturing Patient Acuity through Coding Part 2", a webinar addressing coding acuity for D-SNP, is tentatively scheduled for Wednesday, 10/08/2025 at 12 p.m. and will be led by Deputy Chief Medical Officer/Medical Director of Medicare Services Kermit Jones, MD, JD. The webinar will be promoted to physicians and coding support personnel in the Partnership Advantage counties. Attendees will be eligible for 0.75 CME/CE credits upon completing the post-webinar evaluation. Sixty-six (66) individuals from twenty-eight (28) organizations have registered for the webinar. Registration is available here. • With collaboration with IT, the Medicare Quality team has developed a data pathways document to visualize the path of Medicare data from the data source through data reporting, visualization, vendor relationships, key stakeholders and implementation barriers and considerations. This visualization represents the implementation process of all Quality/IT collaborations for Medicare D-SNP launch in 2027. • The Medicare Quality team is developing an approach to share Stars and DHCS measure information with key stakeholders in a centralized, cloud-based format. This would allow measure sponsors, business owners and process owners key measure information including data sources, measures descriptions and current interventions. Upon finalization, stakeholders from across the organization will be able to access the material.

QUALITY ASSURANCE AND PATIENT SAFETY

ACTIVITY	UPDATE
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: **07/28/2025 TO 08/23/2025**	• 16 PQI referrals were received with 12 coming from Grievance and Appeals, 2 from a Regional Medical Director, 1 from Care Coordination and 1 from Utilization Management • 15 PQI cases were processed and closed. • 70 PQI cases are currently open. • One case was discussed at Peer Review Committee on 8/20/2025 and there are two awaiting Peer Review Committee. • One case was referred to an internal SME physician. • The upgrade of the Sugar CRM PQI application (Processing, Documentation, and Tracking System) was successfully implemented, with a go-live date of 08/18/2025.

FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR THE PERIOD: 07/28/2025 TO 08/22/2025

- As of 8/25/2025, we have a total of 521 reviews, including PCP, OB, multiple check-ins, and delegated reviews.

Primary Care and OB Reviews:

Region	# of FSR conducted	# of MRR conducted	# of FSR CAP issued	# of MRR CAP issued
Auburn	1	0	1	0
Chico	3	3	0	2
Eureka	3	4	0	3
Fairfield	3	3	0	1
Redding	1	1	1	1
Santa Rosa	7	5	2	1

New sites opened this period → None

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS®)

ACTIVITY	UPDATE
Annual HEDIS® Projects	• No update
HEDIS® Program Overall	• Partnership appealed its MY2023 sanction applied by DHCS on three (3) measures in the MY2023 MCAS Measure Set that performed below the 50th percentile: Topical Fluoride for Children (TFL-HC), Developmental Screening in the First Three Years of Life (DEV), and Well Child Visits in the First 30 Months of Life, 0 to 15 Months (W30)-6. Partnership completed a settlement hearing with DHCS on August 26, 2025; a decision on the case is pending. • Partnership received a projected Star Rating of 3.0 Stars from NCQA; a final Star Rating will be released by NCQA in Fall 2025.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation	• NCQA released the new 2026 HPA Standards and Guidelines electronically on 07/28/2025; print copies are expected to be available by 08/29/2025. Partnership will follow the 2026 HPA Standards and Guidelines for its 2026 HPA Renewal Survey, therefore it is critical to align our practices to the newly released

	standards. NCQA will assess Partnership based on the look-back period, measured from the point of the survey submission date, September 2026. ○ This year, NCQA added new requirements and made significant changes to existing standards, which necessitate Business Owners' (BOs) expeditious review and assessment of gaps in compliance. A Summary of Changes between the 2025 and 2026 HPA Standards and Guidelines has been shared with BOs to assist with their gap analysis. BOs have returned their completed gap assessments with action plans, and the NCQA Program Management Team will work closely with BOs over the next several months to ensure changes to required evidence are completely timely. ○ On 08/04/2025, NCQA also invited public comment on updates related to the newly released 2026 HPA Standards and Guidelines. The NCQA Program Management Team has solicited input from the identified BOs. The NCQA Program Management Team submitted a summary of responses to NCQA on behalf of Partnership. The final 2026 HPA Standards and Guidelines are proposed for release in December 2025. • Evidence submission for the HPA Mock Renewal Survey scheduled for 10/27-30/2025 was due by 08/22/2025. The NCQA Program Management Team is reviewing the evidence received and providing feedback to Business Owners, as needed. Once evidence is finalized, it will be shared with our consultant, Managed Healthcare Resources (MHR), who will review prior to the HPA Mock Renewal Survey. During the four (4) days of the HPA Mock Renewal Survey, MHR will share their findings and provide their recommendations for survey compliance, as needed. • As a next step from the HPA Mock File Reviews held with our NCQA Consultant, MHR, in April and May 2025, targeted Mock File Reviews were conducted with selected teams in August 2025, prior to the start of the look-back period in September 2025. These file reviews focused on confirming that the issues identified during the previous file reviews have been corrected and are now in compliance. The NCQA Program Management Team will work with Business Owners to ensure any further recommendations from MHR are addressed promptly to ensure compliance prior to the start of the look-back period.
NCQA Health Equity Accreditation	• Partnership's HEA Initial Survey Closing Call was held on 08/04/2025. During this call NCQA reviewed several topics with Partnership including strengths, opportunities, and next steps. Although no outstanding issues remained, the surveyor did provide some feedback on a few standards to take into consideration. NCQA awarded Partnership the official Health Equity Accreditation status on 08/06/2025. To maintain this status, Partnership undergoes a survey every three (3) years. Partnership's HEA Renewal Survey is tentatively scheduled for 05/16/2028. • On 08/04/2025, NCQA invited public comment on proposed changes for the 2026 HEA Standards and Guidelines. NCQA proposed extensive updates including a new standard, new elements, changes to existing factor language, and reorganizing existing elements from the 2024 HEA Standards and Guidelines. The NCQA

	Program Management Team has solicited input from Partnership key stakeholders. Our feedback may impact NCQA's final decision, as to which changes NCQA includes in the 2026 HEA Standards and Guidelines. The NCQA Program Management Team submitted a summary of responses to NCQA on behalf of Partnership. The standards are scheduled for release in December 2025.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

QUALITY / UTILIZATION ADVISORY COMMITTEE (Q/UAC)

Consent Calendar

Sept. 17, 2025

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

		Pages
	G&A PULSE Report, Issue 18, September 2025 – *direct questions to Latrice Innes*	55 – 68
	1st/2nd Qtrs 2025 UM/Pharmacy IRR / Timeliness – *direct questions to Tony Hightower, CPhT, and Andrea Ocampo, Pharm.D*	69 – 78
Health Services Policies	**Utilization Management**	
	MCUG3118 – Prenatal & Perinatal Care	79 – 95
	MCUP3140 – Palliative Care: Pediatric Program for Members Under the Age of 21	97 – 110

Our Mission

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

GRIEVANCE & APPEALS Pulse Report

G&A PULSE REPORT

INSIDE THIS ISSUE

PG. 4
Statistics Broken Down by Region

ISSUE 18 | SEPTEMBER 2025

The purpose of this report is to provide objective updates to all stakeholders regarding trends in member experience as expressed through Appeals, Grievances, Exempt Grievances, and State Hearings. The report contains data from the second quarter of 2025.

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

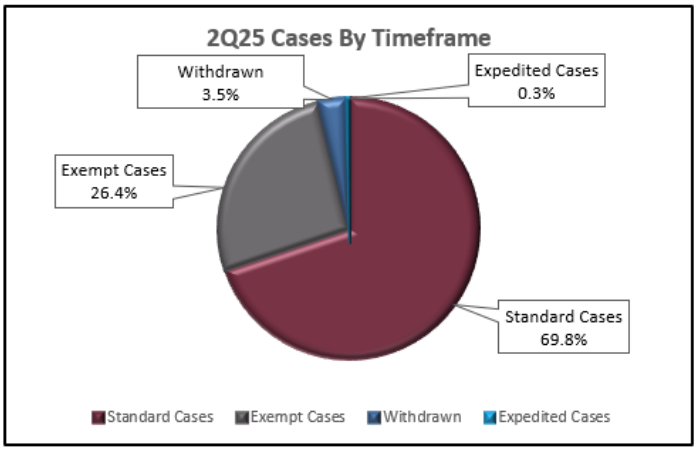
Fluctuations in data can happen. Therefore, statistics included in this report are presented with a 95% confidence level.

2Q25 HIGHLIGHTS

OVERALL NUMBERS

In 2Q25, G&A investigated 2,477 cases. The chart below shows a breakdown of the cases investigated this quarter. Of the 1,773 cases subject to DHCS-mandated timeframes, 99.2% were closed on time and 98.6% of the acknowledgement letters were sent out on time.

2Q25 TOTAL INVESTIGATED CASES		
Case Type	**# Cases**	**% Grand TTL**
Grievance	1,546	62.4%
Exempt	653	26.4%
Appeal	227	9.2%
State Hearing	51	2.1%
Grand Total	**2,477**	**100.0%**



KEY POINTS & TRENDS

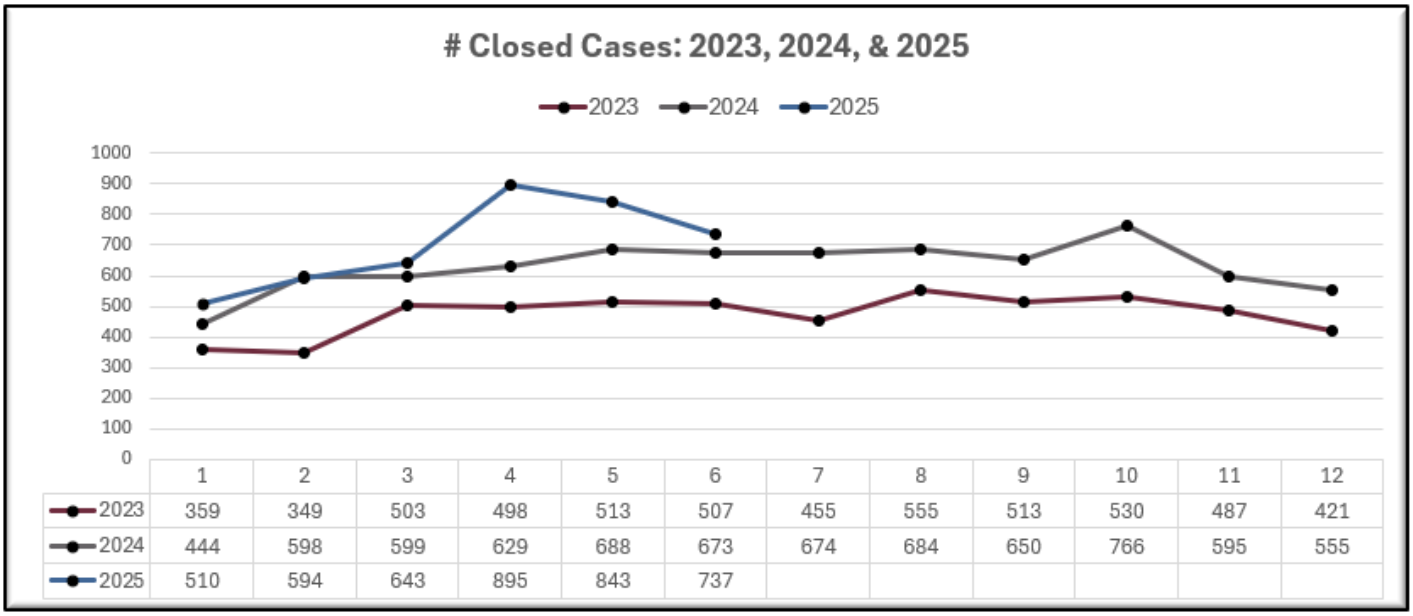
Case Volume Trends — This quarter showed a significant increase in total case volume, rising from 1,748 cases in Q1 to 2,477 cases in Q2, a 41.7% increase overall. The largest increase was seen in exempt grievances, which increased from 279 cases to 653 cases. The rise in exempt cases is largely tied to training conducted by the Transportation department in mid-March, which reminded staff that any expression of member dissatisfaction must be captured. If a member does not wish to file a formal grievance, staff are required to record it as an exempt grievance. While an overall seasonal uptick in case volume is common in spring, this quarter's increase was higher than usual and primarily driven by improved identification and reporting of exempt grievances.

Provider Service – This category accounted for 33.7% of the total case concerns. The most common issue was Communication, followed by Poor Attitude/Service. Treatment plan disputes was the third most commonly reported concern within this category.

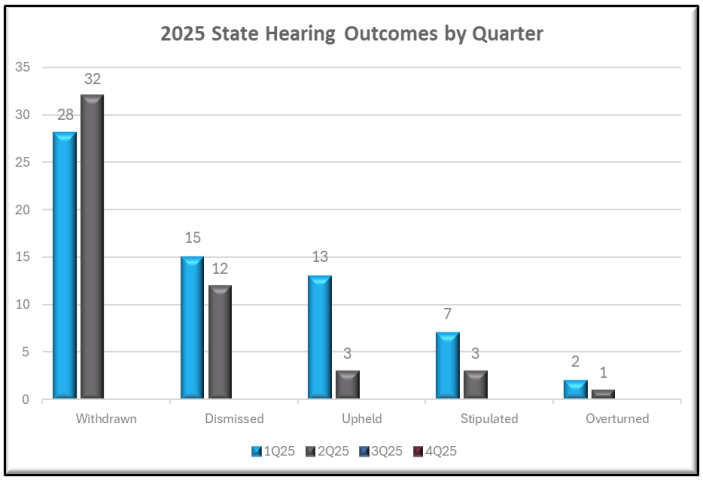
KEY STATISTICS

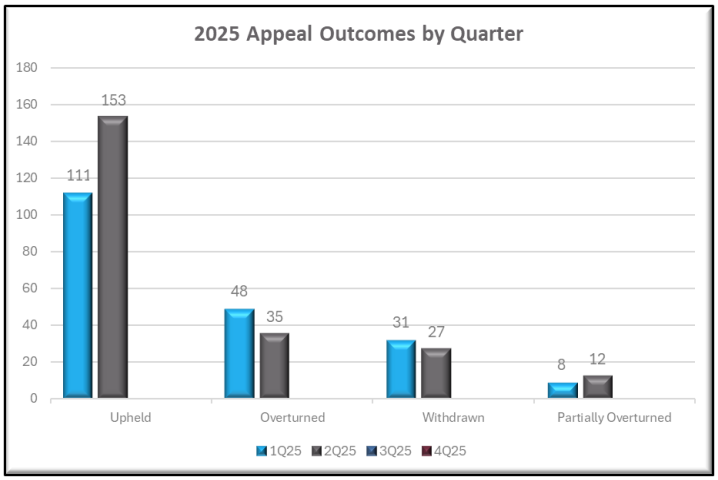
CHARTS OF KEY CASE TRENDS

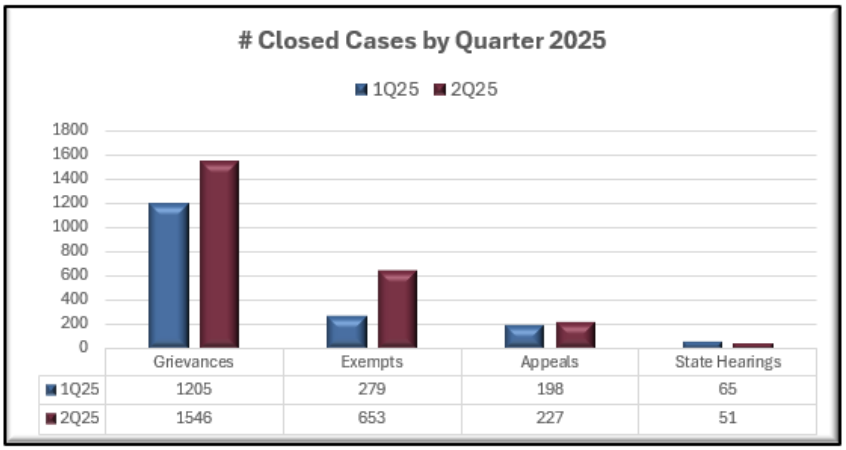
The following charts represent key data metrics used to track and trend Appeals, Grievances, and State Hearings over time.



	1	2	3	4	5	6	7	8	9	10	11	12
2023	359	349	503	498	513	507	455	555	513	530	487	421
2024	444	598	599	629	688	673	674	684	650	766	595	555
2025	510	594	643	895	843	737						





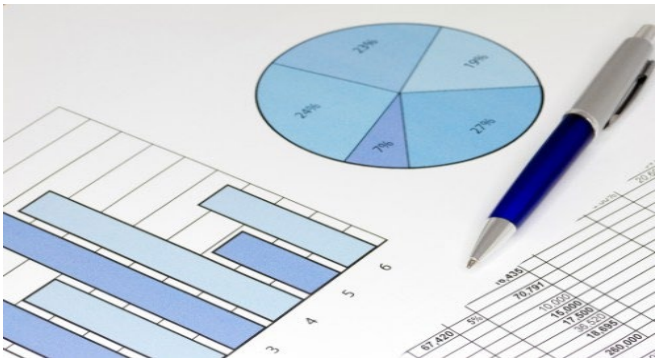


	Grievances	Exempts	Appeals	State Hearings
1Q25	1205	279	198	65
2Q25	1546	653	227	51

STATISTICS BY REGION

CHARTS OF CASE STATISTICS BY REGION

The following charts illustrate the distribution of closed cases across each region, providing a breakdown of the total number of cases closed, the average membership, and the number of cases closed per 1,000 members for 2Q25.



2Q25 CASES BY COUNTY			
AUBURN			
County	# of Cases	Avg Membership	Cases p/1,000
Nevada	100	28,620	3.49
Placer	224	61,402	3.65
Plumas	9	5,812	1.55
Sierra	4	853	4.69
Total	337	96,687	3.49

2Q25 CASES BY COUNTY			
FAIRFIELD			
County	# of Cases	Avg Membership	Cases p/1,000
Solano	293	102,603	2.86
Napa	45	27,473	1.64
Yolo	169	53,876	3.14
Total	507	183,952	2.76

2Q25 CASES BY COUNTY			
CHICO			
County	# of Cases	Avg Membership	Cases p/1,000
Butte	251	85,630	2.93
Colusa	15	10,289	1.46
Glenn	22	13,642	1.61
Sutter	43	43,925	0.98
Yuba	81	37,064	2.19
Total	412	190,550	2.16

2Q25 CASES BY COUNTY			
SANTA ROSA			
County	# of Cases	Avg Membership	Cases p/1,000
Sonoma	212	111,990	1.89
Marin	107	46,825	2.29
Total	319	158,815	2.01

2Q25 CASES BY COUNTY			
EUREKA			
County	# of Cases	Avg Membership	Cases p/1,000
Del Norte	41	12,311	3.33
Humboldt	210	57,765	3.64
Lake	85	34,056	2.50
Mendocino	82	40,710	2.01
Total	418	144,842	2.89

2Q25 CASES BY COUNTY			
REDDING			
County	# of Cases	Avg Membership	Cases p/1,000
Lassen	27	8,713	3.10
Modoc	9	3,943	2.28
Shasta	273	64,954	4.20
Siskiyou	63	17,743	3.55
Tehama	85	29,948	2.84
Trinity	27	5,277	5.12
Total	484	130,578	3.71

DEMOGRAPHICS

CHARACTERISTICS OF FILING MEMBERS

The following charts represent key demographic data of members who filed an Appeal, Grievance, or State Hearing during 2Q25.

> "Thank you for what you did for me, especially Amrit. I appreciate it, you guys were excellent. I'm going to recommend you to everyone I know. You will handle our business. Thank you."
>
> - *Partnership Member*

2Q25 CASES BY AGE		
Member Age	% Cases	% Membership
Age 0-10	5.2%	18.4%
Age 11-19	4.5%	16.4%
Age 20-44	25.9%	34.3%
Age 45-64	42.8%	19.7%
Age 65+	21.6%	11.2%

2Q25 CASES BY LANGUAGE		
Member Language	% Cases	% Membership
English	92.4%	75.7%
Spanish	6.2%	20.8%
Other	0.8%	2.1%
Russian	0.4%	0.6%
Tagalog	0.1%	0.5%
Punjabi	0.1%	0.3%

2Q25 CASES BY ETHNICITY		
Member Ethnicity	% Cases	% Membership
White	56.0%	38.1%
Other/Unknown	17.3%	18.1%
Hispanic	13.8%	34.2%
Black (African American)	8.2%	3.5%
Asian	1.5%	2.5%
Native American	2.1%	1.8%
Asian Indian	0.9%	1.6%
Native Hawaiian or Other Pacific Islander	0.2%	0.2%

2Q25 CASES BY GENDER		
MBR Gender	% Cases	% Membership
Female	62.1%	51.9%
Male	37.9%	48.1%

W&R RELATED

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Wellness & Recovery (W&R) during 2Q25. It should be noted that W&R cases are measured based on the number of cases received per quarter, rather than the number of cases closed per quarter. This is due to DHCS' unique reporting of W&R cases.

2Q25 NUMBERS

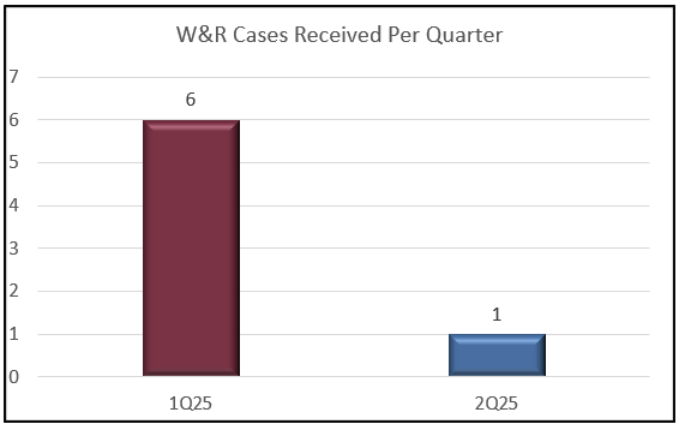
One (1) W&R case was received and five (5) were closed in 2Q25. All the cases were grievances. There were zero appeals reported in the first half of the year.

TRENDING ISSUES

The number of grievances received declined from six (6) in 1Q25 to one (1) in 2Q25.

The grievance reported involved a member in an inpatient facility who felt discriminated against based on their religious beliefs and professional background. The member reported feeling interrogated and treated differently by staff compared to other patients during their stay at the facility. The Program Director indicated that the staff members involved in the reported incident are no longer employed at the facility. The member left the program against medical advice after being informed they could not use the phone during a blackout detox period. He also confirmed that the program is non-faith-based and follows a social model, allowing members to attend religious services outside of the program. Discrimination was deemed unlikely in this case.

Overall, the first half of 2025 has shown that grievances predominantly revolve around issues related to provider care and case management.



DHCS REPORTING

DHCS requires quarterly reporting of W&R cases. The below two tables provide the specific number of W&R cases and which case category Partnership reported to DHCS. The case received in 2Q25 was closed within the 30-day DHCS regulatory timeframe.

2Q25 W&R Cases	
# of Grievance Received	1
# of Grievance Resolutions	5
# of Appeal Received	0
# of Appeal Resolutions	0

2Q25 DHCS Grievance Categories	
Access to Care	0
Quality of Care	0
Program Requirements	0
Failure to Respect Enrollee's Rights	0
Interpersonal Relationship Issues	1
Other	0

CCS RELATED

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to California Children's Services (CCS) and Whole Child Model (WCM) during 2Q25.

2Q25 STATISTICS

During 2Q25, a total of 26 CCS-related cases were closed and reported to DHCS, representing 1.0% of the total of 2,477 closed cases for this quarter. These cases are divided into 15 Standard Grievances, 8 Appeals, and 3 Exempt Grievances.

TRENDING ISSUES

The predominant issue reported this quarter was related to Non-Medical Transportation with 12 cases (5 Appeals, 6 Grievances and 1 Exempt) accounting for almost half of the total CCS related cases.

There were three Exempt cases reported this quarter which included one case related to Transportation services, one case related to PCP enrollment, and the other related to issues scheduling an appointment.

Of the eight appeals closed this quarter, two of the appeals were partially approved, one was approved in full, and five were upheld. There was one appeal involving a critical incident against a nurse from the Sacramento Sutter Medical Center. Upon resolving this case, it was determined to be a quality-of-service issue and was reported to Partnership's RAC department. There were three cases related to Treatment Authorization Requests (TARs). One request was for nursing care that was denied as it was not required for the member anymore, the second case was for wheelchair repair which was approved as the member was wheelchair dependent, and the third case was for a surgery which was denied because this request was not covered by MediCal.

DISCRIMINATION AGAINST CCS MEMBERS

G&A reviews all allegations of discrimination to determine if they fall under a civil rights law. There were no cases of discrimination reported for CCS members during 2Q25.

ETHNICITY AND PREFERRED LANGUAGE

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

2Q25 CASES BY ETHNICITY		
Member Ethnicity	# of Cases	% of Cases
White	9	34.6%
No Response	6	23.1%
Hispanic	5	19.2%
Other Asian	3	11.5%
Black (African American)	2	7.7%
Alaskan Native or American Indian	1	3.8%
Grand Total	26	100.0%

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

2Q25 CASES BY LANGUAGE		
Member Language	# of Cases	% of Cases
English	23	88.4%
Spanish	3	11.5%
Grand Total	26	100.0%

DISCRIMINATION

REPORTING PERIOD

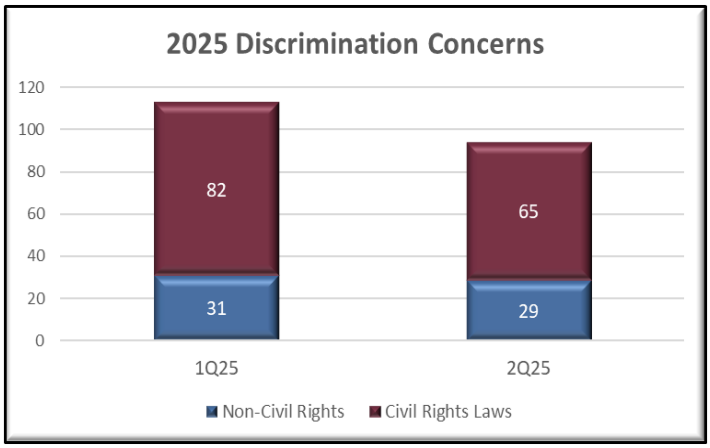
This section covers quarterly statistics and trends in cases related to discrimination during 2Q25.

2Q25 DISCRIMINATION STATISTICS

G&A investigated 94 cases related to discrimination allegations in 2Q25. This represented 3.8% of all cases closed. Of the 94 cases, 65 fell under applicable federal or state civil rights law. Several cases alleged multiple discrimination categories.

After investigation, it was determined that discrimination likely occurred in 10 cases containing 13 discrimination categories. Four (4) cases were regarding disability. There were two (2) each of limited English skills and language assistance services. There was one (1) each of auxiliary aids and services, gender, gender identity, race or ethnicity, and religion.

Discrimination allegations that do not fall under a civil rights law accounted for 29 of the 94 alleged discrimination cases filed. Members alleged discrimination based on reasons such as having Medi-Cal, homelessness, or being labeled a medication/drug seeker.



2Q25 DISCRIMINATION TRENDS

Overall, the number of discrimination allegations has decreased in number, but they continue to remain under 5.0% of total cases filed. After investigation, the number of cases found to have discrimination likely remains low.

2Q25 CASES BY CATEGORY

The charts below show a breakdown of cases wherein discrimination was found to be likely by the reported civil rights law and the most reported categories.

Discrimination Found Likely	
Civil Rights Category	# of Concerns
Disability	4
Language Assistance Services	2
Limited English Skills	2
Auxiliary Aids and Services	1
Gender Identity	1
Race or Ethnicity	1
Religion	1
Total	13

Civil Rights Category	# of Cases	% of Cases
Disability	31	40.3%
Race or Ethnicity	19	24.7%
Language Assistance Services	5	6.5%
Age	5	6.5%
Gender	3	3.9%
Limited English Skills	3	3.9%
Religion	3	3.9%
Sexual Orientation	3	3.9%
Gender Identity	2	2.6%
Genetic Information	1	1.3%
Character Association	1	1.3%
Auxiliary Aids and Services	1	1.3%
Totals	77	100.0%

QUALITY ASSURANCE

INTER-RATER RELIABILITY DEFINED

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

THE RESULTS

Fifty (50) Grievances were evaluated for the 2Q25 IRR review. These were grievances that closed in 1Q25.

The Medical Director noted that one of the cases may have warranted a review of the medical records. However, the member chose to withdraw the case, expressing concern about potentially implicating her sister, who was employed at the facility. The member's primary concern involved her physician's failure to prescribe her medications.

G&A leadership identified a couple of opportunities for improvement. The Grievance Case Analysts did not consistently attach relevant documentation to their cases. Relevant documents can include translated copies of resolution letters, acknowledgement letters, relevant emails, or responses to referrals. They have not been sending the acknowledgement letters on a timely basis. The acknowledgement letters are to be sent to the members by the fifth calendar day after the case is received.

TIMELINESS

The target timeliness goal for closing cases and mailing acknowledgement letters is 98.6%. For 2Q25, 1,773 cases were subject to DHCS Turnaround Times (TAT). We achieved 99.2% timeliness for closing cases. The 14 cases were processed late because of delays in responses from providers, delays in requesting additional information from providers, delays in receiving medical records and cases not being submitted by other departments timely.

There were 25 late acknowledgment letters, achieving 98.6% timeliness. Delays included internal processing challenges, limited time required for translation, and system limitations that make case management cumbersome and prone to accidental closure of required actions before they are complete.

2Q25 DHCS Timeliness Performance

Performance Category	Performance Goal	# Late	Performance Result	Status
Investigations	98.6%	14	99.2%	
Ack-Letters	98.6%	25	98.6%	

TRANSPORTATION

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Transportation during 2Q25.

2Q25 STATISTICS

Transportation cases accounted for 1,243 of the total 2,477 cases closed. This represented 50.2% of all cases closed in 2Q25. There were 753 Grievances, 419 Exempt Grievances, 66 Appeals, and 5 (five) State Hearings.

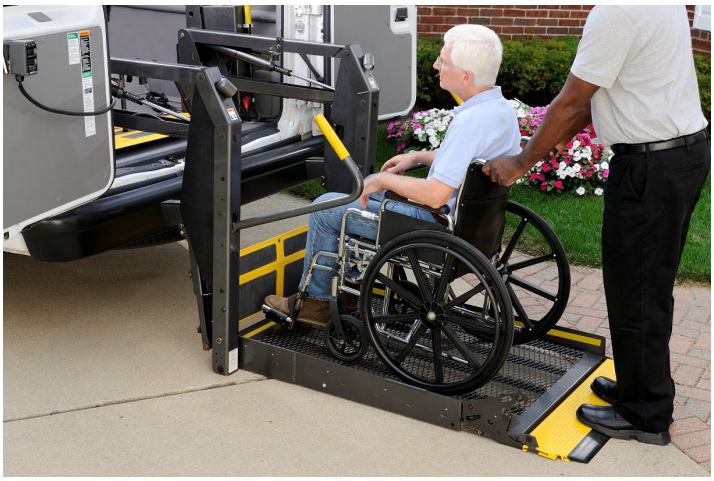
There were 463,816 scheduled rides and 282,796 completed trips for the reporting period.

TRENDING ISSUES

Northbay Transit, Lyft, Redline Transit, Budget Friendly and Wheelcare Express are the top five providers that members complained about. The top five issues that members had during this quarter were missed rides, taxi company preferences, drivers arriving late, and driver behavior. The highest number of transportation cases this quarter were reported in Solano County with 151 cases.

There were five State hearings related to gas mileage reimbursement and transportation-related expenses, out of which 3 cases were withdrawn by the member, one case was dismissed by the court, and the court denied the other.

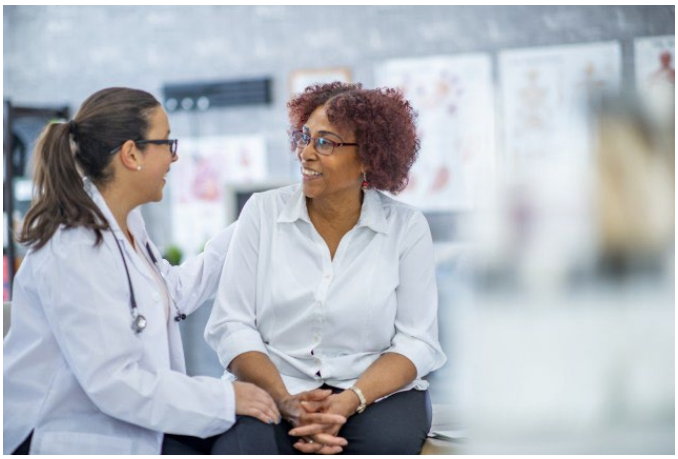
G&A identifies cases related to discrimination specific to transportation providers. In one discrimination grievance, a driver from Greenville Rancheria company allegedly refused to help the member with wheelchair inside the house.



MEMBER EXPERIENCE

REPORTING PERIOD

As required by NCQA, this section reports member dissatisfaction reported in the first half of calendar 2025 compared to all of calendar year 2024. For more details, please reference the attached NCQA ME.7 Member Experience Threshold Report.



OVERVIEW

There were 3,023 Grievances, Second Level Grievances, and Appeals closed in 1Q25 and 2Q25, compared to 6,149 in the entire year of 2024. These cases are broken into two groups. Grievances accounted for 2,655 and Appeals and Second Level Grievances accounted for 368.

Partnership membership decreased slightly by 0.2% from 905,570 to 903,916. The total number of grievances filed per 1,000 members decreased to 2.94 from 6.05. For Appeals and Second Level Grievances, the total number of cases filed per 1,000 members decreased from 0.74 to 0.41.

G&A met the threshold for all categories of Grievances, Appeals and Second Level Grievances for the first half of 2025.

GRIEVANCES

Attitude/Service issues and Access issues were the most frequently reported concerns, with 1,303 and 1,196 cases respectively.

Over 42.0% of the reported concerns pertained to transportation services, including missed rides, delayed driver arrivals, and scheduling inconsistencies. The third most frequently reported issue involved communication, specifically the Member's perception that the provider was not engaging in effective or appropriate communication.

APPEALS & SECOND LEVEL GRIEVANCES

G&A met the threshold for all categories of Appeals and Second Level Grievances for the first half of 2025. Access-related cases rose a little for the first half of this year, and if the numbers continue to increase at the same pace, we may exceed this threshold by the end of the year.

THE UM EXPERIENCE

REPORTING PERIOD

As required by NCQA, this section reports G&A findings about members who encountered problems with the authorization or referral process in January – June 2025 compared to 2024. For more details, please reference the attached NCQA UM 1B: Member Experience-UM Threshold Report.

OVERVIEW

There were 210 reported concerns regarding the UM process from January to June 2025, compared to 270 in the entire 2024 calendar year. When comparing the first half of 2025 to the entire 2024 year, we have met all the thresholds in all categories.

DISSATISFACTION WITH RAF PROCESS

Of the 210 UM concerns, 119 of them were related to the RAF process. Of those, 98 of the concerns were related to a member's primary care provider allegedly delaying their RAF request, which caused delays in getting appointments with specialists. There were 16 cases referred to Quality Improvement for further research.

RAF Process	
# of Reported Concerns	
Delayed by Provider	80
Refused by Provider	18
Member dislikes overall	10
Other	7
Delayed by PHC	3
Refused by PHC	1
Total	119

DISSATISFACTION WITH TAR PROCESS

Members' concerns related to the TAR process account for 91 of the 210 cases reported. The most significant driver was members alleging their provider delayed submission of their TAR to Partnership, which was reported in 56 of the concerns. In one case, the member alleged that the TAR process was delayed due to discrimination based on disability and race. After the investigation, it was found that discrimination was likely since there was a gap in services provided without a reasonable explanation.

TAR Process	
# of Reported Concerns	
Delayed Provider	48
Delayed by PHC	16
Member dislikes overall	9
Refused by Provider	8
Other	8
Med nec unmet by med rec:	2
Total	91

PROVIDER FOCUSED

REPORTING PERIOD

This section highlights trends discovered from January 1, 2025, through June 30, 2025.

APPOINTMENTS

The Partnership Medi-Cal Handbook defines timely access to care as the following:

Urgent Care	48 hours
Non-urgent: w/PCP	10 Business Days
Non-urgent: w/Specialist	15 Business Days
Non-urgent: w/Mental Health	10 Business Days
Non-urgent: w/Ancillary Service	15 Business Days
Telephone Wait Times	10 minutes

G&A regularly reviews member concerns regarding timely access to care. Typically, members are not aware of these timeframes until educated during the Grievance process.

APPOINTMENT DELAYS WITH PROVIDERS

Primary Care Providers – During this reporting period, members submitted 76 concerns related to their primary care provider or office staff regarding difficulties accessing appointments, either in person or by phone. The highest number of cases were attributed to WellSpace Health Roseville, with eight (8) reported concerns, followed by Solano County Health Services with five (5) reported concerns. Due to their higher volumes of reported concerns, they are subject to ongoing monitoring and corrective action, as appropriate, to ensure compliance and improve member access.

Specialists – Partnership approves access to specialists through the RAF process. High-volume and high-impact providers include cardiologists, dermatologists, ophthalmologists,

orthopedists, general surgeons, and OB/GYNs. These providers are closely monitored to ensure timely appointments are available for our members. There were three (3) cases reported, all of which were regarding appointment availability as members had difficulty scheduling timely appointments. One (1) of the three (3) reported cases were involving a high impact provider.

MEETING CULTURAL & LINGUISTIC NEEDS

Partnership monitors our provider network to ensure it reflects and supports the cultural, ethnic, racial, gender, and linguistic diversity of our membership. During the reporting period, nine (9) cases were filed against medical groups or individual providers. Two (2) cases were reported in each of the Auburn, Eureka, Fairfield, and Redding regions, while one case was reported in Santa Rosa.

In Placer County, one case involved a member who received a call back from a provider and was informed that their English skills were sufficient. As a result, an interpreter was not provided during the phone call

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

CONTACT US

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Pharmacy Treatment Authorization Request (TAR) Timeliness Report
Physician Administered Drugs
(January 1, 2025 through June 30, 2025)

Report includes only Adverse Benefit Decision (ABD) determinations resulting from medical necessity review

Urgent Pre-Service *notification within 72 hours of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	126	154	280	
Total # of requests (denominator)	130	156	286	
% compliant	**96.92%**	**98.72%**	**97.90%**	95% (yes)

Urgent Concurrent *notification within 72 hours of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	0	0	0	
Total # of requests (denominator)	0	0	0	
% compliant	**N/A**	**N/A**	**N/A**	95% (N/A)

Non-Urgent Pre-service *notification within 14 calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	266	247	513	
Total # of requests (denominator)	267	247	514	
% compliant	**99.63%**	**100%**	**99.81%**	95% (yes)

Post-Service *notification within 30 calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	23	27	50	
Total # of requests (denominator)	23	27	50	
% compliant	**100%**	**100%**	**100%**	95% (yes)

Pharmacy
Q1 & Q2 2025

Pharmacy Inter-Rater Reliability (IRR) Results
(January 1, 2025 through June 30, 2025)

Pharmacy Technician IRR Results:

Quarter	Raw Score	Concurrence Rate	Goal	Goal Met
Q1	120/120	100%	90%	Yes
Q2	70/70	100%	90%	Yes
Total	**190/190**	**100%**	**90%**	Yes

Pharmacist IRR Results:

Quarter	Raw Score	Concurrence Rate	Goal	Goal Met
Q1	70/70	100%	90%	Yes
Q2	63/64	98%	90%	Yes
Total	**133/134**	**100%**	**90%**	Yes

Pharmacy TAR Volume & Staffing
(January 1, 2025 through June 30, 2025)

All Regions	January	February	March	April	May	June
Total TARs	1047	872	916	906	1060	987
Working Days	21	19	21	22	21	21
Pharmacy Technician FTE	7	7	7	7	7	7
TARs per tech per day	7	7	6	6	7	7
Pharmacist FTE	5	5	5	5	6	6
TARs per pharmacist per day	10	9	9	8	8	8

Pharmacy
Q1 & Q2 2025

Pharmacy TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		TOTAL	
	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025
Approved	625	633	600	531	544	578	562	567	516	696	512	639	3,359	3,644
Approved as Modified	68	41	51	37	47	34	24	33	37	36	32	30	259	211
Medical Necessity Not Justified	119	126	112	101	86	81	95	102	98	111	83	118	593	639
Member Not Eligible	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Health Insurance	23	36	29	29	39	32	18	21	29	20	29	20	167	158
Admin Denial*	206	176	165	142	123	160	147	164	157	174	162	152	960	968
Void	24	35	37	32	38	31	33	19	28	23	30	28	190	168
Total TARs	**1065**	**1047**	**994**	**872**	**877**	**916**	**879**	**906**	**865**	**1060**	**848**	**987**	**5,528**	**5,788**

* Duplicate TAR or No TAR Required

Utilization Management (UM)
Q1 & Q2 2025

UM Treatment Authorization Request (TAR) Timeliness Report
Non-Behavioral Healthcare Decisions
January 1, 2025 through June 30, 2025

Urgent Preservice *notification within 72 hours of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal/ (Goal Met)**
Total # of requests compliant with notification timeframe (numerator)	149	107	256	
Total # of requests (denominator)	191	150	341	
% compliant	**78.01%**	**71.33%**	**75.07%**	95% **(No)**

Urgent Concurrent *notification within 72 hours of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal/ (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	369	737	1106	
Total # of requests (denominator)	372	747	1119	
% compliant	**99.2%**	**98.7%**	**98.84%**	95% **(Yes)**

Nonurgent Preservice *notification within 14 calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal/ (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	3,831	3,600	7,431	
Total # of requests (denominator)	3,932	3,688	7,620	
% compliant	**97.43%**	**97.61%**	**97.52%**	95% **(Yes)**

Post-service *notification within 30 calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal/ (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	34	34	68	
Total # of requests (denominator)	37	38	75	
% compliant	**91.89%**	**89.47%**	**90.67%**	95% **(No)**

Utilization Management (UM)
Q1 & Q2 2025

UM Inter-Rater Reliability (IRR) Results
Non-Behavioral Healthcare Decisions
January 1, 2025 through June 30, 2025

INPATIENT - UM Nurse Coordinator IRR Results:

Quarter	Raw Score	Concurrence Rate	Goal	Goal Met
Q1	341/375	90.93%	90%	Yes
Q2	306/344	88.95%	90%	No
Total	**647/719**	**89.99%**	**90%**	**NO**

OUTPATIENT - UM Nurse Coordinator IRR Results:

Quarter	Raw Score	Concurrence Rate	Goal	Goal Met
Q1	693/705	98.30%	90%	Yes
Q2	641/656	97.71%	90%	Yes
Total	**1334/1361**	**98.02%**	**90%**	**Yes**

LTSS - UM Nurse Coordinator IRR Results:

Quarter	Raw Score	Concurrence Rate	Goal	Goal Met
Q1	147/150	98.00%	90%	Yes
Q2	131/138	94.93%	90%	Yes
Total	**278/288**	**96.53%**	**90%**	**Yes**

Physician UM IRR Results: *(Note: No Pharmacy TARs included in these two quarters)*

Quarter	Raw Score	Concurrence Rate	Goal	Goal Met
Q1	182/184	98.91%	90%	Yes
Q2	205/210	97.62%	90%	Yes
Total	**387/394**	**98.22%**	**90%**	**Yes**

Utilization Management (UM)
Q1 & Q2 2025

UM TAR Volume & Staffing
Non-Behavioral Healthcare Decisions
January 1, 2025 through June 30, 2025

Report includes data for all TARs

INPATIENT TARs – All Regions - UM Nurse Coordinators:

All Regions	January	February	March	April	May	June	TOTALS
Nurse FTE - Inpatient	22	22	22	23	24	24	**22.8**
Total TARs	5732	5260	5253	5188	5638	5554	**32625**
Working Days	21	19	21	22	21	21	**125**
TARs per Nurse per day	12.4	12.6	11.4	10.3	11.2	11.0	**11.4**

OUTPATIENT TARs – All Regions - UM Nurse Coordinators:

All Regions	January	February	March	April	May	June	TOTALS
Nurse FTE - Outpatient	41	43	43	43	37	45	**42**
Total TARs	20127	18702	20729	21499	20728	19766	**121,551**
Working Days	21	19	21	22	21	21	**125**
TARs per Nurse per day	23.4	22.9	23.0	22.73	26.68	20.92	**23.2**

LTSS TARs – All Regions - UM Nurse Coordinators:

All Regions	January	February	March	April	May	June	TOTALS
Nurse FTE - LTSS	10	10	9	9	9	10	**9.5**
Total TARs	2211	1814	1822	1666	1771	1985	**11,269**
Working Days	21	19	21	22	21	21	**125**
TARs per Nurse per day	10.5	9.5	9.6	8.4	9.4	9.5	**9.5**

(FTE: *Full-Time Equivalent***)**

INPATIENT TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEPT		OCT		NOV		DEC		TOTAL	
	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025
Approved	4,912	4,963	4,649	4,540	4,481	4,408	4,814	4,402	4,841	4,628	4,591	4,413	5,177		4,661		4,631		4,997		4,300		4,208		56,262	27,354
EB Approved	20	2	6	1	17	2	14	2	8	5	6	2	9		14		2		2		1		1		100	14
IB Approved	12	13	35	22	61	92	10	11	19	31	70	146	15		29		91		18		46		524		930	315
CTC / Capped Review	3	4	9	7	31	15	0	12	0	8	15	29	5		5		20		7		6		69		170	75
Correction Received	0	0	1	2	3	0	1	0	2	2	1	2	2		1		4		1		4		9		29	6
Modified per Correction Request	3	2	0	0	3	2	3	1	4	1	4	2	1		0		0		0		1		1		20	8
TOTAL (APPROVED)	**4,950**	**4,984**	**4,700**	**4,572**	**4,596**	**4,519**	**4,842**	**4,428**	**4,874**	**4,675**	**4,687**	**4,594**	**5,209**	**0**	**4,710**	**0**	**4,748**	**0**	**5,025**	**0**	**4,358**	**0**	**4,812**	**0**	**57,511**	**27,772**
Approve as Modified	**34**	**102**	**39**	**109**	**45**	**108**	**40**	**93**	**49**	**136**	**52**	**135**	**69**		**71**		**63**		**67**		**81**		**48**		**658**	**683**
Admin Modification	**0**	**1**	**0**	**0**	**0**	**2**	**0**	**1**	**0**	**0**	**0**	**0**	**0**		**0**		**0**								**0**	**4**
Med Nec Not Justified	64	123	66	119	73	139	75	164	80	220	94	257	82		90		106		103		127		128		**1,088**	**1,022**
Denied by Cap Hospital	3	3	3	6	5	9	6	4	5	0	8	4	7		9		11		9		3		6		**75**	**26**
Member not Eligible	17	15	10	12	12	9	8	13	10	9	8	13	18		19		10		8		15		11		**146**	**71**
Not Timely	0	1	0	0	0	0	0	0	0	1	1	0	0		1		0		0		0		0		**2**	**2**
Other Insurance	190	177	110	111	129	164	126	135	119	144	118	158	171		191		191		137		148		172		**1,802**	**889**
TOTAL (MED NEC DENIALS)	**274**	**319**	**189**	**248**	**219**	**321**	**215**	**316**	**214**	**374**	**229**	**432**	**278**	**0**	**310**	**0**	**318**	**0**	**257**	**0**	**293**	**0**	**317**	**0**	**3,113**	**2,010**
Admin Denial (Duplicate TAR)	110	95	63	100	63	81	69	93	72	185	63	169	84		104		124		109		83		92		**1,036**	**723**
Admin Denial (No Auth Required)	96	105	144	95	108	105	86	110	88	140	79	117	88		103		109		90		77		84		**1,152**	**672**
Admin Denial (Void)	512	110	161	136	222	116	114	117	114	125	109	106	166		181		157		118		96		106		**2,056**	**710**
TOTAL (ADMIN DENIALS)	718	310	368	331	393	302	269	320	274	450	251	392	338	0	388	0	390	0	317	0	256	0	282	0	**4,244**	2,105
TOTAL (DENIALS)	**992**	**629**	**557**	**579**	**612**	**623**	**484**	**636**	**488**	**824**	**480**	**824**	**616**	**0**	**698**	**0**	**708**	**0**	**574**	**0**	**549**	**0**	**599**	**0**	**7,357**	**4,115**
Grievance Overturned	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	0
Overturned by Appeal	1	3	1	0	0	0	2	2	1	0	0	0	4		1		1		2		1		0		14	5
Appeal Partially Overturned	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	0
Appeal Upheld	17	13	5	0	2	1	19	28	17	3	6	1	14		10		1		6		5		0		102	46
TOTAL TARs	**5,994**	**5,732**	**5,302**	**5,260**	**5,255**	**5,253**	**5,387**	**5,188**	**5,429**	**5,638**	**5,225**	**5,554**	**5,912**	**0**	**5,490**	**0**	**5,521**	**0**	**5,674**	**0**	**4,994**	**0**	**5,459**	**0**	**65,642**	**32,625**
IP Nurse FTE	**11**	**22**	**13**	**22**	**15**	**22**	**15**	**23**	**14**	**24**	**16**	**24**	**17**		**17**		**18**		**20.00**		**20.00**		**20.00**			
Working Days	**21**	**21**	**20**	**19**	**21**	**21**	**22**	**22**	**22**	**21**	**20**	**21**	**22**	**22**	**22**	**21**	**20**	**21**	**23**	**23**	**19**	**18**	**19**	**20**		
TARs per Nurse per Day	25.95	12.41	20.39	12.58	16.68	11.37	16.32	10.25	17.63	11.19	16.33	11.02	15.81	#DIV/0!	14.68	#DIV/0!	15.34	#DIV/0!	12.33	#DIV/0!	13.14	#DIV/0!	14.37	#DIV/0!		

OUTPATIENT TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEPT		OCT		NOV		DEC		PY	CURRENT
	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025
Approved	20,105	11,803	17,394	11,776	17,474	13,387	17,182	13,714	17,000	13,160	15,412	12,773	15,055		14,964		10,380		11,222		9,497		9,558		175,243	76,613
EB Approved	921	896	788	852	756	935	651	997	651	1,004	845	1,078	1,023		1,145		998		942		738		849		10,307	5,762
CTC / Capped Review	0	0	1	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		1	0
Correction Received	70	47	74	55	103	92	62	34	96	62	78	54	45		49		54		26		38		62		757	344
Modified per Correction Request	1,427	976	898	680	579	638	1,252	1,059	920	782	556	429	1,056		799		358		773		457		229		9,304	4,564
TOTAL (APPROVED)	**22,523**	**13,722**	**19,155**	**13,363**	**18,912**	**15,052**	**19,147**	**15,804**	**18,667**	**15,008**	**16,891**	**14,334**	**17,179**	**0**	**16,957**	**0**	**11,790**	**0**	**12,963**	**0**	**10,730**	**0**	**10,698**	**0**	**195,612**	**87,283**
Approve as Modified	**71**	**270**	**70**	**214**	**74**	**212**	**94**	**203**	**74**	**239**	**70**	**242**	**177**		**101**		**110**		**181**		**167**		**167**		**1,356**	**1,380**
Admin Modification	**149**	**284**	**158**	**270**	**179**	**286**	**177**	**406**	**133**	**497**	**156**	**553**	**275**		**289**		**245**		**324**		**308**		**334**		**2,727**	**2,296**
Med Nec Not Justified	258	1,143	226	952	313	796	426	914	255	889	239	758	715		358		470		902		982		633		**5,777**	**5,452**
Denied by Cap Hospital	1	3	0	1	2	0	0	0	2	1	2	1	0		0		1		0		0		1		**9**	**6**
Member not Eligible	27	22	13	20	23	22	29	22	23	27	26	21	30		40		20		20		15		24		**290**	**134**
Not Timely	1	3	3	0	2	3	1	8	0	20	1	1	1		2		0		17		1		1		**30**	**35**
Other Insurance	418	424	369	347	371	404	351	399	379	385	366	411	422		415		346		423		325		293		**4,478**	**2,370**
TOTAL (MED NEC DENIALS)	**705**	**1,595**	**611**	**1,320**	**711**	**1,225**	**807**	**1,343**	**659**	**1,322**	**634**	**1,192**	**1,168**	**0**	**815**	**0**	**837**	**0**	**1,362**	**0**	**1,323**	**0**	**952**	**0**	**10,584**	**7,997**
Admin Denial (Duplicate TAR)	801	967	627	899	739	1,045	792	1,080	863	1,004	848	1,036	983		920		706		776		745		849		**9,649**	**6,031**
Admin Denial (No Auth Required)	2,255	2,740	1,994	2,220	2,230	2,476	2,251	2,153	1,988	2,212	2,666	2,050	2,257		2,102		3,301		3,696		2,545		2,433		**29,718**	**13,851**
Admin Denial (Void)	605	496	435	395	388	425	478	476	351	418	412	358	589		466		423		598		399		369		**5,513**	**2,568**
TOTAL (ADMIN DENIALS)	3,661	4,203	3,056	3,514	3,357	3,946	3,521	3,709	3,202	3,634	3,926	3,444	3,829	0	3,488	0	4,430	0	5,070	0	3,689	0	3,651	0	**44,880**	22,450
TOTAL (DENIALS)	**4,366**	**5,798**	**3,667**	**4,834**	**4,068**	**5,171**	**4,328**	**5,052**	**3,861**	**4,956**	**4,560**	**4,636**	**4,997**	**0**	**4,303**	**0**	**5,267**	**0**	**6,432**	**0**	**5,012**	**0**	**4,603**	**0**	**55,464**	**30,447**
Grievance Overturned	4	8	3	6	1	6	2	3	1	9	0	0	6		7		3		4		3		3		37	32
Overturned by Appeal	0	17	2	4	4	0	8	8	3	5	1	1	8		2		1		8		2		0		39	35
Appeal Partially Overturned	0	0	1	0	0	0	0	0	0	1	0	0	0		0		0		1		0		0		2	1
Appeal Upheld	4	28	6	11	2	2	20	23	5	13	1	0	10		6		0		12		0		0		66	77
TOTAL TARs	**27,117**	**20,127**	**23,062**	**18,702**	**23,240**	**20,729**	**23,776**	**21,499**	**22,744**	**20,728**	**21,679**	**19,766**	**22,652**	**0**	**21,665**	**0**	**17,416**	**0**	**19,925**	**0**	**16,222**	**0**	**15,805**	**0**	**255,303**	**121,551**
OP Nurse FTE	**23**	**41**	**23**	**43**	**24**	**43**	**24**	**43**	**27**	**37**	**30**	**45**	**28**		**29**		**29**		**32.00**		**36.00**		**38.00**			
Working Days	**21**	**21**	**20**	**19**	**21**	**21**	**22**	**22**	**22**	**21**	**20**	**21**	**22**	**22**	**22**	**21**	**20**	**21**	**23**	**23**	**19**	**18**	**19**	**20**		
TARs per Nurse per Day	56.14	23.38	50.13	22.89	46.11	22.96	45.03	22.73	38.29	26.68	36.13	20.92	36.77	#DIV/0!	33.96	#DIV/0!	30.03	#DIV/0!	27.07	#DIV/0!	23.72	#DIV/0!	21.89	#DIV/0!		

LTSS TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEPT		OCT		NOV		DEC		PY	CURRENT
	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025
Approved	2,098	1,648	1,321	1,367	1,210	1,384	1,133	1,180	1,083	1,288	1,765	1,507	1,545		1,217		1,192		1,239		1,221		1,376		16,400	8,374
EB / IB Approved	239	48	187	72	209	108	190	66	219	64	195	116	243		205		192		192		85		122		2,278	474
Correction Received	25	11	18	12	66	18	3	6	16	3	28	9	12		13		38		22		22		51		314	59
Modified per Correction Request	13	126	9	110	12	51	22	152	19	109	7	71	27		17		9		19		13		4		171	619
TOTAL (APPROVED)	**2,375**	**1,833**	**1,535**	**1,561**	**1,497**	**1,561**	**1,348**	**1,404**	**1,337**	**1,464**	**1,995**	**1,703**	**1,827**	**0**	**1,452**	**0**	**1,431**	**0**	**1,472**	**0**	**1,341**	**0**	**1,553**	**0**	**19,163**	**9,526**
Approve as Modified	**4**	**24**	**2**	**25**	**9**	**16**	**5**	**29**	**7**	**48**	**7**	**36**	**6**		**2**		**3**		**12**		**16**		**6**		**79**	**178**
Admin Modification	**0**	**4**	**0**	**1**	**0**	**2**	**1**	**5**	**0**	**7**	**1**	**2**	**0**		**0**		**0**		**3**		**1**		**0**		**6**	**21**
Med Nec Not Justified	10	32	6	28	24	23	20	27	31	41	29	30	29		33		18		25		15		21		**261**	**181**
Member not Eligible	7	2	3	2	4	2	3	3	3	6	4	3	7		0		2		3		4		6		**46**	**18**
Not Timely	0	1	1	2	0	3	3	3	1	0	1	2	1		0		4		1		0		2		**14**	**11**
Other Insurance	7	8	9	7	17	4	25	3	5	4	6	3	8		6		7		4		3		3		**100**	**29**
TOTAL (MED NEC DENIALS)	**24**	**43**	**19**	**39**	**45**	**32**	**51**	**36**	**40**	**51**	**40**	**38**	**45**	**0**	**39**	**0**	**31**	**0**	**33**	**0**	**22**	**0**	**32**	**0**	**421**	**239**
Admin Denial (Duplicate TAR)	79	99	95	63	105	70	94	64	81	72	75	97	82		80		111		67		63		63		**995**	**465**
Admin Denial (No Auth Required)	1	0	0	0	1	0	0	0	1	0	0	0	0		0		0		0		0		0		**3**	**0**
Admin Denial (Void)	294	208	112	123	82	141	67	126	55	127	84	109	90		88		84		97		69		93		**1,215**	**834**
TOTAL (ADMIN DENIALS)	374	307	207	186	188	211	161	190	137	199	159	206	172	0	168	0	195	0	164	0	132	0	156	0	**2,213**	1,299
TOTAL (DENIALS)	**398**	**350**	**226**	**225**	**233**	**243**	**212**	**226**	**177**	**250**	**199**	**244**	**217**	**0**	**207**	**0**	**226**	**0**	**197**	**0**	**154**	**0**	**188**	**0**	**2,634**	**1,538**
Grievance Overturned	1	0	0	1	0	0	0	1	0	0	0	0	0		0		0		0		0		0		1	2
Overturned by Appeal	0	0	2	0	0	0	1	1	0	1	0	0	0		0		0		0		0		0		3	2
Appeal Partially Overturned	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	0
Appeal Upheld	1	0	1	1	0	0	1	0	0	1	0	0	0		0		0		0		0		0		3	2
TOTAL TARs	**2,779**	**2,211**	**1,766**	**1,814**	**1,739**	**1,822**	**1,568**	**1,666**	**1,521**	**1,771**	**2,202**	**1,985**	**2,050**	**0**	**1,661**	**0**	**1,660**	**0**	**1,684**	**0**	**1,512**	**0**	**1,747**	**0**	**21,889**	**11,269**
LTSS Nurse FTE	**4**	**10**	**3**	**10**	**4**	**9**	**5**	**9**	**6**	**9**	**9**	**10**	**10**		**10**		**9**		**9.00**		**9.00**		**10.00**			
Working Days	**21**	**21**	**20**	**19**	**21**	**21**	**22**	**22**	**22**	**21**	**20**	**21**	**22**	**22**	**22**	**21**	**20**	**21**	**23**	**23**	**19**	**18**	**19**	**20**		
TARs per Nurse per Day	33.08	10.53	29.43	9.55	20.70	9.64	14.25	8.41	11.52	9.37	12.23	9.45	9.32	#DIV/0!	7.55	#DIV/0!	9.22	#DIV/0!	8.14	#DIV/0!	8.84	#DIV/0!	9.19	#DIV/0!		

Wellness & Recovery (BH) TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEPT		OCT		NOV		DEC		PY	CURRENT
	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025
Approved	125	123	91	78	73	53	137	110	90	97	44	44	107		73		44		94		61		27		966	505
EB Approved	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	0
IB Approved	20	36	22	51	84	92	20	34	60	61	78	97	32		61		89		47		80		103		696	371
Correction Received	5	19	11	19	17	34	8	6	8	12	19	13	7		11		13		6		19		27		151	103
Modified per Correction Request	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	0
TOTAL (APPROVED)	**150**	**178**	**124**	**148**	**174**	**179**	**165**	**150**	**158**	**170**	**141**	**154**	**146**	**0**	**145**	**0**	**146**	**0**	**147**	**0**	**160**	**0**	**157**	**0**	1,813	**979**
Approve as Modified	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**0**		**0**		**0**		**0**		**0**		**0**	**0**
Admin Modification	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**0**		**0**		**0**		**0**		**0**		**0**	**0**
TOTAL (MED NEC DENIALS)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**	**0**	**0**	**0**		**0**		**0**		**0**		**0**		**0**		**0**	**2**
Admin Denial (Duplicate TAR)	3	4	5	7	4	6	4	2	1	12	4	3	1		1		2		4		0		0		**29**	**34**
Admin Denial (No Auth Required)	0	0	0	1	0	0	0	0	0	0	0	0	2		0		0		0		0		0		**2**	**1**
Admin Denial (Void)	1	0	1	1	2	2	2	1	2	1	0	0	4		1		1		0		1		2		**17**	**5**
TOTAL (ADMIN DENIALS)	4	4	6	9	6	8	6	3	3	13	4	3	7	0	2	0	3	0	4	0	1	0	2	0	**48**	40
TOTAL (DENIALS)	**4**	**4**	**6**	**9**	**6**	**8**	**6**	**4**	**3**	**14**	**4**	**3**	**7**	**0**	**2**	**0**	**3**	**0**	**4**	**0**	**1**	**0**	**2**	**0**	**48**	**42**
Grievance Overturned	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	0
Overturned by Appeal	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	0
Appeal Partially Overturned	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	0
Appeal Upheld	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	0
TOTAL TARs	**154**	**182**	**130**	**157**	**180**	**187**	**171**	**154**	**161**	**184**	**145**	**157**	**153**	**0**	**147**	**0**	**149**	**0**	**151**	**0**	**161**	**0**	**159**	**0**	1,861	1,021
SUD Nurse FTE	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**1**		**1**		**1**		**2.00**		**2.00**		**2.00**			
Working Days	**21**	**21**	**20**	**19**	**21**	**21**	**22**	**22**	**22**	**21**	**20**	**21**	**22**	**22**	**22**	**21**	**20**	**21**	**23**	**23**	**19**	**18**	**19**	**20**		
TARs per Nurse per Day	3.67	4.33	3.25	4.13	4.29	4.45	3.89	3.50	3.66	4.38	3.63	3.74	6.95	#DIV/0!	6.68	#DIV/0!	7.45	#DIV/0!	3.28	#DIV/0!	4.24	#DIV/0!	4.18	#DIV/0!		

Total All TAR Types	344,695	166,466
	2024	2025 (Q1&Q2)

DATA SUMMARY FOR ALL TAR TYPES

	Year	Total Griev. Over-turned	Total Appeals	Total Appeals Over-turned	% Appeals Over-Turned	Total Appeals Partially Over-turned	% Appeals Partially Over-Turned	Total Appeals Upheld	% Appeals Upheld
	2024	38	**226**	53	23.5%	2	0.9%	171	75.66%
Q1 & Q2	**2025**	34	**168**	42	25.0%	1	0.6%	125	74.40%

	Year	Total	Total App-roved TARS	% App-roved	Total App. as Mod.	% App. as Mod.	Total Admin. Mod.	% Admin. Mod.	Total Med. Nec. Denials	% Med. Nec. Denials	Total Admin Denials	% Admin Denials
	2024	**344,695**	274,099	79.5%	2,093	0.61%	2,733	0.8%	14,118	4.1%	51,385	14.9%
Q1 & Q2	**2025**	**166,466**	125,560	75.4%	2,241	1.35%	2,321	1.4%	10,248	6.2%	25,894	15.6%

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MCUG3118 (previously MCQG1017 & QG100117)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Prenatal & Perinatal Care</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/22/1994 (Policy HS-1)</td><td colspan="4">Next Review Date: ~~09/11/2025~~10/08/2026
Last Review Date: ~~09/11/2024~~10/08/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td>☒ IQI</td><td>☐ P & T</td><td>☒ QUAC</td><td colspan="2"></td></tr>
<tr><td>☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td colspan="2">☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td>☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td colspan="2">☒ PAC</td></tr>
<tr><td>☐ CEO ☐ COO</td><td>☐ CREDENTIALS</td><td colspan="3">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~09/11/2024~~10/08/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3141 – Delegation of Inpatient Utilization Management
B. MPQP1022 – Site Review Requirements and Guidelines
C. ~~MCUP3028~~ MPBP8003 – Mental Health Services
D. MPCP2017 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines
E. MCND9006 – Doula Services
F. MPCR15 – Doula Credentialing
G. MCUP3124 – Referral to a Specialist
H. MCUP3052 – Medical Nutrition Services
I. MCCP2020 – Lactation Policy and Guidelines
J. MCUP3113 – Telehealth Services
K. MCQG1015 – Pediatric Preventive Health Guidelines

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Comprehensive perinatal services are defined as obstetrical, psychosocial, nutritional, and health education services and related case coordination provided by or under the personal supervision of a physician during the perinatal period.
B. The Comprehensive Perinatal Services Program (CPSP) has divided authority between the California Department of Health Services (DHCS) and the California Department of Public Health (CDPH). It is an enhanced program of perinatal services to be offered through the Medi-Cal program and reimbursed (by DHCS) at higher rates than traditional obstetrical services. The CPSP provider certification process is administered and approved by the CDPH. *Note:* Partnership HealthPlan of California (Partnership) encourages, but does not require, providers to be CPSP certified in order to provide obstetrical and perinatal services, however, obstetrics providers need to provide CPSP-like services or refer to another CPSP provider for non-obstetric CPSP or CPSP-like services. (*see also the Partnership HealthPlan Perinatal Services (PHPS) definition below*)
C. Certified Nurse Midwife is licensed as a Registered Nurse and certified as a Nurse Midwife by the California Board of Registered Nursing. (*see related definition for Licensed Midwife below)*
D. Doula: A trained birth worker credentialed by Partnership who provides health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and

after childbirth, including support before, during, and after miscarriage, stillbirth, and abortion. Doulas are not licensed and they do not require clinical supervision.

E. Licensed Midwife is licensed as a Midwife by the Medical Board of California.

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

G. Perinatal Case Manager: Provides services of health education and case management in a perinatal program using CPSP or other protocols and under the supervision of the Clinical Director.
   1. A Perinatal Case Manager is equivalent to a Comprehensive Perinatal Health Worker (CPHW) in a CPSP program

H. Perinatal services are defined as pregnancy related services given before and during delivery and for a period of 12 months following delivery

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IV. ATTACHMENTS:

A. Partnership HealthPlan Perinatal Services (PHPS) Application and Update Form
B. Partnership Perinatal Case Management TAR Thresholds
C. Applying for the CDPH CPSP program

V. PURPOSE:

To describe, define and provide guidelines for the perinatal services to be provided to Members of Partnership HealthPlan of California (Partnership).

VI. GUIDELINE / PROCEDURE:

A. Goals of the Partnership HealthPlan Perinatal Services (PHPS) Program
   1. To make comprehensive perinatal services accessible to all pregnant Partnership Members.
   2. To assure all Members initiate prenatal care within the first twelve (12) weeks of pregnancy and pregnant Members who are new to the HealthPlan obtain prenatal care on the enrollment start date or within forty-two (42) calendar days after enrollment in the Plan.
   3. To support and expand the range of comprehensive perinatal services provided to Partnership Members.
   4. To strongly encourage obstetrical (OB) providers to become CPSP certified providers or to have an agreement with a CPSP provider to provide comprehensive perinatal services.
   5. To inform all Partnership Members about the availability of comprehensive perinatal services and the added benefits of these programs.
   6. To assist Members with engaging in perinatal services .
   7. To assess each Member during each trimester and postpartum, utilizing an assessment tool and to develop an individualized care plan that addresses deficiencies for:
      a. Psychosocial Needs/ Risks/ Concerns (prenatal tool / postpartum tool)
      b. Health Education Learning Needs/ Risks/ Concerns (prenatal tool / postpartum tool)
      c. Nutrition (prenatal tool / postpartum tool)
   8. To increase provider awareness of comprehensive perinatal services and the potential benefits for pregnant Members.

B. Partnership HealthPlan Perinatal Services (PHPS)
   1. All pregnant Members are eligible to receive perinatal case management services.
      a. Partnership encourages universal participation in the CPSP and CPSP-like programs, collectively called Partnership HealthPlan Perinatal Services (PHPS). Members are eligible for PHPS services from the time they believe they may be pregnant through 12 months post-partum.
      b. PHC offers a perinatal program called the Growing Together Program, open to all pregnant and post-partum individuals.

c. For patients with additional needs and risks, Partnership shall refer Members to Partnership Care Coordination and local resources for programs (e.g. Enhanced Care Management (ECM), home visiting programs, Black infant health, targeted case management, etc.).

2. Program materials for PHPS are subject to audit and review during the Site Review process at least every three years for prenatal care providers and Perinatal Case Managers.
   a. A PHPS program may submit claims for services using Z-codes for any affiliated practice site.
   b. PHPS services may be performed in the home, office or via telemedicine, using the appropriate modifiers and place of service codes.
   c. Partnership allows all practices sites of a provider organization that has a CDPH-approved CPSP program to submit claims for perinatal services using applicable CPSP billing codes for the services provided.
3. Modular Approach: All organizations with a CDPH-certified CPSP program are expected to follow the statutory standards. To meet Member needs, PHPS providers may provide and bill for a subset of perinatal support services. If a CPSP program is unable to provide comprehensive services, they are expected to partner with other providers to ensure all Member needs and program requirements are fulfilled. In the event that CDPH-certified programs experience a temporary challenge with providing a subset of CPSP/PHPS services due to staffing or capacity challenges, they are also expected to solicit partner organization(s) to fill any gaps. To accomplish this, perinatal providers may submit claims for any CPSP service, whether or not they are providing case management services. For example, "CPSP-like Program A" may provide case management for a member but needs to use a Registered Dietician (RD) at "CPSP-like Program B" to provide nutrition education services. Each program will bill for the services that they provide and ensure that any services and assessments are centralized in the care plan of the program providing primary case management responsibilities (in the example, "CPSP-like Program A").
4. Partnership Tracking of Perinatal Services Providers: To ensure Partnership oversight of Perinatal Case Management Services, all PHPS providers (including both CPSP programs and providers offering CPSP-like services) need to complete an application (see Attachment A).
   a. All components of the PHPS program relying on outside providers (including delivering providers) require a written letter of agreement from the outside provider.
   b. Providers that may have a PHPS program include: physicians specializing in OB/GYN, Pediatrics, Family Physician; a physician group; a health center, including Federally Qualified Health Centers, Rural Health Centers and Tribal Health Centers; an alternative birthing center; a county run health clinic; a hospital outpatient clinic; a Certified Nurse Midwife run practice; a Licensed Midwife practice.
   c. Quality Monitoring of PHPS providers will be completed as follows:
      1) At the time of the Site Review of all PHPS and perinatal providers which occurs at least every three years
      2) Monitoring of grievances
      3) Reviewing administrative data to evaluate quality outcomes and utilization. Specific measures to be evaluated include:
         a) The percentage of all deliveries in which a patient has at least one PHPS service
         b) The percentage of pregnant members with at least one PHPS service who complete at least:
            i. three antenatal and one postpartum PHPS case management visit
            ii. one mental health service (either PHPS service or other)
            iii. four nutrition services (either PHPS or other)
            iv. one doula visit
5. In areas with a hospital capitation agreement, perinatal services including antenatal care, labor and delivery services, should be provided by perinatal providers who deliver at or collaborate with

delivery teams at the contracted hospital nearest the Member or a hospital associated with capitation agreements that pertain as related to Member's primary care or other capitation factors. Exceptions to this include emergency deliveries and out-of-area hospital admissions authorized according to policy MCUP3141 Delegation of Inpatient Utilization Management, Members determined to be high risk who require the services of a perinatologist, and pregnant Members who are not assigned to a primary care provider because they are in a Direct Member category.

6. Obstetrics providers and Perinatal Services Providers are encouraged to refer Partnership Members who are pregnant to Partnership's Growing Together Program for support and to assist Members with connections to community resources when and where appropriate.
7. Obstetrics providers are encouraged to refer Partnership Members who are pregnant that may have clinical, behavioral and/or psycho-social risk, or those who have intensive case management and/or care coordination needs to Partnership's Care Coordination department for support.
8. All providers of perinatal services must deliver services in conformance with the following:
   a. Current ACOG Standards for Obstetric-Gynecologic Services, (available at this website): https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx
   b. Perinatal care should generally follow the CPSP Program guidelines which can be found in the CPSP Provider Handbook. Updates to these guidelines may be made, but these should be standardized and memorialized in written clinical policies, procedures and protocols. Specific recommendations for addition are:
      1) Screening for Adverse Childhood Events (ACES). See Partnership policy MCQG1015 Pediatric Preventive Health Guidelines
      2) Universal Substance Use Screening using the 4Ps Plus or other evidenced based standardized screening tool to screen for substance use
      3) Screening for Anxiety with the GAD 2, with reflex follow up and referrals for positive result to the GAD7
      ~~3)~~4) Screening for Intimate Partner Violence
   c. Claims for PHPS services should be submitted using the codes defined by DHCS for CPSP services. These Z-codes should be used by all PHPS programs, both CDPH-recognized CPSP programs and by CPSP-like programs.
   d. Newborn Screening Regulations as set forth in Title 17, California Code of Regulations, Section 6500 et seq.
   e. Hemolytic disease of the Newborn Requirements as set forth in Title 17, California Code of Regulations, Section 6510 et seq.
   f. Title 22 regulations; Title 17 regulations and all applicable sections of the Health and Safety Code.
   g. The California Prenatal Screening Program.
   h. Pregnant and post-partum patients must be screened for perinatal mood disorders using a standardized tool.
      1) Patients who meet diagnostic criteria or have risk factors for perinatal mood disorders should be referred to a behavioral health specialist for further treatment (see policy ~~MCUP3028~~ MPBP8003 Mental Health Services and/or policy MPCP2017 Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines).
9. Perinatal service providers include all of the following practitioners for the purpose of providing perinatal services:
   a. Physicians who are general practitioners, family medicine physicians, pediatricians, or obstetrician-gynecologists
   b. Certified Nurse Midwives
   c. Licensed Midwives
   d. Nurse Practitioners

e. Physician Assistants
f. Registered Nurses, Licensed Vocational Nurses, Social Workers, Health Educators, Childbirth Educators, Registered Dietitians, Comprehensive Perinatal Health Workers or Perinatal Case Managers

10. Doulas can provide non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion.

C. PHPS Standards of Perinatal Case Management

1. All obstetrical practitioners are required to provide a comprehensive initial risk assessment that includes medical nutrition, health education, mental health and psychosocial risks, on all pregnant Members at the initiation of pregnancy related services.
2. Formal re-assessments must be offered in each subsequent trimester and in the postpartum period. All identified risk conditions must be followed up by interventions designed to eliminate or remedy the condition or problem in a prioritized manner.
3. Individualized care plans must be developed to include obstetrical, nutritional, health education and psychosocial interventions when indicated by identified risk factors.
4. Every PHPS program should have a designated Clinical Director who may be an OB/GYN, a Family Physician, a Certified Nurse Midwife or Licensed Midwife, Physician Assistant-c, or Nurse Practitioner. The Clinical Director approves all clinical policies, procedures, and protocols; oversees quality oversight of the program; and keeps the staff updated on major advances related to perinatal standards of care.
   a. All Clinical Directors will function within the scope of their license.
5. Perinatal Provider may use group visits for prenatal nutrition, behavioral health and health education issue to address concerns that are identified (using the appropriate group visit CPSP codes)
6. Postpartum health education group visits (using code Z6412) can include topics related to parenting.
7. All services/resources provided must be clearly documented on the Care Plan in the Member's medical record.
8. A non-CPSP provider may choose to use a trained staff person to administer the comprehensive risk assessments and to make referrals to a PHPS or CPSP program or other appropriate program for interventions and completion of care plans.
9. Initial visits with the perinatal case manager are highly recommended to be conducted in-person.
10. Obstetrics office visits may occur via telemedicine when a clinical exam is not medically needed.
11. Group prenatal obstetrical visits using the centering pregnancy model should include (with appropriate chart documentation) a brief individualized visit with the clinician, which would then qualify as a prenatal care visit.
12. Providers for PHPS
    a. Case management services may be provided by a Perinatal Case Manager/CPHW meeting the qualifications specified by the CPSP program.
    b. Nutrition education services:
       1) Perinatal Case managers are expected to provide core educational messages related to nutrition and nutritional risk assessment. These services would be included in their case management services and not billed separately. Targeted nutrition education services may be billed with the nutrition-specific Z-codes, when provided by one of the following:
          a) Nutritionist or Nutrition Coach: General information on healthy diet in pregnancy, which may include motivational interviewing techniques, may be provided by a health educator, a community health worker, or other staff person who has completed at least 6 months of training in nutrition and health coaching. Complex dietary needs or issues would be referred to a Registered Dietician
          b) Certified Registered Dietician: May perform general nutrition education, but also has the expertise to handle more complex issues, such as diet modifications for obesity,

gestational diabetes, celiac disease, hyperemesis, food allergies, restrictive diets (such as those with no dairy products or no meat), etc. In addition, many registered dieticians are certified diabetes educators, and the usual nutritional Z-codes can be used when billing for these services by a Registered Dietician.

c) Pregnant individuals can be more motivated to make changes, and obesity is usually very difficult to treat with little nutrition services available to non-pregnant individuals; we highly recommend that all individuals with a pre-pregnancy BMI greater than 25 have at least one visit with a Nutritionist or Nutrition coach, with additional visits if the patient needs them to reinforce changed behavior.

c. Mental Health Services

1) Perinatal Case Managers are expected to screen for depression and anxiety as part of their initial, ongoing and post-partum assessments and to recommend and arrange for referrals for birthing individuals who screen positive. Additionally, Perinatal Case Managers / CPHWs are expected to offer support and encouragement and to encourage social activities to build mental health resilience. These services would be included as part of their case management services, but they are encouraged to bill separately for depression screening so such screening can be captured using claims data, using one of the following codes:

a) Preferred:

i. HCPCS: G8431 for a positive screen with a plan

ii. HCPCS: G8510 for a negative screen

b) Other option:

i. CPT: 96127 used for each screening tool used (can bill two units if G codes above not used and both the PHQ2 $\geq$ 9 (for depression) and the GAD 2 $\geq$ 7 (for anxiety) are used). If the depression screening is reported using the G-codes above, if a GAD is also done, it can be reported using one unit of 96127.

ii. ICD10: use Z13.31 if screening is done on patient without symptoms concerning for depression or anxiety; use a more specific code if a screening is done in response to signs or symptoms.

2) Mental Health Counselors (including counseling for substance use disorders):
The United State Preventive Services Task Force (USPSTF) recommends that ALL low-income pregnant individuals receive preventive counseling on building resilience and detecting early signs of depression and anxiety that would require evaluation. Such preventive counseling, and counseling for mild dysphoria, can be provided by a community health worker (CHW) or health educator with special training on such preventive mental health counseling, under the supervision of a licensed mental health clinician. The mental health Z-codes may be used.

3) Licensed mental health and substance use professionals:
Any licensed mental health or substance use professional may provide mental health and substance use services to pregnant patients using the mental health Z-codes. This includes psychiatrists, clinical psychologists, licensed clinical social workers, licensed marriage and family therapists, licensed professional clinical counselors, certified alcohol and drug abuse counselors etc. The CPSP or CPSP-like program hiring these mental health/behavioral health specialists is responsible for ensuring that the clinical problems addressed by the individual professionals match their training and experience.

d. Perinatal Health Education services may be provided by staff with the qualifications outlined in the CPSP program or by educators or health workers with specific training competencies related to one or more aspects of wellness for birthing individuals. Education conducted in the course of routine prenatal/post-partum/peripartum care provided by clinicians or doulas is not separately reimbursable; it is considered a part of their professional services. Separate and

stand-alone educational services, whether individual or in a group setting, may be billed by a CPSP program or a CPSP-like program using the education Z-codes. CHW provided education may be billed as a CHW service or a perinatal education service, but not both.

D. CPSP/Perinatal Services Case Management Responsibilities
   1. The Perinatal Case Manager/CPHW is expected to plan and ensure the provision of comprehensive perinatal services, including nutrition, health education, and psychosocial assessments and reassessments, individualized care plan development, coordination of services, and referrals. At a minimum, for low-risk individuals, four case management visits are recommended: one in each trimester and one in the post-partum period.
   2. The Perinatal Services case manager must assure that the following has been provided to the Member and documented in the medical record:
      a. An orientation about the purpose of the Perinatal program and the guidelines about the services which have been offered
      b. Identify the location/ provider of medical prenatal care, with planned location of delivery.
      c. Review the warning signs and symptoms that warrant urgent attention and office procedures for the perinatal services.
      d. Information about the available adjunctive referral services available to the Member.
      e. Advise the Member about their rights and responsibilities in accepting or refusing the services offered.
      f. Notification regarding Partnership appeal and grievance policies.
      g. An offering of the initial nutrition, health education and psychosocial assessments, and individualized care plan development, including both individual and group interventions for each service as recommended in the individualized care plans.
      h. Documentation of referrals to services which are not specifically included in the definition of comprehensive perinatal services, but which are appropriate for the medical and/or psychosocial health of the Member, should be noted in the record by the Perinatal case manager.
   3. The Perinatal Services case manager must use orientation, assessments, re-assessments, individual and group process interventions and family support participation as methods for the provision of comprehensive perinatal services.
      a. Standardized assessment and reassessment tools, and the individualized care plan must be revised as necessary at least each trimester and at the post-partum visit
         1) The CDPH standardized tool or a modification of this tool may be used, but it should be standardized and documented in the provider's organizational policies and procedures and, where feasible, integrated into the shared medical record.
      b. Each component of the individualized care plan should identify risk conditions; prioritize the Member's needs, referrals, and proposed interventions including methods, time frames and outcome objectives for psychosocial, health education, and nutrition services.
      c. The perinatal provider must document the assessment of the member's obstetrical status at each visit.
   4. A Member has the right to decline to participate in any part of the Comprehensive Perinatal Services Program. This should be documented clearly in the medical record.
      a. Members who initially declined should be offered ~~the services~~services throughout pregnancy and postpartum period
   5. Within 3 business days of completion of an initial problem list and care plan, and upon update of this care plan each trimester, a copy must be transmitted to the prenatal care provider in a manner agreed upon by the PHPS provider and the prenatal care provider. Any urgent changes or developments should be additionally communicated via phone, secure text, a centralized health information exchange, or secure email (as requested by the prenatal care provider).
      Providers of PHPS must submit a TAR to Partnership for the provision of services in excess of the

Partnership maximum frequency allowance for nutrition, psychosocial and health education services.

6. Perinatal Services providers must maintain an updated list of staff working in their program, with their job titles and training/licensure. These will be reviewed at Site Reviews of the perinatal provider at least every 3 years.

E. Perinatal Services Health Education Roles
   1. Provide education based on the Assessment and Reassessment in the following areas with supervision of licensed clinical staff and referral to Behavioral Health/Nutritionist/Licensed clinical staff per agency protocols:
      a. Pregnancy related nutrition
      b. Behavioral Health self-management, goal setting and motivational interviewing
      c. Lactation support education and lactation counseling

F. Diabetes Care in Pregnancy (formerly known as "Sweet Success" programs)
   1. Birthing people with diabetes are at risk of a variety of serious complications for both the birthing person and their baby. A large body of research shows that intensive education, case management and obstetrical support reduces the incidence of complications and improves outcomes (summarized by the American Diabetes Association in the references).
   2. To optimize outcomes for pregnant persons with diabetes, the PHPS program allows for the following services:
      a. Diabetes education (including the use of continuous glucose monitoring) may be provided by any Certified Diabetes Educator (CDE), whether through a PHPS provider or through any other Partnership contracted CDE. When a Registered Dietitian (RD) performs CDE services in a PHPS program, the nutrition Z-codes may be used. When a contracted RD performs CDE services outside of a PHPS program, the codes listed in policy MCUP3052 Medical Nutrition Services may be used. If a nurse within a PHPS program conducts CDE services, the education Z-codes may be used.
      b. Extra perinatal case management services are required for optimal outcomes in patients with pregnancy and diabetes. Any TARS for increased visit frequencies for diabetes in pregnancy will be evaluated with this in mind.
      c. Diabetes education for pregnant individuals may be done either in-person or through video telemedicine visits.
      d. While any licensed prescriber may adjust medications for diabetes in pregnancy, expertise and experience in this area is associated with tighter control and improved outcomes. Ideally there is a hierarchy of expertise in such prescribing, with all levels thoroughly educated on and in alignment of the goal of excellent blood sugar control in a pregnant individual. The details of the hierarchy can vary, but may include a CDE-RN adjusting medication via a written protocol under supervision of a physician with expertise in more complex cases. Such medication titration by an RN is typically associated with additional diabetes education and thus can be billed through PHPS using the education Z-codes.
      e. The decision as to who will provide CDE services and who will manage medication must account for the geographic location of the patient, their preferences for telemedicine, regional access to technology that supports telemedicine, visits, the availability of staff with expertise in this area, and the language and cultural concordance of different provider options. Requiring all patients to travel long distances on a frequent basis for care that could safely be provided locally or via telemedicine results in inequitable care as patients choose to forgo the care altogether.
         1) Where cellular and internet service are unreliable, PHPS programs can consider "hosting" telemedicine visits at their practice sites with non-local consultants to ease access and avoid long distance travel

G. Lactation Counseling and Education
   1. Basic lactation education, more formal lactation counseling or lactation consultation may be

included as part of PHPS case management services, nutrition service or health education services, depending on the credentials of the person providing the services, using the corresponding Z-codes. Non-PHPS providers may also provide lactation counseling or consultation services as outlined in MCCP2020 Lactation Policy and Guidelines.

H. Referral Procedures
   1. Specialist care with an obstetrics provider (e.g. Maternal Fetal Medicine or High Risk Obstetrics) does not require an approved Referral Authorization Form (RAF). However, some specialists and practices require a referral and medical records prior to scheduling a consultation.
      a. Consultation during pregnancy with a non-Obstetrics specialist (Cardiology, Endocrine) requires that a Referral Authorization Form (RAF) be submitted by the Primary Care Provider.
   2. It is the responsibility of the perinatal provider to confirm the Member's eligibility and PCP information with Partnership at each visit.

VII. REFERENCES:

A. Guidelines for Perinatal Care –8th Edition by the American College Obstetricians & Gynecologists (ACOG) and the American Academy of Pediatrics (AAP), September 2017.
B. Title 22 regulations; Title 17 regulations and all applicable sections of the Health and Safety Code
C. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-022 Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services (12/19/2018)
D. DHCS APL 22-024 Population Health Management Policy Guide (11/28/2022)
E. DHCS APL 23-024 *Revised* Doula Services (11/03/2023)
F. California Department of Public Health CPSP Program https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx
G. American Diabetes Association Professional Practice Committee; 15. Management of Diabetes in Pregnancy: Standards of Care in Diabetes—2024. Diabetes Care 1 January 2024; 47 (Supplement_1): S282–S294. https://doi.org/10.2337/dc24-S015

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. OB/GYN practice sites
C. Partnership Department Directors

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

X. REVISION DATES:

(HS-1 - 12/10/96; 10/10/97 [name change only]; 02/17/99; 06/21/00, 10/17/01; 06/19/02; 10/20/04; 04/20/05; 05/18/05; 05/17/06; 08/15/07; 08/20/08; 06/17/09; 01/16/13; 03/19/14; 09/17/14; 02/18/2015; 01/20/16; 01/18/17; *06/13/18; 06/12/19; 06/10/20; 02/10/21; 03/09/22; 03/08/2023; 11/08/23; 09/11/24; 10/08/25

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

PREVIOUSLY APPLIED TO: N/A

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

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

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

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

Partnership HealthPlan of California

Partnership HealthPlan Perinatal Services (PHPS) Application and Update Form and Contracted Provider Addendum

Note: This application does not substitute for the usual provider contracting/credentialing processes. All providers must complete the usual Partnership provider contracting/enrollment/credentialing processes prior to, or concurrent with, the completion of this application.

Check one:

____Initial (New Perinatal Case Management Service Program)

____Ongoing (long-standing Perinatal Case Management services, but first time completing this form)

____ Change (Prior completion of this form; this is an update)

Date form completed: _____

Date effective (if services were provided prior to form completion, may be up to 9 months prior): _____

Core Organizational Information: All PHPS providers must be enrolled in the Medi-Cal Program and have an organizational NPI number

Name of Organization: _____

Organizational NPI Number: _____

Organizational Medi-Cal ID Number: _____

Mailing Address of Organization Headquarters:_____

County where Organizational Headquarters is located: _____

Counties primarily served by PHPS program: _____

Contact Person: _____

Email of Contact Person: _____

Name of CEO or signing authority: _____

Email of CEO or signing authority: _____

Name of Clinical Director of PHPS program: _____

Circle one: OB/GYN Family Physician Pediatrician Certified Nurse Midwife Licensed Midwife Nurse Practitioner Physician Assistant- certified

Email of Clinical Director: _____

NPI of Clinical Director: _____

Administrative Director of PHPS program: _____

Email of Administrative Director: _____

Primary phone number for program: _____

Type of Perinatal Services:

_____Organization has at least one site that is certified by CDPH as a CPSP program (attach letter of approval)

_____Organization is not currently CPSP-certified, but has applied for this certification (attach a copy of the application cover page)

_____Organization is not currently certified, nor planning to obtain CPSP-certification status

List ALL sites in your organization that may offer and bill for any Perinatal Case Management or support services:

Site number	Name of site	Complete Address of Site
1		
2		
3		
4		
5		
6		

(Add more rows if needed)

Identify the Perinatal Services Provider at *any* site in your organization:

Service	Check if Provided in-person	Check If Provided virtually	If service is not provided in your organization or is shared with another organization, indicate partner organization(s) who will provide this service (If known/ finalized)	Indicate Capacity to accept outside referrals for this service. **Choose one**: • No outside referrals • Limited outside referrals • None currently but planning capacity for outside referrals • Currently open to all outside referrals
Pre-natal care (Physician/NP/PA or midwife)				
Perinatal Case Management				
Nutrition Services				
Mental Health/ Behavioral health services				
Health Education Services				
Diabetes in Pregnancy Diabetes Education				
Diabetes in Pregnancy Nutrition Education				
Diabetes in Pregnancy: Insulin/Medication titration/adjustment				
Lactation Counseling or Consultation				

Attachments:

- Please attach a list of staff providing these services, with their names, job titles and licensure/credentials. Please include any support staff.

Role	Total FTE	Professional Training RD/CDE/RN/LVN/MPH/MSW, ASW, LCSW, MD (OB/Gyn, Family Med) NP/PA-c CNM/LM	Number of staff in each provider type and training	License/Certification Numbers or equivalent (or send an Employment Roster with the information
Perinatal Case Manager				
Nutrition				
Mental /Behavioral Health				
Medical Providers				
Support Staff				

- If your organization performs perinatal case management, please include a copy of the standard assessment that you use or plan to use.
- All Licensed staff must be credentialed with Partnership or with a Partnership delegate, if applicable, ~~(e.g. Carelon)~~ by July ~~2025~~2026

The Clinical Director's signature below attests that the Perinatal Services staff meet the required background and training to complete their tasks as outlined in policy MCUG3118 *Prenatal & Perinatal Care* for each participating staff member.

_____
Clinical Director's Name and Signature

Submit to: PHPS@partnershiphp.org

For internal use:

Date Perinatal Site Review Last Completed:_____

Date Perinatal Site Review Passed: _____

Date Parent Organization Contract Executed: _____

Parent Organization Provider Number: _____

Other Notes:

MCUG3118 Attachment B
Partnership HealthPlan of California

Frequency Limits ~~TAR Requirements~~ for Partnership HealthPlan Perinatal Services (PHPS)

PHPS Code	Description	TAR required when services exceed:
Z1032.ZL	Initial prenatal visit performed within 16 weeks of LMP	1 per pregnancy (6 months)
Z6500	Initial Comprehensive Assessment (90 minutes)	1 per pregnancy (6 months)
Nutrition Services		
Z6200	Initial nutritional assessment and development of care plan, initial 30 minutes (Must be billed before antenatal follow-ups Z6202-6)	1 per pregnancy (9 months)
Z6202	Initial Assessment, each additional 15 minutes	12 in 9 months
Z6204	Follow up antenatal nutritional assessment/treatment/intervention, individual, per 15 minutes	72 in 9 months
Z6206	Follow up nutritional assessment/treatment/intervention, group, per 15 minutes (may be antenatal or postpartum)	12 in 9 months
Z6208	Postpartum assessment/treatment/intervention, individual, per 15 minutes	16 in 6 months
S0197	Prenatal Vitamins, 30 day supply	10 per pregnancy (9 months)
Comprehensive Psychosocial Services		
Z6300	Initial psychosocial assessment and development of care plan, initial 30 minutes (Must be billed before antenatal follow-ups Z6302-6)	1 per pregnancy (9 months)
Z6302	Initial Assessment, each additional 15 minutes	12 in 9 months
Z6304	Follow up antenatal psychosocial assessment/treatment/intervention, individual, per 15 minutes	72 in 9 months
Z6306	Follow up psychosocial assessment/treatment/intervention, group, per 15 minutes (may be antenatal or postpartum)	32 in 9 months
Z6308	Postpartum psychosocial assessment/treatment/intervention, individual, per 15 minutes	32 in 12 months

Frequency Limits for Partnership HealthPlan Perinatal Services (PHPS)

Comprehensive Health Education Services		
Z6400	Client orientation, each 15 minutes	16 in 9 months
Z6402	Initial health education assessment and development of care plan, initial 30 minutes (Must be billed before antenatal follow-ups Z6402-12)	1 per pregnancy (9 months)
Z6404	Initial Assessment, each additional 15 minutes	6 per pregnancy (9 months)
Z6406	Follow up antenatal psychosocial assessment/treatment/intervention, individual, per 15 minutes	72 in 9 months
Z6408	Follow up psychosocial assessment/treatment/intervention, group, per 15 minutes	16 in 9 months
Z6410	Perinatal education, individual each 15 minutes	Max 16 units/pregnancy (6 months)
Z6412	Perinatal education group per patient, each 15 minutes (may be antepartum or postpartum)	Max 16 units/day, max 72 units per pregnancy (6 months)
Z6414	Postpartum health education assessment/treatment/intervention, individual, per 15 minutes	32 in 12 months
Prenatal/Postpartum Care		
Z1032 or 99205 (same)	Initial Prenatal Visit	1 per pregnancy (6 months)
Z1034	Other prenatal visit	13 in 9 months
Z1038	Postpartum visit	2 per 6 months

Applying for the CPSP Program

Reference: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx

Enrollment Requirements:

- Applicant's site must be actively enrolled in Medi-Cal under an organizational National Provider Identifier (NPI) and be a CPSP-eligible provider type.
- Applicants must have an approved CPSP Provider Application on file with CDPH/MCAH.

Eligible CPSP Provider Types:

- Physician specializing in obstetrics and gynecology, pediatrics, family medicine, or general medicine
- Physician group
- Certified nurse midwife (CNM)
- Licensed midwife (LM)
- Hospital outpatient clinic
- Community clinic
- County clinic
- Alternative birth center

To apply for CPSP approval:

1. Download the current version of the CPSP Provider Application (CDPH 4448) and Additional CPSP Practitioners Form (CDPH 4448A), if applicable, from the CPSP website.
2. Complete and submit forms CDPH 4448 and CDPH 4448A to CDPH/MCAH Division to CPSP Provider Enrollment .
3. Newly approved CPSP providers are advised to download the CPSP protocols, assessments, and individual care plan (ICP) templates listed below. The assessment/ICP templates are for the staff's use when delivering CPSP services. The protocol template and assessment/ICP templates are designed to be utilized together.
4. Submit customized, site-specific CPSP protocols to General program inquiries within six months of application approval.

Changes to approved CPSP Protocols must be documented and filed and kept in the provider's office for audit purposes. CDPH is only collecting new CPSP provider Protocols as part of the CPSP Application process. Changes to approved CPSP Protocols may include, but are not limited to:

- Nutrition, Psychosocial, and Health Education Assessment Tools
- General Description of Practice
- List of Delivery Hospitals
- Antepartum/Intrapartum/Postpartum and Dual Provider Agreements
- Staff updates
- Protocol updates

New Information for all approved CPSP Providers

As part of monitoring/oversite of the CPSP Program, CDPH/MCAH will be conducting a yearly CPSP Annual Survey and will be requesting CPSP Protocols for review or audit purposes. The CPSP Annual Survey and CPSP Protocol reviews will be in lieu of the chart reviews and Administrative Reviews previously conducted by the PSCs.

CPSP Annual Survey

- Starting July 1, 2023, all approved CPSP providers will be required to complete and submit the CPSP Annual Survey beginning one year following approval as a requirement for the CPSP provider to remain in "good standing." CPSP Annual Surveys must be completed by April 30 of each calendar year. CPSP providers will be sent a Letter of Non-Compliance from CDPH/MCAH for surveys not received.

Protocol Changes

- CDPH is not routinely collecting updates to CPSP Protocols for current CPSP providers. Updates or changes to a provider's "Approved" CPSP Protocols **must be documented and filed in the provider's office/clinic and will be made available upon CDPH's request for review or for CPSP audit purposes.**

Link to application:
https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph4448.pdf

Link to program and other handouts.

https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx#

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3140</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Palliative Care: Pediatric Program for Members Under the Age of 21</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 05/08/19
Effective Date: 01/01/2019 per DHCS</td><td colspan="4">Next Review Date: ~~09/11/2025~~10/08/2026
Last Review Date: ~~09/11/2024~~10/08/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☐ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~09/11/2024~~10/08/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3020 – Hospice Service Guidelines
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
C. MCUP3124 – Referral to Specialists (RAF) Policy
D. MP~~C~~UP3137 – Palliative Care: Intensive Program (Adult)
E. MCCP2022 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services
F. MPCR300 – Physician Credentialing and Re-credentialing Requirements
G. MPCR301 – Non-Physician Clinician Credentialing and Re-credentialing Requirements
H. MPCR13A – Credentialing of Hospice and Palliative Care Medicine Specialist
I. CGA024 – Medi-Cal Member Grievance System
J. MPQP1022 – Site Review Requirements and Guidelines
K. MCUP3106 – Waiver Programs
L. MPQP1038 – Physician Orders for Life-Sustaining Treatment (POLST)

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. ED: Emergency Department
B. Hospice Care: Services provided to a terminally ill patient with a prognosis of life of 6 months or less, if the disease follows its normal course. For children, curative services may be provided concurrently with hospice services.
C. Outpatient Pediatric Palliative Care (OPPC): A Partnership HealthPlan of California-defined outpatient palliative care program for ~~member~~Members under age 21 years, provided by a team over an extended period of time, usually in the home. Defined by the Department of Health Care Services (DHCS) as covered as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.
D. Medical Necessity: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
E. Palliative Care: Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care can be provided as part of Hospice Care at the end of life, or as a set of supportive services for individuals with life-threatening conditions who have a life expectancy that is longer than 6 months.

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

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

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

IV. ATTACHMENTS:

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

V. PURPOSE:

To define Partnership HealthPlan of California's Palliative Care services to Partnership Medi-Cal eligible beneficiaries under age 21. See policy MP~~C~~UP3137 for a description of palliative care for ~~member~~Members age 21 and over.

VI. POLICY / PROCEDURE:

A. Range of palliative care services available for pediatric ~~member~~Members.
   1. In its general definition, palliative care services may range in intensity and be provided in different settings and by different configurations of teams. Any level of palliative care services may be part of the care plan for a ~~member~~Member under age 21, as developed by the primary care provider, specialist, case management team, or specialty care center. Members under age 21 may have concurrent curative and palliative treatments. The major categories that may apply for ~~member~~Members under age 21 are:
      a. Primary palliative care
      b. Outpatient specialty palliative care—low intensity
      c. Outpatient pediatric palliative care—high intensity
      d. Hospice
   2. Primary palliative care is provided by primary care clinicians or by specialists who are not board certified or specialty trained in palliative care. It may be provided in the inpatient or outpatient setting. Partnership considers such services as integral parts of usual evaluation and management services; no prior authorization is required; no special billing codes apply.
   3. Outpatient specialty palliative care—low intensity is provided by specialty trained palliative care physicians outside the hospital setting, independent of a supporting team. Board Certified Palliative Care Physicians may apply to be a credentialed Palliative Care Specialist (See policy MPCR13A – Credentialing of Hospice and Palliative Care Medicine Specialist). Like other outpatient specialist consultation, Partnership's specialty referral policies apply (See policy MCUP3124 – Referral to Specialists (RAF) Policy).
   4. Outpatient pediatric palliative care is provided by a team over an extended period of time, usually in the home. Services are similar in scope to hospice, but the eligibility criteria are different. Sections VI. B. through F. define criteria and services for outpatient palliative care for Partnership ~~member~~Members under age 21.
   5. Hospice services are limited to ~~member~~Members with a life expectancy of 6 months or less but may

also include curative care. (See policy MCUP3020 Hospice Services Guidelines)

B. Outpatient Pediatric Palliative Care Eligibility Criteria
   1. Members must meet criteria stated in a. through f. below:
      a. Have Partnership HealthPlan of California as their primary insurance, or Partnership as secondary coverage with a rejection of coverage by the primary insurance.
      b. Are under 21 years of age
      c. The parent(s) or legal guardian and the child (if cognitively able) agree to the provision of pediatric palliative care services; and
      d. The parent or legal guardian declines hospice enrollment or the ~~member~~Member is not eligible for hospice enrollment
      e. Documentation of an Eligible Medical Condition: Member must have a life-threatening diagnosis. Conditions may include but are not limited to:
         1) Conditions for which curative treatment is possible, but may fail (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease); or
         2) Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
         3) Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
         4) Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms)
      f. Projected Level of Care: At least one of the following
         1) The ~~member~~Member has started to use the hospital or emergency department as a means to manage the unanticipated decompensation of the ~~member~~Member's disease.
         2) The attending physician estimates that the ~~member~~Member would be expected to be hospitalized for at least 30 days in the next year.
   2. If the ~~member~~Member continues to meet eligibility criteria, the ~~member~~Member may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death.

C. Outpatient Pediatric Palliative Care Engagement and Enrollment Process
   1. Palliative Care Assessment and Consultation (Engagement):
      a. Partnership contracted Outpatient Pediatric Palliative Care providers will contact ~~member~~Members referred to their program for evaluation within 7 calendar days to arrange an evaluation and assessment.
      b. No prior authorization is required for the engagement process before speaking with a ~~member~~Member.
      c. No prior authorization is required prior to providing initial coordinated care (G9001). However, payment will require submission of a TAR. If the patient meets enrollment criteria specified in VI. B. above, the TAR for G9001 should be submitted with a TAR for ongoing case management and other services being requested (see VI. C.f. below). If the patient does not meet criteria, the TAR may be submitted for only the initial coordinated care service (G9001).
      d. The initial TAR for initial coordinated care (G9001) should include the Outpatient Pediatric Palliative Care Eligibility Assessment Form (Attachment A).
      e. The initial coordinated care covers a comprehensive assessment and support services for a period of 30 days. The applicable time period should be indicated on the TAR and on the claim submitted.
      f. A TAR for ongoing services (enrollment) based on the care plan developed in the initial coordinated care visit should be submitted during the initial coordinated care period (30 days).

To ensure no gap in services, it is recommended that this TAR be submitted no later than 20 days after the initiation of the one month of initial coordinated care. The TAR for ongoing services should include

1) Dates of visits of the palliative care team ~~member~~Members to the Partnership ~~member~~Member (for G9001 services)
2) Advanced care discussion with goals of care document
3) A multidisciplinary comprehensive assessment, including assessment by a Registered Nurse and a Licensed Clinical Social Worker
4) Care Plan addressing medical, social, emotional and spiritual needs

g. Partnership intensive care management teams may identify and refer care managed ~~member~~Members (who are potentially eligible for this benefit) to a contracted Partnership palliative care provider.

2. Pediatric Enrollment Process
   a. Submit a TAR for the ~~member~~Member's enrollment into the Outpatient Pediatric Palliative Care program to Partnership in accordance with Partnership policy MCUP3041 TAR Review Process. With an enrollment TAR, the Provider must submit the information required for the engagement TAR (VI.B.1.e. and f.), as well as the Outpatient Pediatric Palliative Care Eligibility Assessment Form (Attachment A).
   b. For ~~member~~Members in the hospital, enrollment will take place after discharge.
   c. Continued approval will require subsequent TAR submission, every 6 months, with the following information included:
      1) Detailed progress notes, documenting current disease status
      2) Dates of face to face and telemedicine visits
   d. TAR is required for these services (typically submitted as a package for a single patient):
      1) Minimum ongoing services required is **monthly care coordination** (T2022) which includes 4-12 hours of care coordination services per 30 day period. Included in this monthly care coordination is at least one monthly visit to the ~~member~~Member in their home by one of the OPPC staff. Additional services that should be included on the TAR include:
         a) **Activity therapy** (G0176), 45 minutes or more per session, includes art, music, child life therapy and massage therapy. Maximum of three units per day, up to 60 hours per 90 days.
         b) **Initial case management** (G9001) as detailed above in section VI.C.1
      2) **Other specified case management** (G9012), provided by any OPPC staff, hourly for each hour of case management beyond 12 hours, which is covered by T2022. Maximum of 60 hours per 90 days.
      3) **Family home care training** by a Registered Nurse (S5110), 15 minutes per unit, maximum of 12 units per day, 100 hours per year.
      4) **Family Counseling** (90837) provided by psychologist or LCSW. One unit = 15 minutes; with a maximum of 22 units per rolling 12 month period (equal to 330 minutes per rolling 12 month period).
      5) **Pain and Symptom Management** (S9123), provided by a Registered Nurse, one hour per unit. Maximum of 100 hours per year.

3. Pediatric Re-Enrollment Criteria
   A new TAR is required every six (6) months for all ~~member~~Members receiving Pediatric Palliative Care services. The TAR must include documentation and submission of the following items:
   a. Current clinical summary of ~~member~~Member's condition and individualized care plan.
   b. Detailed progress notes completed by the palliative care physician, nurse practitioner or specialist documenting relevant specific clinical information showing continued eligibility for

c. Medical records must include a recent face to face visit by the registered nurse, medical provider (MD or DO, nurse practitioner, or physician assistant) that documents the patient's current clinical condition.

4. OPPC Disenrollment Criteria
   a. Member is not eligible for Partnership for more than 30 days
   b. Member moves out of the service area
   c. Member, parent(s) or legal guardian declines participation after enrollment
   d. Member, parent(s) and legal guardian refuses to be contacted
   e. Member, parents(s) and legal guardian cannot be reached or is lost to follow-up for 30 days
   f. Member, parent or legal guardian exhibits inappropriate or threatening behavior towards staff
   g. Member, parent or legal guardian poses a safety or security risk to staff, other patients or clinic property
   h. Member is deceased
   i. Member begins hospice services
   j. Member's condition changes such that palliative care is no longer medically necessary or no longer reasonable. (Consultation with Partnership Palliative Care team may be necessary in some cases)

D. Outpatient Pediatric Palliative Care: Scope of Services
   1. Outpatient Pediatric Palliative Care (OPPC) Services include the following:
      a. Care Coordination, including monthly in person or telephonic meetings with Partnership Care Coordination staff
      b. Advance care planning conversations
      c. Development of a treatment plan, including patient goals
      d. Control of pain, medication side effects, and other symptoms
      e. Addressing spiritual concerns
      f. Addressing social service needs
      g. Basic child and family counselling
      h. Expressive therapies
      i. Telephone advice line, available 24 hours per day, 7 days per week
      j. Close communication with Primary Care Provider
   2. Outside optional auxiliary services that may be ordered by the palliative care team are not strictly part of the package of services specified above as part of OPPC. These are provided fee for service, according to usual Partnership processes.
      a. Skilled nursing visits
      b. Home health aide visits
      c. Physical therapy visits
      d. Occupational therapy visits
      e. Speech therapy visits
      f. Registered dietician visits
      g. Respiratory therapy visits
      h. Psychotherapy - More intensive counselling may be provided outside the OPPC services by licensed therapists through the Partnership mental health benefit
      i. Durable Medical Equipment

E. Providers of Services
   1. General:
      a. In order to receive payment for services described in this policy, provider organizations must submit an application for approval (Attachment C) and have a palliative care contract in place with Partnership.
      b. Partnership will contract with qualified palliative care providers such as hospitals, long-term

care facilities, clinics, hospice agencies, home health agencies, and Community Based Adult Service (CBAS) facilities who utilize providers with current palliative care training and/or certification to deliver authorized palliative care services to ~~member~~Members in accordance with this policy, existing Medi-Cal contracts and/or All Plan Letters. Certification of qualified palliative care providers shall occur in accordance with Partnership policy MPCR13A Credentialing of Hospice and Palliative Care Medicine Specialist. Partnership will authorize palliative care services to be provided in a variety of settings including, but not limited to, inpatient, outpatient or community-based settings. Palliative care provided in a ~~member~~Member's home must comply with existing Partnership policies and Medi-Cal requirements for in-home providers, services, and authorization such as physician assessments and care plans.

2. All approved Palliative Care service providers shall be listed in Partnership's Provider Directory.
3. Outpatient Pediatric Palliative Care: Provider organization must submit an application to become contracted Outpatient Palliative Care Providers (See Attachment C for application).
   a. Criteria for consideration includes the following:
      1) Completed application (Attachment C)
      2) Organization or all providers are contracted Medi-Cal providers
      3) Organization must have the capacity to bill Partnership for services provided
      4) Organizations that are already contracted with Partnership for other services must be providers in good standing
      5) Clinical staff are trained in palliative care. Minimum training is the Cal State San Marcos Shiley Institute for Palliative Care Training Curriculum, or equivalent, which must be completed by a staff ~~member~~Member no later than 3 months after beginning to work for the Outpatient Palliative Care Organization. Medical Director may be board certified, board eligible or have one year (at least 200 hours) in hospice or palliative care experience.
      6) Provider organizations that include pediatric patients must have staff trained in the principles of pediatric palliative care.
      7) Core staffing identified (hired or contracted to be hired by contract start date):
         a) Medical Director
         b) Registered Nurse
         c) Social Worker
         d) Administrator
      8) Organization or Medical Director already providing services in the region for at least 6 months prior to contracting
   b. Submission of an application does not guarantee that Partnership will contract with an organization. Submitted applications will be evaluated based on a variety of criteria including, but not limited to, the quality and completeness of the application, geographic network adequacy, and history of the organization submitting the application.
   c. Contracted sites must pass a Partnership facility and medical records site audit within 3 months of contract start date, and every 3 years afterwards. Sites which do not pass the audit may have their contract terminated for cause, or may be required to submit and complete a corrective action plan. Timelines and appeals process for this audit will follow the general standards defined in Partnership Policy MPQP1022 Site Review Requirements and Guidelines.

F. Respite Care
   1. Respite care services, out-of-home for use in a Congregate Living Health Facility, are covered for ~~member~~Members under age 21 and require prior authorization and submission of a TAR. A maximum of 30 days per year is covered. Other approved facilities, such as skilled nursing facilities, should use policies and procedures for that location of services.
   2. Home-based respite therapy services are not covered by Partnership.

G. Transition of Care When Member Turns 21
   a. Pediatric ~~member~~Members receiving palliative care who are turning 21 will be transitioned to the appropriate program or service, such as adult palliative care (see policy MP~~C~~UP3137 – Palliative Care: Intensive Program [Adult]) or applicable state waiver program (see policy MCUP3106 – Waiver Programs).

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines: Palliative Care *(palli care)*
~~A.~~B. Section 2302 of the Patient Protection and Affordable Care Act (ACA)
~~B.~~C. Centers for Medicare & Medicaid Services *Medicare Benefit Policy Manual*
~~C.~~D. Department of Health Care Services, *SB 1004 Medi-Cal Palliative Care October 2, 2015* (2015).
~~D.~~E. Title 22, California Code of Regulations (CCR) / Hospice Care 51349
~~E.~~F. Social Security Act 1812(d)(1)
~~F.~~G. Welfare and Institutions Code Section 14132.75
~~G.~~H. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020 Palliative Care (12/07/2018)
~~H.~~I. DHCS Numbered Letter (NL) 12-1119 Subject: Palliative Care Options for CCS Eligible Children-*Revised* (11/18/2019)
~~I.~~J. DHCS All Plan Letter (APL) 23-022 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll In Medi-Cal Managed Care from Medi-Cal Fee-for-Service, on or After January 1, 2023. (08/15/2023)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

05/13/20; 05/12/21; 06/08/22; 08/09/23; 09/11/24; 10/08/25

PREVIOUSLY APPLIED TO:
N/A

****

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

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

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

Policy/Procedure Number: MCUP3140			Lead Department: Health Services Business Unit: Utilization Management
Policy/Procedure Title: Palliative Care: Pediatric Program for Members Under the Age of 21			☒ **External Policy** ☐ **Internal Policy**
Original Date: 05/08/2019 **Effective Date:** 01/01/2019 per DHCS		**Next Review Date:** ~~09/11/2025~~10/08/2026 **Last Review Date:** ~~09/11/2024~~10/08/2025	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

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

Partnership HealthPlan of California
Outpatient Pediatric Palliative Care
Eligibility Assessment Form

Member Name:_____ CIN: _____

County of Residence: _____ Contact Phone Number: _____

DOB: _____ Today's Date:_____ Current Age: _____

Name of Palliative Care Provider Organization: _____

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

- ☐ **Has Partnership HealthPlan of California as their primary insurance**
- ☐ **Parent(s) or legal guardian and the child (if cognitively able) agree to accept Outpatient Pediatric Palliative Care Services**
- ☐ **Is 20 years of age or younger**
- ☐ **Has an eligible medical condition**
- ☐ **Parent or legal guardian declines hospice enrollment or the M~~m~~ember is not eligible for hospice enrollment**
- ☐ **Meets the Level of Care criteria**

Diagnosis:_____ ICD10 Code: _____

Date of Diagnosis _____

Date(s) of most recent hospitalizations (in the last 6 months) _____

_____

Highlights of Treatment Course to Date:

Estimate of anticipated unplanned inpatient days in the next calendar year if palliative care is not provided:_____

Which one or more of the following apply:

- ☐ Curative treatment is possible, but may fail (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease)
- ☐ Intensive long-term treatment aimed at maintaining quality of life is required (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy)
- ☐ Progressive condition for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta)
- ☐ Severe, non-progressive disability
- ☐ Extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).

Supporting Details:

Engagement and Enrollment Process for Outpatient Palliative Care

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

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

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

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

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

Partnership HealthPlan of California

Application to be a Contracted Outpatient Palliative Care Provider

Please submit the following to contracting@partnershiphp.org

Organization Information

1. **Name of Organization**

2. **Contact Information:**
   Administrative Contact of Parent Organization (if applicable)
   Name

   Title

   Phone

   e-mail

   Billing Department
   Name

   Title

   Phone

   e-mail

   Palliative Care Program Director

   Name

   Title

   Phone

   e-mail

   Palliative Care Medical Director
   Name

   Title

   Phone

   e-mail

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

   Yes ☐ No ☐

4. Medi-Cal provider number:

Palliative Care Program Description

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

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

   Medicare:

   Medi-Medi:

   Medi-Cal only:

   Uninsured:

   Total:

   Not applicable ☐

7. Number of patients enrolled annually in your organization's ☐ hospice or ☐ home care program (if applicable)

   Medicare:

   Medi-Medi:

   Medi-Cal only:

   Uninsured:

   Total:

   Not applicable ☐

8. Does your organization provide palliative care services to children? ☐ Yes ☐ No
   If Yes, please describe level of experience and training in pediatric palliative care:

Program Information

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

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

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

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

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

14. Attachments:

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

Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the Sept. 17, 2025 Quality / Utilization Advisory Committee (Q/UAC) meeting.
It is recommended that you look over the changes to each and note any questions or comments you may have to help keep a progressive meeting agenda.

Policy Number & Name	**Page #**	**Summary of Revisions** (include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	**External Documentation** (Notice required outside of originating department)
Policy Owner: Utilization Management – *Tony Hightower, CPhT, Associate Director UM Regulations*			
MCUG3007 – Authorization of Ambulatory Procedures and Services	113 – 135	**Section IV** All attachments have been removed from this section and policy attachment number referenced throughout the policy instead. Information included in the attachments was all duplicated in policies MCUP3041 and MCUP3049. **Section VI.C.1.** A reference to policy MPUP3139 Criteria and Guidelines for Utilization Management was added and information duplicate in that policy was removed. **Attachment B:** While this attachment is being archived from this policy, it is also a shared document with MCUP3041-A. For that purpose, the (Treatment Authorization Request) TAR Requirements document is also updated at this time to • Removed Allergy Injections as a TAR is no longer required • Add Behavioral Health Treatment – TAR is required • Add Hearing Aids – TAR is required • Add ICF - – TAR is required	Configuration Provider Relations
MCUP3013 – Durable Medical Equipment (DME) Authorization	137 – 151	During this annual review, details for Partnership's enhanced benefit for Compression garments were added [as approved by the Benefit Review Evaluation Workgroup (BREW)] **Section VI.G.3.** New section for Compression Garments added **Section VII.G.** Reference to BREW form added **Attachment B:** Codes E0652, E0675, E0676 were deleted under lymphedema pump/compression devices because they are no longer listed in the Provider Manual	Configuration Provider Relations
MCUP3119 – Sterilization Consent Protocol	153 – 158	During the annual review of this policy, we noted that DHCS has replaced Consent Form PM 330 (in use since 1999) with an updated PDF version of the same form that is now named DHCS 8469 and specified as "New 04/2025) **Section III.A. and throughout:** Definition updated to DHCS Form 8469 "Consent for Sterilization" **Section VII.C. and D.:** Reference to form 8469 updated with new hyperlink. DHCS web page added with hyperlink for information on the new form	Configuration Claims Provider Relations Member Services
MPUD3001 – Utilization	159 – 198	**This policy is updating off-cycle to remove references to "Carelon" as our delegated managed behavioral health organization because they are being de-delegated for triage and referral services: Partnership will handle these calls in-house as of Sept. 29.**	Provider Relations Member Services

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	External Documentation (Notice required outside of originating department)
Management Program Description		**Page 1:** The Behavioral Health department is added to the Health Services department team. **Page 3:** The Medical Director program staff description is updated to specify that this position has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for UM activities. **Page 5:** The Senior Director of Behavioral Health program staff description is added. **Page 12:** The Nurse Auditor (RN) program staff description is added. **Page 17-19:** The descriptions of the Community Advisory Committee (CAC), Physician Advisory Committee (PAC), Quality/Utilization Advisory Committee (QUAC) and Quality Improvement Health Equity Committee (QIHEC) are updated. **Page 22-23:** The Mental Health section is updated to remove reference to Carelon **Page 26:** A new section is added to describe "Addition of Benefits and Modification of TAR Requirements."	
Policy Owner: Grievance & Appeals – *Latrice Innes, Compliance Manager, Grievance & Appeals*			
CGA024 – Medi-Cal Member Grievance System	199 – 217	**Language is updated according to added and hyperlinked Department of Health Care Services All Plan Letters 25-005 and 24-017,** respectively: Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Service, and Alternative Formats and Transgender, Gender Diverse or Intersex Cultural Competency Training Program and Provider Directory Requirements. **Section I.** MCND9004 Regulatory Required Notice and CMP26 Verification of Caller Identity and Release of Information have been added as Related Policies and referenced in the policy text as well. **Section III. Some definitions have been updated, added or deleted.** "Authorized Representative" now aligns with CMP26 and MCUP3037 Appeals of Utilization Management and Pharmacy Decisions. **VI.G. is deleted** since Partnership has brought in-house some Behavioral Health interfaces once delegated to Carelon. **The new VI.G.c. specifies** Quality of Care Grievances must be investigated and resolved within 30 calendar days, even if they involve Potential Quality Issue (PQI) concerns. **VI.O. is added** to spell out Transgender (Trans) inclusive care per APL 24-017. **IX.A. Timeliness Monitoring and Risk Mitigation is modified** to say the department uses a "real-time" tracker and will shift staff when necessary. **XIII. References** are updated to reflect the additional APLs.	Health Services Member Services Provider Relations

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

Guideline/Procedure Number: MCUG3007 (previously UG100307)			**Lead Department: Health Services** **Business Unit:** Utilization Management	
Guideline/Procedure Title: Authorization of Ambulatory Procedures and Services			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 08/1998		**Next Review Date:** ~~09/11/2025~~10/08/2026 **Last Review Date:** ~~09/11/2024~~10/08/2025		
Applies to:	☒ **Medi-Cal**		☐ **Employees**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~09/11/2024~~10/08/2025	

I. RELATED POLICIES:

A. MP~~C~~UP3139 – Criteria and Guidelines for Utilization Management
B. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
C. MCUP3041 – Treatment Authorization Request (TAR) Review Process
D. MCUP3049 – Pain Management Specialty Services
E. MCUG3024 – Inpatient Utilization Management
F. CMP26 – Verification of Caller Identity and Release of Information

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Adverse Benefit Determination (ABD): The definition of an Adverse Benefit Determination encompasses all previously existing elements of an "Action" as defined under federal regulations with the addition of language that clarifies the inclusion of determinations involving medical necessity, appropriateness, setting, covered benefits, and financial liability. An ABD is defined to mean any of the following actions taken by a Managed Care Plan (i.e. Partnership HealthPlan of California):
   1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
   2. The reduction, suspension, or termination of a previously authorized service.
   3. The denial, in whole or in part, of payment for a service.
   4. The failure to provide services in a timely manner.
   5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
   6. The denial of the Member's request to obtain services outside the network.
   7. The denial of a Member's request to dispute financial liability.

B. Authorized Representative: An adult Member has the right to designate a friend, family Member, or other person to have access to certain protected health information (PHI) to assist the Member with making medical decisions. The Member will need to provide appropriate legal documentation as defined in CMP26 Verification of Caller Identity and Release of Information and submit to Partnership HealthPlan of California (Partnership) for review prior to releasing PHI. Until the form has been submitted and validated by Partnership staff, the Member can give verbal consent to release non-sensitive PHI to a designated person. Verbal consent expires at close of business the following business

day. The Member can give additional Verbal Consent when the prior Verbal Consent window of time has expired.

C. NC: Nurse Coordinator

IV. ATTACHMENTS:

A. N/A~~Treatment Authorization Request (TAR) form~~

B. ~~Partnership TAR Requirements (including Outpatient Surgical Procedures CPTs Requiring TAR list and Pain Management CPTs Requiring TAR list)~~

C. ~~Partnership - Supplemental Partnership requirements for medical necessity for Pain Management Procedures~~

V. PURPOSE:

To provide guidelines for certification of ambulatory procedures and services. Certain outpatient procedures and tests must be prior authorized to evaluate and confirm the appropriateness of the proposed treatment plan along with the appropriateness of the location and level of care prior to the delivery of care. The process also allows the health plan to determine that the requested service is a covered benefit and that the patient is an eligible Member.

VI. GUIDELINE / PROCEDURE:

A. Outpatient services which require authorization are defined in ~~Attachment B.~~policy MCUP3041 Treatment Authorization Request (TAR) Review Process.

B. Review Objectives
   1. Medical necessity
   2. Appropriate level of care
   3. Network eligibility of provider(s)
   4. Referral from primary care provider
   5. Member eligibility
   6. Covered Benefit

C. Criteria used in medical necessity determinations
   1. The Nurse Coordinator (NC) compares the medical information against the ~~following~~ criteria and guidelines described in policy MPUP3139 Criteria and Guidelines for Utilization Management ~~which are used~~ to evaluate the appropriate use of services, matching medical needs and treatment plans.
      ~~a. InterQual® Criteria~~
      ~~b. Medi-Cal Provider Manual/ Guidelines~~
      ~~c. Department of Health Care Services (DHCS) All Plan Letters (APLs)~~
      ~~d. California Children's Services (CCS) Numbered Letters~~
      ~~e. Partnership Health Services Policies and Guidelines~~
      ~~f. Other government or specialty society guidelines as noted in Partnership policies~~
   2. If a request is received for authorization of services for which review criteria are not available, the NC, in conjunction with the Chief Medical Officer (CMO) or Physician Designee, uses clinical judgment and noted documentation from authorized medical references, journals, and articles to make a determination regarding the request. (See MP~~C~~UP3139 Criteria and Guidelines for Utilization Management)

D. Authorization Process
   1. The provider of the service completes a Treatment Authorization Request (TAR) and submits it to Partnership's Health Services Department. This process should be initiated by the ordering provider a minimum of five business days prior to the procedure or test.
   2. The NC reviews the information received from the provider utilizing Partnership approved review

guidelines. The NC approves the request if it meets medical necessity criteria. Refer to policy MCUP3041 Treatment Authorization Request (TAR) Review Process for a full description of the process. A determination decision is based upon:

a. The appropriateness of the proposed place of treatment
b. The number of treatments or services
c. The treatment plan
d. The appropriateness of the proposed treatment

3. The provider should verify that the TAR has been approved prior to rendering services.
4. Confirmation documents and/or telephone confirmation will be provided to any of the following depending on the service request (i.e. inpatient or outpatient)
   a. Requesting provider
   b. Facility
   c. Member
5. Adverse Benefit Determinations
   a. If a request for treatment does not meet established criteria, the NC may request more information or refer the request for review to the ~~Chief Medical Officer or~~CMO/~~-~~Physician Designee. The ~~Chief Medical Officer or~~CMO/ Physician Designee may consult with the requesting provider to evaluate the request.
   b. If the ~~Chief Medical Officer or~~CMO/~~-~~Physician Designee determines the requested service is not medically necessary, the ~~Chief Medical Officer or~~CMO/~~-~~Physician Designee or NC will:
      1) Notify the requesting provider and Member
      2) Provide objective criteria for the decision
      3) Document reasons for the decision
      4) Notify the requesting provider and Member of rights to an appeal
   c. A Notice of Action (NOA) letter from the Physician Designee and/or telephone confirmation will be forwarded to any of the following listed below depending on the service request (i.e. inpatient or outpatient).
      1) Requesting provider
      2) Provider of service
      3) Member
   d. The NOA letter will clearly state the reason for the denial or modification in terms specific to the Member's condition and in language that a layperson would understand.
6. Appeals
   a. A Member, a Member's authorized representative, or a provider acting on behalf of a Member may appeal an adverse benefit decision as described in Partnership's policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions.
7. Reauthorization
   a. All authorizations which may recur are subject to the following requirements:
      1) Assessment and demonstration of continued need for treatment/service
      2) Reevaluation of plan of treatment, appropriateness of level of care and physician orders
      3) Documentation of patient compliance with treatment/service

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines
B. Current InterQual® Criteria
C. DHCS All Plan Letter (APL) 21-011 *Revised* Grievance and Appeals Requirements, Notice and "Your Rights" Templates (08/31/2022)
D. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 20254) UM 7 Denial Notices Element B

Guideline/Procedure Number: MCUG3007 (previously UG100307)		**Lead Department: Health Services** **Business Unit:** Utilization Management
Guideline/Procedure Title: Authorization of Ambulatory Procedures and Services		☒**External Policy** ☐**Internal Policy**
Original Date: 08/1998	**Next Review Date:** ~~09/11/2025~~10/08/2026 **Last Review Date:** ~~09/11/2024~~10/08/2025	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES: 06/01/00; 09/19/01; 10/20/04; 10/19/05; 10/17/07; 08/20/08; 05/19/10; 05/16/12; 10/15/14; 05/20/15; 03/16/16; 04/19/17; *06/13/18; 05/08/19; 09/11/19; 09/09/20; 08/11/21; 08/10/22; 09/13/23; 09/11/24; 10/08/25

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

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

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

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

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

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

MEDI-CAL TREATMENT AUTHORIZATION REQUEST FORM (TAR)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
4665 Business Center Drive
Fairfield CA 94534
(707) 863-4133 or (800) 863-4144
FAX # (707) 863-4118
www.partnershiphp.org

PROVIDER USE ONLY

PROVIDER NAME: PHONE NUMBER:

FACILITY NAME: FAX NUMBER:

ADDRESS: GROUP NPI:

CITY, STATE, ZIP: TAX ID:

This TAR is: ☐ Urgent (72 hours): potentially life-threatening condition.

☐ Routine (Up to 5 business days): important to health; not life-threatening

MEMBER NAME:
PRINT NAME: (FIRST, LAST)

ADDRESS: MEMBER CIN:

CITY: DATE OF BIRTH:

STATE, ZIP: GENDER:

DIAGNOSIS DESCRIPTION(S): ICD-CM CODE(S):

MEDICAL JUSTIFICATION:

SERVICES REQUESTED:	CPT CODE/HCPCS:	MODIFIER(S):	QUANTITY:	CHARGES:

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN OR PROVIDER | NAME/ TITLE | DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED

START DATE | END DATE

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBLITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.

ARCHIVED 10/08/2025 Refer to MCUP3041

PARTNERSHIP TAR REQUIREMENTS

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

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

B. **Allergy Injections** – A TAR is required when services exceed Medi-Cal frequency limit of eight (8) allergy injections in any 120-day period for code 95115 or four (4) allergy injections in any 120-day period for code 95117. (For codes 95115 and/or 95117 in any combination, a maximum of eight (8) allergy injections in any 120-day period is reimbursable to any provider for the same recipient without authorization.)

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

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

E. **Community Health Worker (CHW) Services** *(see policy MCCP2033 Community Health Worker (CHW) Services Benefit)* Partnership does not require prior authorization for CHW services as preventive care for the first 12 units. A TAR is required for Members who need multiple CHW services or continued CHW services in excess of 12 units.

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

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

H. **Diagnostic Studies**

1. MRA (MR Angiogram)
2. MSI
3. MEG
4. PET scan *[see policy MPUP3116 Positron Emission Tomography Scans (PET Scans)]*
5. Transcranial Doppler
6. Sleep Studies / Polysomnography: Facility based sleep studies/polysomnography always require a TAR. Home based studies/polysomnography require a TAR when more than 1 per year is requested. *(see policy MCUG3110 Evaluation and Management of Obstructive Sleep Apnea in Adults (Medi-Cal)*
7. Non-specific radiology codes for X-rays and ultrasound including 76497, 76380, 76506

I. **Doula Services** *(see policy MCNP9006 Doula Services Benefit*) While most doula services are provided with no TAR requirement, please refer to the policy for details on when a TAR may be required for additional visits (beyond eight) during the postpartum period.

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

1. Orthotics – Cumulative costs for repair/maintenance or purchase exceeds $250 / item (*see policy MCUG3032 Orthotic and Prosthetic Appliances Guidelines*)
2. Prosthetics – Cumulative costs for repair / maintenance or purchase exceeds $500 / item (*see policy MCUG3032 Orthotic and Prosthetic Appliances Guidelines). **Also any unlisted / miscellaneous code and any custom made item that does not have a Medi-Cal rate (by-report or by-invoice)***
3. Hearing Aids and Cochlear Implant Replacement Supplies – (*see policy MCUG3019 Hearing Aid Guidelines*)
4. Repairs or maintenance over $250.00 / item - (Out of guarantee repairs are to be guaranteed for at LEAST three (3) months from the date of repair. Reimbursement will NOT be allowed for parts or labor during a guarantee period if due to a defect in material or workmanship)

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

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

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

M. **Fecal Microbiota Transplant (FMT)** A TAR is required for all procedures related to fecal microbiota transplant. *(see policy MPUP3136 Fecal Microbiota Transplant)*

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

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

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

Q. **Home Infusion Therapy**

R. **Hysterectomy**

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

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

Archived 10/08/2025 Refer to MCUP3041

U. **Hyperbaric Oxygen Pressurization**

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

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

***Note:** *Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 22-012 Revised. TARs will be operationally denied if submitted to Partnership for supplies which are carved out from managed care reimbursement and are only provided through Medi-Cal Rx as Pharmacy claims. See Medi-Cal Rx Provider Manual for covered medical supplies and limits. Supplies that can only be billed to Medi-Cal Rx include Insulin Syringes, Pen needles, Lancets, Diabetic Test Strips, Peak Flow Meters, and Inhaler Assistive Devices.*
+ **Note**: *For detailed information regarding Medi-Cal frequency limits and TAR requirements for ostomy, urological, tracheostomy and wound care supplies, please reference Medi-Cal Provider Manual/ Guidelines section Medical Supplies Billing Codes, Units and Quantity Limits*

X. **Medications Provided by a Pharmacy:** Effective January 1, 2022 with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 22-012 *Revised* and all medications (Rx and OTC) which are provided by a pharmacy must be billed to State Medi-Cal/DHCS contracted pharmacy administrator instead of Partnership.

Y. **Medications Administered in a Medical Setting, and Billed as a Medical Claim [Physician Administered Drugs (PADs) given in an outpatient clinic, office, dialysis center, hospital]:**
Partnership requires a TAR for certain prescription drugs, over-the-counter drugs and injectable drugs (including drugs compounded for IV infusion therapy) as outlined in policy *MCRP4068 Medical Benefit Medication TAR Policy*.

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

AA. **Occupational Therapy** *(see policy MPUP3114 Physical, Occupational and Speech Therapies)*
- Partnership Members under age 21 can be referred by a licensed clinician for one consultation visit

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through a physician order. Partnership's referral authorization system need not be used. Following the initial evaluation, the service provider must submit a TAR for the requested services.
Note: *No TAR is required for Members age 21 and over up to 12 visits (limit one visit per day) for OT services in a rolling 12-month period. (A TAR will be required for services in excess of 12 visits.)*

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

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

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

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

EE. **Phototherapy** for dermatological condition

FF. **Physical Therapy** *(see policy MPUP3114 Physical, Occupational and Speech Therapies)*

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

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

HH. **Speech Therapy** *(see policy MPUP3114 Physical, Occupational and Speech Therapies)*

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

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

JJ. **ANY UNLISTED OR MISCELLANEOUS CODE**

Archived 10/08/2025 Refer to MCUP3041

HCPCS Codes	Description
P9020	Platelet rich plasma unit
V2531	Contact Lens, Scleral, Gas Permeable, Per Lens
C9757	Spine/Lumbar Surgery

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
10040	Acne Surgery
15769	Graft of Autologous Soft Tissue, Other, Direct Excision

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
15771	Graft of Autologous Fat Harvested by Liposuction; 50cc or less injectate
15772	Graft of Autologous Fat Harvested by Liposuction; each additional 50cc
15773	Graft of Autologous Fat Harvested by Liposuction; 25cc or less injectate
15774	Graft of Autologous Fat Harvested by Liposuction; each additional 25cc
15788 Thru 15793	Chemical Peel, Facial Et Al
15820 Thru 15823	Revision Of Lower Or Upper Eyelid
15845	Skin And Muscle Repair, Face
17360	Skin Peel Therapy
17999	Skin Tissue Procedure
19300	Mastectomy For Gynecomastia
19316	Mastopexy
19318	Reduction Mammoplasty
19324/25	Breast Augment; W/O Prosthetic Implant
19499	Correction Of Inverted Nipples
19380	Revise Breast Reconstruction
19396	Design Custom Breast Implant
19499	Unlisted Procedure, Breast
20999	Musculoskeletal Surgery
21208	Augmentation Of Facial Bones
22899	Spine Surgery Procedure
22999	Abdomen Surgery Procedure
28292, 28296, 28297, 28298, 28299, 28899	Correction Of Bunion
28289	Repair Hallux Rigidus
28300 Thru 28345	Osteotomy / Repair / Reconstruction
30400, 30410, 30420, 30430, 30435, 30450, 30460, 30465, 30468, 30520	Reconstruct Of Nose
30520	Repair Nasal Septum
32999	Chest Surgery Procedure
36299	Vessel Injection Procedure
36522	Photopheresis, extracorporeal
37700	Ligation And Division of Long Saphenous Vein at Saphenofemoral Junction, Or Distal Interruptions
37718	Ligation, Division, And Stripping, Short Saphenous Vein
37722	Ligation, Division, And Stripping, Long (Greater) Saphenous Veins from Saphenofemoral Junction to Knee or Below
37735	Ligation And Division And Complete Stripping of Long or Short Saphenous Veins With Radical Excision of Ulcer And Skin Graft And/or Interruption of Communicating Veins Of Lower Leg, With Excision of Deep Fascia

Archived 10/08/2025 Refer to MCUP3041

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
37760	Ligation of Perforator Veins, Subfascial, Radical (Linton Type) Including Skin Graft, When Performed, Open, 1 Leg
37761	Ligation of Perforator Vein(S), Subfascial, Open, Including Ultrasound Guidance, When Performed, 1 Leg
37765	Stab Phlebectomy Of Varicose Veins, 1 Extremity; 10-20 Stab Incisions
37766	More Than 20 Incisions
37780	Ligation and Division of Short Saphenous Vein at Saphenopopliteal Junction (Separate Procedure)
37785	Ligation, Division, And/or Excision Of Varicose Vein Cluster(S) 1 Leg
38205, 38206	Stem Cell Harvesting
38230	Bone Marrow Harvesting
36511	Therapeutic Apheresis Of WBC 's
36512	Therapeutic Apheresis Of RBCs
38204	Unrelated Harvesting Of Cells
38205	Stem Cell Harvesting From Siblings
38207	Stem Cell Storage
41899	Gum Surgery Procedure
43770	Laparoscopy, Surgical, Gastric Restrictive Procedure
43771	Laparoscopy, Surgical, Revision Of Adjust Gastric Band
43772	Laparoscopy, Surgical, Removal Of Adjustable Gastric Band
43773	Laparoscopy, Surgical, Removal & Placement Of Adj Gastric Band
43774	Laparoscopy, Surgical, Removal Of Adjustable Gastric Band
43775	Lap Sleeve Gastrectomy
43842	Gastroplasty, Vertical Banded, For Morbid Obesity
43843	Gastroplasty, Other Than Vertical-Banded, For Morbid Obesity
43845	Gastroplasty
43846	Gastric Bypass For Obesity
43847	Gastric Restrictive Procedure With Gastric Bypass
43848	Revision Of Gastric Restrictive
43886	Gastric Restrictive Procedure
43887	Gastric Restrictive Procedure, Removal Of Subcutaneous Port Component
43888	Gastric Restrictive Proc, Removal & Replacement Of Subcutaneous Port
43999	Stomach Surgery Procedure
48160	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells transplantation of pancreas or pancreatic islet cells
49999	Abdomen Surgery Procedure
54161	Circumcision –TAR not required if patient < 4 months of age (See policy MCUP3121 Neonatal Circumcision)
54360	Penis Plastic Surgery

Archived 10/08/2025 Refer to MCUP3041

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
54400, 54406 - 54440	Penile Prosthesis / Plastic Procedure For Penis
55175/80	Revision Of Scrotum
55200	Incision Of Sperm Duct
56800	Repair Of Vagina
58150 Thru 58294, 58570	Hysterectomy
58350	Reopen Fallopian Tube
58550 Thru 58554	Laparoscopy, Surgical; With Vaginal Hysterectomy With Or Without Removal of Tube(s), With or Without Removal Of Ovary(ies) (Laparoscopic Assisted Vaginal Hysterectomy)
58578/79	Unlisted Procedure, Uterus
58999	Unlisted procedure, female genital system
61867, 61868, 61880, 61888, 64999	Insertion, Revision Or Removal Of Cranial Neurostimulator
62287	Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumber (e.g. manual or automated percutaneous discectomy,
62290, 62291	Discography, Lumbar (62290) and Cervical/Thoracic (62291)
63650, 63655, 63662, 63664, 63685	Insertion or Revision of Spinal Neurostimulator
66987	Extracapsular Cataract Removal W/ Insertion Of Intraocular Lens Prosth complex
66988	Extracapsular Cataract Removal W/ Insertion Of Intraocular Lens Prosth
67900 Thru 67924	Repair Brow, Ptosis, Blepharoptosis, Lid
67950 Thru-66	Revision Of Eyelid
67971-75	Reconstruction Of Eyelid
67999	Unlisted Eyelid Procedure
69300	Revise External Ear
69399	Outer Ear Surgery Procedure
72285	Cervical and Thoracic Discography
72295	Lumbar discography

Archived 10/08/2025 Refer to MCUP3041

Pain Management CPTs Requiring TAR	
CPT Code	**Description**
22510, 22511, 22512, 22513, 22514, 22515	Percutaneous vertebroplasty and percutaneous vertebral augmentation
27096	Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid
62263	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or

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

Archived 10/08/2025 Refer to MCUP3041

PARTNERSHIP TAR REQUIREMENTS

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

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

~~B. **Allergy Injections** - A TAR is required when services exceed Medi-Cal frequency limit of eight (8) allergy injections in any 120-day period for code 95115 or four (4) allergy injections in any 120-day period for code 95117. (For codes 95115 and/or 95117 in any combination, a maximum of eight (8) allergy injections in any 120-day period is reimbursable to any provider for the same recipient without authorization.)~~

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

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

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

E. **Community Health Worker (CHW) Services** *(see policy ~~MCCP2033~~ MPAP7004 Community Health Worker (CHW) Services Benefit)* Partnership does not require prior authorization for CHW services as preventive care for the first 12 units. A TAR is required for Members who need multiple CHW services or continued CHW services in excess of 12 units.

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

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

H. **Diagnostic Studies**

A. MRA (MR Angiogram)
B. MSI
C. MEG
D. PET scan *[see policy MPUP3116 Positron Emission Tomography Scans (PET Scans)]*
E. Transcranial Doppler
F. Sleep Studies / Polysomnography: Facility based sleep studies/polysomnography always require a TAR. Home based studies/polysomnography require a TAR when more than 1 per year is requested. *(see policy MP~~C~~UG3110 Evaluation and Management of Obstructive Sleep Apnea in Adults (Medi-Cal)*
G. Non-specific radiology codes for X-rays and ultrasound including 76497, 76380, 76506

I. **Doula Services** *(see policy MCNP9006 Doula Services Benefit*) While most doula services are provided with no TAR requirement, please refer to the policy for details on when a TAR may be required for additional visits (beyond eight) during the postpartum period.

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

1. Orthotics – Cumulative costs for repair/maintenance or purchase exceeds $250 / item (*see policy MCUG3032 Orthotic and Prosthetic Appliances Guidelines*)
2. Prosthetics – Cumulative costs for repair / maintenance or purchase exceeds $500 / item (*see policy MCUG3032 Orthotic and Prosthetic Appliances Guidelines). **Also any unlisted / miscellaneous code and any custom made item that does not have a Medi-Cal rate (by-report or by-invoice)***
3. Hearing Aids and Cochlear Implant Replacement Supplies – (*see policy MP~~C~~UG3019 Hearing Aid*

Guidelines)

4. Repairs or maintenance over $250.00 / item - (Out of guarantee repairs are to be guaranteed for at LEAST three (3) months from the date of repair. Reimbursement will NOT be allowed for parts or labor during a guarantee period if due to a defect in material or workmanship)
5. Oxygen and related supplies
6. Positive Airway Pressure (PAP) devices - No TAR is required for PAP supplies for a PAP machine owned by the member (as per Medi-Cal guidelines for ordering/quantity limits).
7. Purchase items when the cumulative cost of items within a group exceeds $100.00 within the calendar month. Providers may refer to the *Durable Medical Equipment (DME): Billing Codes and Reimbursement Rates* section in the Medi-Cal manual to determine if items are related within a group. Items grouped together under specific headings, such as "Hospital Beds" or "Bathroom Equipment," are considered within the same group. (Vendor to guarantee for a MINIMUM of six (6) months from the date of purchase)
8. Rental items when the cumulative cost of rental for items within the group exceeds $50.00 within a 15-month period. This includes any daily amount that an individual item, or a combination of a similar group of DME items, exceeds the $50 threshold. The 15-month period begins on the date the first item is rented. (Rental rate includes equipment related supplies.)
9. Purchase of any wheelchairs for Medi-Medi members
10. Purchase of knee scooters with appropriate criteria met. Invoice is required and maximum payable benefit amount is $200. *(see policy MCUP3013 DME Authorization*)
9. Incontinence Supplies *(see policy MCUG3022 Incontinence Guidelines*)
    a. Note that codes A4335 for skin wash and A4665 for skin cream for members with incontinence do not require a TAR unless claim quantity exceeds normal frequency limits. However, providers are encouraged to include these items on the incontinence supply TAR as the authorization will be good for one year and the provider will be able to submit claims electronically without attaching the prescription each month. If these items are not included on the incontinence supply TAR, then the provider must submit a paper claim and attach a prescription form with each submission.

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

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

M. **Fecal Microbiota Transplant (FMT)** A TAR is required for all procedures related to fecal microbiota transplant. *(see policy MPUP3136 Fecal Microbiota Transplant)*

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

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

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

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

~~Q.~~R. **Home Infusion Therapy**

~~R.~~S. **Hysterectomy**

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

~~T.~~U. **Hospitalization**

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

~~U.~~V. **Hyperbaric Oxygen Pressurization**

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

~~V.~~X. **Long Term Care**

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

~~W.~~Y. **Medical Supplies***

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

***Note:** *Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 22-012 Revised. TARs will be operationally denied if submitted to Partnership for supplies which are carved out from managed care reimbursement and are only provided through Medi-Cal Rx as Pharmacy claims. See Medi-Cal Rx Provider Manual for covered medical supplies and limits. Supplies that can only be billed to Medi-Cal Rx include Insulin Syringes, Pen needles, Lancets, Diabetic Test Strips, Peak Flow Meters, and Inhaler Assistive Devices.*

+ **Note**: *For detailed information regarding Medi-Cal frequency limits and TAR requirements for ostomy, urological, tracheostomy and wound care supplies, please reference Medi-Cal Provider Manual/ Guidelines section Medical Supplies Billing Codes, Units and Quantity Limits*

X. **Medications Provided by a Pharmacy:** Effective January 1, 2022 with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 22-012 *Revised* and all medications (Rx and OTC) which are provided by a pharmacy must be billed to State Medi-Cal/DHCS contracted pharmacy administrator instead of Partnership.

Y. **Medications Administered in a Medical Setting, and Billed as a Medical Claim [Physician Administered Drugs (PADs) given in an outpatient clinic, office, dialysis center, hospital]:** Partnership requires a TAR for certain prescription drugs, over-the-counter drugs and injectable drugs (including drugs compounded for IV infusion therapy) as outlined in policy *MCRP4068 Medical Benefit Medication TAR Policy*.

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

AA. **Occupational Therapy** *(see policy MPUP3114 Physical, Occupational and Speech Therapies)*

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

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

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

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

EE. **Phototherapy** for dermatological condition

FF. **Physical Therapy** *(see policy MPUP3114 Physical, Occupational and Speech Therapies)*

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

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

HH. **Speech Therapy** *(see policy MPUP3114 Physical, Occupational and Speech Therapies)*

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

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

JJ. **ANY UNLISTED OR MISCELLANEOUS CODE**

HCPCS Codes	Description
P9020	Platelet rich plasma unit
V2531	Contact Lens, Scleral, Gas Permeable, Per Lens
C9757	Spine/Lumbar Surgery

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

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
36522	Photopheresis, extracorporeal
37700	Ligation And Division of Long Saphenous Vein at Saphenofemoral Junction, Or Distal Interruptions
37718	Ligation, Division, And Stripping, Short Saphenous Vein
37722	Ligation, Division, And Stripping, Long (Greater) Saphenous Veins from Saphenofemoral Junction to Knee or Below
37735	Ligation And Division And Complete Stripping of Long or Short Saphenous Veins With Radical Excision of Ulcer And Skin Graft And/or Interruption of Communicating Veins Of Lower Leg, With Excision of Deep Fascia
37760	Ligation of Perforator Veins, Subfascial, Radical (Linton Type) Including Skin Graft, When Performed, Open, 1 Leg
37761	Ligation of Perforator Vein(S), Subfascial, Open, Including Ultrasound Guidance, When Performed, 1 Leg
37765	Stab Phlebectomy Of Varicose Veins, 1 Extremity; 10-20 Stab Incisions
37766	More Than 20 Incisions
37780	Ligation and Division of Short Saphenous Vein at Saphenopopliteal Junction (Separate Procedure)
37785	Ligation, Division, And/or Excision Of Varicose Vein Cluster(S) 1 Leg
38205, 38206	Stem Cell Harvesting
38230	Bone Marrow Harvesting
36511	Therapeutic Apheresis Of WBC ‘s
36512	Therapeutic Apheresis Of RBCs
38204	Unrelated Harvesting Of Cells
38205	Stem Cell Harvesting From Siblings
38207	Stem Cell Storage
41899	Gum Surgery Procedure
43770	Laparoscopy, Surgical, Gastric Restrictive Procedure
43771	Laparoscopy, Surgical, Revision Of Adjust Gastric Band
43772	Laparoscopy, Surgical, Removal Of Adjustable Gastric Band
43773	Laparoscopy, Surgical, Removal & Placement Of Adj Gastric Band
43774	Laparoscopy, Surgical, Removal Of Adjustable Gastric Band
43775	Lap Sleeve Gastrectomy
43842	Gastroplasty, Vertical Banded, For Morbid Obesity
43843	Gastroplasty, Other Than Vertical-Banded, For Morbid Obesity
43845	Gastroplasty
43846	Gastric Bypass For Obesity
43847	Gastric Restrictive Procedure With Gastric Bypass
43848	Revision Of Gastric Restrictive
43886	Gastric Restrictive Procedure

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
43887	Gastric Restrictive Procedure, Removal Of Subcutaneous Port Component
43888	Gastric Restrictive Proc, Removal & Replacement Of Subcutaneous Port
43999	Stomach Surgery Procedure
48160	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells transplantation of pancreas or pancreatic islet cells
49999	Abdomen Surgery Procedure
54161	Circumcision –TAR not required if patient < 4 months of age (See policy MCUP3121 Neonatal Circumcision)
54360	Penis Plastic Surgery
54400, 54406 - 54440	Penile Prosthesis / Plastic Procedure For Penis
55175/80	Revision Of Scrotum
55200	Incision Of Sperm Duct
56800	Repair Of Vagina
58150 Thru 58294, 58570	Hysterectomy
58350	Reopen Fallopian Tube
58550 Thru 58554	Laparoscopy, Surgical; With Vaginal Hysterectomy With Or Without Removal of Tube(s), With or Without Removal Of Ovary(ies) (Laparoscopic Assisted Vaginal Hysterectomy)
58578/79	Unlisted Procedure, Uterus
58999	Unlisted procedure, female genital system
61867, 61868, 61880, 61888, 64999	Insertion, Revision Or Removal Of Cranial Neurostimulator
62287	Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumber (e.g. manual or automated percutaneous discectomy,
62290, 62291	Discography, Lumbar (62290) and Cervical/Thoracic (62291)
63650, 63655, 63662, 63664, 63685	Insertion or Revision of Spinal Neurostimulator
66987	Extracapsular Cataract Removal W/ Insertion Of Intraocular Lens Prosth complex
66988	Extracapsular Cataract Removal W/ Insertion Of Intraocular Lens Prosth
67900 Thru 67924	Repair Brow, Ptosis, Blepharoptosis, Lid
67950 Thru-66	Revision Of Eyelid
67971-75	Reconstruction Of Eyelid
67999	Unlisted Eyelid Procedure
69300	Revise External Ear
69399	Outer Ear Surgery Procedure
72285	Cervical and Thoracic Discography
72295	Lumbar discography

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Medical Necessity Criteria for Pain Management Procedures

22510, 22511, 22512, 22513, 22514, 22515 Percutaneous vertebroplasty and percutaneous vertebral augmentation	**InterQual® criteria followed.** **Subset:** *Vertebroplasty or Kyphoplasty* **Exception(s) to InterQual criteria:** None Well-controlled study shows no benefit over placebo for longstanding vertebral fractures/pain. (Reference: Treatment of Symptomatic Osteoporotic Spinal Compression Fractures, *Journal of the American Academy of Orthopedic Surgeons*, March 2011; Spine J. 2012 Nov; 12(11): 998-1005)
27096 SI joint injection	**InterQual® criteria followed.** **Subset:** *Sacroiliac (SI) Joint Injection* **Exception(s) to InterQual criteria:** • Imaging to confirm sacroiliac joint disease is not required
62263, 62264 Percutaneous lysis of epidural adhesions	**Requests are reviewed on a case-by-case basis** upon review of clinical information provided.
62290, 62291 Discography, Lumbar and Cervical	**InterQual® criteria followed.** **Subset:** *Discography, Spine, Lumbar* InterQual criteria shows limited evidence to support this procedure.
62360, 62362 Implantable or replacement device for intrathecal or epidural drug infusion; subcutaneous reservoir	**InterQual® criteria followed.** **Subset:** *Epidural or Intrathecal Catheter Placement* **Exception(s) to InterQual criteria:** • Physician review required
63650, 63655, 63662, 63664, 63685 Insertion, revision, or removal of spinal neurostimulator	**InterQual® criteria followed.** **Subset:** *Spinal Cord Stimulator (SCS) Insertion* **Exception(s) to InterQual criteria:** None **Note:** Revisions/Replacements may be considered when the Elective Replacement Indicator (ERI) reflects that replacement is required in ≤ 6 months.

Archived 10/08/2025 - Refer to MCUP 3049

64479, 64480, 64483, 64484 Transforaminal epidural injection	**InterQual® criteria followed.** **Subset:** *Epidural Steroid Injection* **Exception(s) to InterQual criteria:** 1. A minimum of 30 days conservative treatment is required before eligible for epidural steroid injection. 2. TFESI may be considered for cervical radicular pain with nerve root impingement confirmed by imaging or testing. 3. Repeat injections require a minimum of 50% improvement in pain symptoms lasting a minimum of 8 weeks from previous injection. 4. The interval between injections per site must be no more frequent than every 3 months, and the maximum number of injections per site is 3 per year.
64490, 64491, 64492, 64493, 64494, 64495 Paravertebral facet injections and medial branch blocks	**InterQual® criteria followed.** **Subset:** *Facet Joint Injection* **Exception(s) to InterQual criteria:** 1. The progress note should document a physical examination of the back, including pain elicited with movement. 2. Trial of physical therapy & NSAIDS/ acetaminophen is not required. 3. Imaging required only to rule out nerve root impingement for any radicular complaints. 4. No more than 3 levels will be approved, either 3 levels unilaterally or 3 levels bilaterally.
64633, 64634, 64635, 64636 Destruction by neurolytic agent, paravertebral facet joint	**InterQual® criteria followed.** **Subset:** *Neuroablation, Percutaneous* **Exception(s) to InterQual criteria:** None
72285, 72295 Cervical, Thoracic, Lumbar discography	*Same as 62290 and 62291 above.* **InterQual® criteria followed.** **Subset:** *Discography, Spine, Lumbar* InterQual criteria shows limited evidence to support this procedure.

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: **MCUP3013** (previously UP100313)			**Lead Department: Health Services** **Business Unit:** Utilization Management	
Policy/Procedure Title: Durable Medical Equipment (DME) Authorization			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/25/1994		**Next Review Date:** ~~08/14/2025~~10/08/2026 **Last Review Date:** ~~08/14/2024~~10/08/2025		
Applies to:	☒ **Medi-Cal**		☐ **Employees**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~08/14/2024~~10/08/2025	

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3124 – Referral to Specialists (RAF) Policy
C. MCUP3133 – Wheelchair Mobility, Seating and Positional Components
D. MCUG3134 – Hospital Bed/ Specialty Mattress Guidelines
E. MP~~C~~UP3039 – Direct Members

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status is based on the Member's aid code, prime insurance, demographics, or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see Partnership network providers and/or certified Medi-Cal providers willing to bill Partnership for covered services. However, many specialists still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP.
B. DME: Durable Medical Equipment
C. Medical Necessity: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
D. MTU: Medical Therapy Unit - Outpatient clinics located in designated public schools where Medical Therapy Program (MTP) services are provided.
E. MTP: Medical Therapy Program – A special program within California Children's Services (CCS) that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have disabling conditions, generally due to neurological or musculoskeletal disorders. Services are provided at Medical Therapy Units (MTUs).
F. RAF: Referral Authorization Form
G. TAR: Treatment Authorization Request

IV. ATTACHMENTS:

A. DME Rental Only

B. DME Limited to Special Circumstances
C. Oxygen O_2 Request Verification Form
D. Certificate of Medical Necessity for all Durable Medical Equipment (DME)
E. MTU DME Review Process and Example Form

V. PURPOSE:

To describe the process of authorizing durable medical equipment (DME) for Partnership HealthPlan of California (Partnership) Members.

VI. POLICY / PROCEDURE:

A. Partnership covers certain durable medical equipment when prescribed by a physician, physician assistant, or advanced practice registered nurse (which includes nurse practitioner, nurse anesthetist, nurse midwife, and clinical nurse specialist).
   1. Partnership will authorize items of DME in accordance with this policy and Partnership's MCUP3124 Referral to Specialists (RAF) Policy and MCUP3041 Treatment Authorization Request (TAR) Review Process policy, as well as Title 22, Medi-Cal Provider Bulletins and InterQual® Criteria to meet the Member's needs for medically necessary equipment. These needs are limited to services or devices necessary to protect life, to prevent significant illness or disability, or to alleviate severe pain.
   2. Partnership covers durable medical equipment that is the lowest cost to meet the patient's medical needs.

B. When the need for new or modified equipment is identified, the patient's treating provider must confirm the medical necessity of the DME. A written prescription for rental or purchase must clearly contain the following information:
   1. Full name, address and telephone number of the prescribing provider
   2. Date of prescription (must be current - written within one year of today's date)
   3. Item(s) being prescribed. If multiple or custom items are prescribed, they must be separately specified. Specific billing codes and modifiers MUST be requested.
   4. Medical condition necessitating the particular DME item
   5. Duration of medical necessity stated as precisely as possible (i.e. "3 months" or "permanent")

C. Partnership Health Services Department will refer to DHCS Medi-Cal Guidelines sections for Durable Medical Equipment including DME: Billing Codes *(dura cd)* and DME: Other DME Equipment (*dura other*) to determine which items may be rented and/or purchased. Attachment A summarizes "DME Rental Only" items.
   1. Partnership follows the guidelines as set forth in Title 22 Div 3 Sub 1 Chap 3 Article 3 51224.5 that when previously paid rental charges equal the maximum allowable purchase price of the rented item, the item is considered to have been purchased and NO FURTHER reimbursement to the provider shall be made for the beneficiary's use of the item UNLESS repair and maintenance is separately authorized.
   2. Ten months of rental is equal to purchase unless otherwise noted in DHCS guidelines/Attachment A.
   3. Unless otherwise noted, DME rental is based on a rental period of one calendar month, with the beginning date of rental as the date of service.
   4. For codes that are available for both purchase and rental, if the rental costs exceed purchase, then the provider should be purchasing rather than renting

D. Refer to Attachment B "DME Limited to Special Circumstances" for a list of items that are authorized for specific categories of Members.

E. Modifications of Equipment – If a piece of equipment is provided to a Member whose medical condition has not changed since the time the equipment was provided, and the item does not meet the patient's needs when in actual use, then the provider is responsible for adjusting or modifying the equipment as

necessary to meet the patient's medical needs.

F. DME for Disabled Parent - DME items may be covered to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian.
   1. The recipient's need for DME items must be reviewed annually by a physician.
   2. DME items cannot include common household items such as strollers, wraps, slings, or soft-structured carriers.
   3. A TAR is required for DME for a disabled parent, stepparent, foster parent, or legal guardian. The following documentation must be submitted with each TAR:
      a. A prescription from the physician for the specific DME item, and
      b. Documentation from the parent's/guardian's physician, nurse practitioner, clinical nurse specialist or physician assistant of the parent's/guardian's medical disability that justifies the need for the DME item.
   4. Claims for DME for a disabled parent, stepparent, foster parent, or legal guardian must be submitted using HCPCS code A9999, ICD-10 code Z73.6 (Limitation of activities due to disability) and modifier SC (medically necessary service/supply).

G. Specific Equipment Requirements
   1. Augmentative and Alternative Communication Devices – Partnership considers authorization for Augmentative and Alternative Communication (AAC) Devices as a benefit for eligible Members with speech, language and hearing disorders if the following conditions have been met:
      a. The request must be accompanied by an assessment acceptable to Partnership, conducted by a licensed speech and language pathologist.
      b. Additional assessments will be considered from other appropriately licensed providers, such as physical or occupational therapists, if the Member has physical limitations which could impact his/her ability to use the AAC device.
      c. A signed prescription from the Member's physician must accompany the request.
      d. The Partnership Chief Medical Officer or physician designee will apply current Medi-Cal criteria when making a determination.
   2. Bathroom Equipment must be ordered by the Member's PCP or specialist treating the Member through a referral from the PCP. For Direct Members, the bathroom equipment must be ordered by the physician currently managing the medical care for the Member.
      a. The following types of bathroom equipment are covered by Partnership provided that medical necessity has been demonstrated. (Note that DME items are covered as medically necessary only to preserve bodily functions essential to activities of daily living or to prevent significant physical disability, but not necessarily to restore the Member to previous function.)
         1) Toilet rail or armrest
         2) Raised toilet seat
         3) Tub stool, bench or bath seat
         4) Bathtub safety rail or grab bars
         5) Transfer tub bench
         6) Commode (bedside)
      b. The TAR for bathroom equipment must include documentation of medical necessity for use of the device that includes the following information related to the condition:
         1) Length of time Member has been or will be needing the equipment
         2) Assessment of mental status
         3) Evaluation of functional abilities including assessment of body strength/mobility
         4) Information concerning the Member's ability to properly use the bathroom equipment
   3. Compression Garments – Effective October 1, 2024, Partnership covers Over the Counter (OTC) compression garments as follows:
      a. Procedure code A6593 may be billed for OTC compression garments and will be limited to two

units (per limb) every six months.

b. Claims billed for greater than two units every six months will be denied for exceeding the service limitations.

c. No prior authorization is required for this service and no invoice needs to be billed with the claim. A written physician prescription is required, but does not have to be attached to the claim.

d. The maximum allowable for this code is $50 per unit.

~~3.~~4. Defibrillator Vests – Partnership reviews authorization requests for defibrillator vests on a case-by-case basis based on InterQual® criteria.

~~4.~~5. Enuresis Alarm Pads – Partnership will cover one enuresis alarm pad per lifetime with no TAR requirement. Outside of this frequency, a TAR is required.

~~5.~~6. Home Oxygen Therapy – Partnership reviews authorization requests for home oxygen therapy based on the criteria as stated in Attachment C of this policy – "Oxygen (O_2) Request Verification Form." Please submit form with TAR.

6. Infant Monitor Guidelines
   a. The monitor must be ordered by the PCP or by a specialist who is treating the Member through a referral from the PCP. For Direct Members, the monitor must be ordered by the physician who is currently managing the medical care for the Member.
   b. A monitor can be ordered for a Member who has a history of bradycardia or apnea.
   c. The TAR must include documentation of medical necessity for use of the monitor that includes the following information related to the condition:
      1) Length of time Member needs the monitor
      2) Description of the history of the condition
   d. Infant monitors are generally authorized until the baby reaches 46 weeks post-conceptual age. Extension beyond this age requires submission of clinical justification.
   e. For all requests, the individual needs of the Member and the characteristics of the delivery system are considered in the authorization process. The general criteria for authorization of monitors are as follows:
      1) Documented apneic spells defined as a cessation of breathing for 20 seconds or longer or a shorter pause accompanied by bradycardia (<100 beats per minute), cyanosis, or pallor
      2) Significant apnea or bradycardia requiring infant stimulation
      3) Frequent periods of apnea and/or bradycardia
   f. The TAR for an infant monitor should include information concerning the caretaker's ability to properly use the monitor.
   g. TARs are typically authorized for rental only. If medical necessity is demonstrated, authorization for purchase may be approved.
7. Knee Scooters require a TAR and may be billed with code E0118 under the following guidelines:
   a. Knee scooters may be billed when a Member is expected to be non-weight bearing for 3 weeks or longer and one of the following criteria are met:
      1) Member has fracture, dislocation, tendon rupture or surgery which requires absolute non-weight bearing to maximize chances for optimal healing and recovery. The Member is unable to utilize crutches effectively, or is unable to perform tasks of daily living with crutches.
      2) Member has an ulcer or infection which requires absolute non-weight bearing to maximize chances for optimal healing and recovery. This patient is unable to utilize crutches effectively, or is unable to perform tasks of daily living with crutches.
      3) Member has a neurologic or musculoskeletal condition which makes him/her unable to effectively or safely bear weight on one foot. The knee scooter will greatly increase this person's ability to function independently.
   b. Wheelchairs will not be authorized in conjunction with knee scooters.

c. The resale of the knee scooter is prohibited. Partnership recommends the equipment be donated to a charitable organization when no longer in use.

8. Pediatric Adaptive Equipment – Requests for pediatric adaptive equipment (e.g. specialty strollers, adaptive car seats, floor sitters/activity chairs, stair climbers, etc.) will be reviewed on a case by case basis using criteria described in CCS Numbered Letter (N.L.) 09-0703 Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R) *08/08/2003.* For Members enrolled in the Medical Therapy Program, medical appropriateness of devices and/or equipment will be determined and recommended by the Medical Therapy Unit providing services. The MTU must submit a TAR with an MTU DME form and all required information as per the process described in Attachment E - MTU DME Review Process and Example Form.
9. Portable ramps are a covered benefit under Partnership. Prior authorization is required.
   a. Portable ramps are those that meet the following conditions:
      1) Foldable or collapsible
      2) Not attached
      3) Suitcase types, which can be easily and readily carried and transported by the recipient for use in multiple locations.
   b. Ramps are not considered portable when they are fixed or modular or in any way attached. Non-portable ramps are not a Medi-Cal benefit.
   c. Criteria for authorization are as follows:
      1) The Member utilizes a manual or power wheelchair for home and/or community access (see policy MCUP3133 Wheelchair Mobility, Seating and Positional Components).
      2) Access to variable height surfaces at home, to a vehicle, and in the community is needed.
      3) The weight of the Member and wheelchair does not exceed the manufacturer's recommended weight limit for the ramp.
      4) Caretaker / Member must demonstrate the ability to safely use the ramp.
      5) Based on the Member's needs, the portable ramp is safer and more efficacious than permanent structural modifications to the Member's residence.
         a) Partnership reimburses for a maximum of one vehicle ramp and one home access ramp. If the ramp is needed for employment, the benefit is to be provided through the Department of Rehabilitation.
   d. If the Treatment Authorization Request (TAR) includes all information required, the request is reviewed by a Partnership Nurse Coordinator (and the Chief Medical Officer or physician designee if needed.) If the medical necessity of the request is uncertain or questionable, all information is sent to an independent consultant with expertise in the area of the equipment requested. The consultant evaluates all information and may schedule an appointment with the Member, perform an independent evaluation of the request and submit a report to Partnership with recommendations as to the medical appropriateness of the request.
10. Tumor Treating Field Devices – Partnership reviews authorization requests for tumor treating field devices (electrical stimulation devices used for cancer treatment) on a case-by-case basis based on Medi-Cal criteria. Initial TARs are approved for 3 months rental. Re-authorization may be granted when all of the following criteria are met:
    a. A magnetic resonance imaging (MRI) scan has been performed not more than 2 months prior to date of renewal request and documents no evidence of disease progression, and
    b. The Karnofsky Performance Status score is 60 or higher, and
    c. The patient has been wearing the device at least 18 hours daily.
10. Ventilators – Partnership reviews authorization requests for non-invasive ventilators on a case-by-case basis based on InterQual criteria. Initial TARs are approved for 3 months rental. Reauthorizations can be approved in up to 12 month increments. Authorization requests for invasive

ventilators are reviewed on a case by case basis based on Medi-Cal criteria.

11. Dynamic Splinting
    a. Partnership reviews authorization requests for dynamic splints for the knee (E1810) on a case by case basis. Authorizations may be approved as follows:
        1) Pre-operatively: As an adjunct to physical therapy for a Member having surgery to correct knee joint stillness or a contracture due to a previous injury or surgery to the knee.
        2) Post-operatively: As an adjunct to physical therapy if there is documentation of joint stiffness or contracture causing functional limitation of range of motion in the subacute post-operative period defined as > 3 weeks and up to 4 months after surgery.
    b. Dynamic splinting is not considered medically necessary for the following:
        1) Pre-operative request unless the surgery is to correct knee joint stiffness or contraction due to previous injury or surgery
        2) No evidence of knee contracture or stiffness in the subacute post-operative period
        3) Chronic joint stiffness or fixed contractures
        4) No significant improvement to the joint after 4 months of use

H. Reauthorization
    1. All authorizations which may recur are subject to the following requirements:
        a. Assessment and demonstration of continued need for treatment/service
        b. Reevaluation of plan of treatment, appropriateness of level care and physician orders
        c. Documentation of patient compliance with treatment/service

I. Non Covered Items - The following DME items are not included as Medi-Cal or Partnership benefits:
    1. Books or other items of a primarily educational nature
    2. Air conditioners/air filters or heaters
    3. Food blenders
    4. Reading lamps or other lighting equipment
    5. Bicycles, tricycles or other exercise equipment
    6. Television sets
    7. Orthopedic mattresses, recliners, recliners with lift system, rockers, seat lift chairs or other furniture items
    8. Waterbeds
    9. Household items
    10. Modifications of automobile or other highway motor vehicles
    11. Other items not used primarily for health care and which are regularly and primarily used by persons who do not have a specific medical need for them

J. Monitoring of DME Authorizations
    1. A periodic random sample of authorization requests for DME may be audited by the Utilization Management (UM) staff or Chief Medical Officer or physician designee for appropriateness and accuracy. Medical record audits may also include survey for proper use and documentation of DME.

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

VII. REFERENCES:

A. Medi-Cal Provider Manual/Guidelines: Durable Medical Equipment (DME): Overview (*dura*), Billing

Codes *(dura cd),* Billing Codes: Frequency Limits *(dura cd fre),* Other DME Equipment (*dura other*) and Oxygen and Respiratory Equipment (*dura oxy*); Orthotic and Prosthetic Appliances and Services: Criteria for Authorization and Reimbursement – Orthotics (*ortho auth ortho*)

B. DHCS All Plan Letter (APL) 15-018 Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components (07/09/2015)
C. Title 22 California Code of Regulations (CCR) Div 3 Sub 1 Chap 3 Article 3 51224.5
D. InterQual Criteria®
E. CCS Numbered Letter (N.L.) 09-0703 Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R) (08/08/2003)
F. CCS Numbered Letter (N.L.) 02-0107 Authorization of Rental of Portable Home Ventilators (01/05/2007)
G. Partnership Benefits Review and Evaluation Workgroup (BREW) Form #24 OTC/Off-the-Shelf Compression Garments. (07/25/2024)

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

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

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

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

PREVIOUSLY APPLIED TO:
MCUG3008 Bathroom Equipment Guidelines was Archived 01/11/2023
MCUG3023 Infant Monitor Guidelines was Archived 01/11/2023

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

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

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

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

DME RENTAL ONLY

Decubitus Care Equipment

E0202	Phototherapy (bilirubin) light with photometer (daily rental)

Oxygen and Related Equipment

E0424	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing
E0431 *	Portable Gas Oxygen
E0433 *	Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge
E0434 *	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adapter, contents gauge, cannula or mask, and tubing
E0439*	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0465 *	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)
E0466 *	Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)
E0467*	Home ventilator; multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions.
E0481	Intrapulmonary percussive ventilation system and related accessories. This code is reimbursable only for repairs to patient-owned equipment
E0482	Cough stimulating device, alternating positive and negative airway pressure
E0483	High frequency chest wall oscillation air-pulse generator system, includes all accessories and supplies
E1390*	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate
E1391*	Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate
E1392*	Portable oxygen concentrator, rental
K0738*	Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing)

*Rental Only without a 10-month limit. (See MCUP3013 VI.C. for further information on DME rental limits)

DME RENTAL ONLY

Traction and Trapeze Equipment

E0935	Continuous passive motion exercise device for use on knee only (daily rental)
E0936	Continuous passive motion exercise device for use other than knee (daily rental)

Miscellaneous

E0604	Breast Pump, heavy duty, hospital grade, electric (AC and/or DC), any type. This is also known as a hospital grade (multi-user) electric breast pump.
E0720	TENS device, two lead, localized stimulation [+]
E0730	TENS device, four or more leads, for multiple nerve stimulation [+]
	[+] *~~Partnership does not require prior authorization for TENs units unless the request is outside of the allowable frequency limits per DHCS Medi-Cal Provider Manual/Guidelines: Durable Medical Equipment~~ (DME) ~~Billing Codes: Frequency Limits (dura cd fre)~~*
E0766	Electrical stimulation device used for cancer treatment, includes all accessories, any type must be billed with modifier RR (rental) and KF
E2402	Negative pressure wound therapy electrical pump, stationary or portable (daily rental)
K0606	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type
K0743	Suction pump, home model, portable, for use on wounds (modifier RR)

[+] Partnership does not require prior authorization for TENs units unless the request is outside of the allowable frequency limits per DHCS Medi-Cal Provider Manual/Guidelines: Durable Medical Equipment (DME) Billing Codes: Frequency Limits (dura cd fre)

Rental Period

- Unless otherwise noted, DME rental is based on a rental period of one calendar month, with the beginning date of rental as the date of service.
- Ten months rental is equal to purchase except as noted above by *.

DME LIMITED TO SPECIAL CIRCUMSTANCES

All lymphedema pumps/compression devices (codes as noted below) require authorization and evidence of meeting medical criteria as stated in the Durable Medical Equipment (DME): Other DME Equipment section of the DHCS Medi-Cal guidelines:

HCPCS codes E0650, E0651, ~~E0652,~~ E0655, E0656, E0657, E0660, E0665, E0666, E0667, E0668, E0669, E0670, E0671, E0672, ~~-~~E0673, ~~E0675, E0676,~~ E0678, E0679, E0680, E0681, E0682

Limited to recipients OVER age 12 (Any request for Members aged 12 and under will require review for medical necessity)

Cervical Traction Device

E0840	Traction frame, attached to headboard, cervical traction
E0849	Traction equipment, cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible
E0850	Traction stand, free standing, cervical traction
E0860	Traction equipment, overdoor, cervical

Limited to CCS ONLY

A4606	Oximeter replacement probe
E0635	Electric patient lift
E0639	Movable patient lift

Limited to Recipients Who Are Disabled Parents, Stepparents, Foster Parents, or Legal Guardians

Please see section VI.F. of this policy MCUP3013 DME Authorization

Items Requiring Initial Rental Prior to Partnership's Consideration for Purchase

Hospital Beds
Manual Wheelchairs
Continuous Positive Airway Pressure (CPAP)
Bi-Level Positive Airway Pressure (Bi-PAP)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Oxygen (O_2) REQUEST VERIFICATION FORM

Please attach patient reports verifying this information and document activity level and/or sleep during the exam.

Member Name: _____ PHC ID Number (CIN):_____

Date of Birth: _____ Physician: _____

1. What is the diagnosis for which the Oxygen is requested? _____

2. Date of O_2 Saturation test: _____

3. Is the O_2 request

Continuous use? _____

Supplemental use with activity? _____

Nocturnal use? _____

	YES	NO
4. <u>For Continuous Requests:</u>		
Is the Oxygen Saturation <89% awake and at rest? (*Testing must show that this is the usual resting saturation for the patient*.)	____	____
5. <u>For Supplemental Requests:</u>		
Is the Oxygen Saturation <89% during the 6-minute walk test? (*Testing must show that the patient has an Oxygen Saturation over 89% at rest that drops to under this value with exercise*.)	____	____
6. <u>For Nocturnal Requests:</u>		
Is Oxygen Saturation <89% for at least 5 minutes during sleep? (*Testing must show that during sleep there is at least one continuous period of Oxygen Saturation <89% for at least 5 minutes. Cases where there are frequent drops of Oxygen Saturation to <89% but not in a continuous 5 minute period will be reviewed individually*.)	____	____

I have reviewed and concur with this information._____

Requesting Physician Signature/Please Also Print Name

State of California - Health and Human Services Agency

Department of Health Care Services

CERTIFICATE OF MEDICAL NECESSITY FOR ALL DURABLE MEDICAL EQUIPMENT (DME)

(EXCEPT WHEELCHAIRS AND SCOOTERS)

The provider must complete all applicable areas not completed by the clinician or therapist.

Dear Clinician/DME Provider: Cooperation in completing this form will ensure that the beneficiary receives full Medi-Cal consideration regarding the request for Durable Medical Equipment. Medi-Cal reimbursement is based on the least expensive medically appropriate equipment that meets the patient's medical need.

Incomplete information will result in a deferral, denial or delay in payment of the claim.

REQUIRES THE ATTENDING CLINICIAN TO COMPLETE AND SIGN

SECTION 1—Clinician's Information:

Clinician Name *(Print)* Last	First	Phone Number ( )	License Number

Address Street	City	State	ZIP

Clinician's description of the patient's current functional status and need for the requested equipment: _____

SECTION 2—Patient's Information: New Rx *(For Rx Renewal, please also complete 2A below)*

Patient Name *(Print)* Last	First	Phone Number ( )	Date of Birth mm / dd / yy	Medi-Cal Number

Address Street	City	State	ZIP

Date of last face-to-face visit with the beneficiary: _____

Is this beneficiary expected to be institutionalized within the next 10 months? Yes ❒ No ❒ Explain "Yes" answer: _____

Equipment required for:

❒ Less than 10 months *(code the TAR for a rental)*

❒ More than 10 months *(code the TAR for a purchase)*

SECTION 2A—For Renewal:

Verification of continued medical necessity and continued usage by the beneficiary must be done at each TAR renewal.

SECTION 3—Equipment Requested:

a) _____

b) STANDARD: _____ BARIATRIC: _____

c) Replacing existing equiment? Yes ❒ No ❒ If yes, explain why: _____

d) Attach repair estimate if replacement with similar equipment is requested.

e) Other DME the beneficiary has: _____

f) How many hours per day of usage? _____

g) Accessories requested and why: _____

h) Custom features requested and why: _____

i) Other equipment currently in the home: Cane ❒ Walker ❒ Crutches ❒ Prosthesis ❒ Manual Wheelchair ❒ Power Wheelchair ❒ Hospital Bed ❒ Oxygen ❒ POV (scooter) ❒ Other: _____

j) Patient currently using the following equipment: _____

k) When/How often: _____

l) State specific reason for accessories requested: _____

SECTION 4—Diagnosis Information

Diagnoses: _____ Date of onset: _____

Prognosis: _____

SECTION 5—Pertinent History:

_____

_____

SECTION 6—Functional Status:

Beneficiary's height: _____ Beneficiary's weight: _____

a) Ambulation: Independent ❒ Walker/Cane ❒ Assisted ❒ Unassisted ❒ Unable ❒ Bed confined ❒
Recent fall(s) ❒ Dizziness/Vertigo ❒ Incoordination ❒ Ataxia ❒ Severe shortness of breath ❒

b) Transfer: Self ❒ Self, but with great dificulty ❒ Self with a transfer device ❒
Stand by assistant ❒ With assistance ❒ Mechanical or person lift ❒

c) Pertinent physical findings: Edema (location):
Pressure sore(s), state and location: Amputee ❒ Cast ❒ Ataxia ❒

Paralysis/weakness (location): _____ Sitting Posture/Deformity: _____

Cognitive status: _____ Vision: Impaired ❒ Normal ❒

Contractures:

SECTION 7—Living Environment:

House/condominium ❒ Apartment ❒ Stairs ❒ Elevator ❒ Ramp ❒ Hills ❒ SNF ❒ ICF/DD ❒ B&C ❒

Other: _____

Living Assistance: Lives alone ❒ With other person(s) ❒ Alone most of the day ❒ Alone at night ❒

Attendant care: Live in attendant ❒ or _____ Hours/day Homemaker ❒ Hours _____

Transportation:

SECTION 8—Hospital Bed:

Document that this beneficiary requires positioning not feasible in an ordinary bed: _____

_____

Is frequent repositioning required throughout the day? Yes ❒ No ❒ Explain: _____

Is frequent repositioning required throughout the night? Yes ❒ No ❒

Can the beneficiary or caretaker use a "manual" bed? Yes ❒ No ❒

If no, explain why: _____

_____

For any anti-decubitus bed, please attach to the TAR, photos and explanation of previous therapies attempted, the nutritional status, and the latest hemoglobin and hematocrit of the beneficiary.

SECTION 9—DME provider/Therapist attestation and signature/date:

By my signature below, I certify to the best of my knowledge that the information contained in this Certificate of Medical Necessity is true, accurate and complete and I understand that any falsification, omission or concealment may subject me to criminal liability under the laws of the State of California.

Name of therapist answering these sections, if other than prescribing clinician or DME provider (please print):

Name: _____ *(Please print)* Title: _____ *(OT, PT, RESNA, etc.)* DME Provider Name: _____ *(Please print)*

✍ _____ *(Use Ink - A signature stamp is not acceptable)* Date: _____

✍ _____ *(Use Ink - A signature stamp is not acceptable)*

SECTION 10—Clinician attestation and signature/date:

I certify that I am the clinician identified in this document. I have reviewed this Certificate of Medical Necessity and I certify to the best of my knowledge that the medical information is true, accurate, current and complete, and I understand that any falsification, omission, or concealment may subject me to criminal liability under the laws of the State of California.

Clinician's Signature:

✍ _____ *(Use Ink - A signature stamp is not acceptable)* Date: _____

Medical Therapy Unit (MTU)/ Durable Medical Equipment (DME) Review Process

- Member is seen at the MTU
- MTU therapists and physicians agree on the need for DME
- Physician writes prescription for medically appropriate equipment or device(s)
- MTU staff reach out to DME provider/vendor to request quote

When quote is agreed upon,

- MTU therapists complete an MTU DME Request form (see example below)
- Rx and MTU DME Request form are forwarded to the DME provider/vendor
- DME provider/vendor submits a packet of information to PHC including the following:
  - Signed Rx
  - MTU DME Request form (*Specifying any items in quote that were not approved by the MTU*)
  - Treatment Authorization Request (TAR) – (may be submitted electronically)
  - Agreed upon quote
- TAR reviewed (*additional documentation may be required if packet submission was not complete*)

The spirit of this procedure is to allow the MTU and PHC to work seamlessly on DME approvals in replication of legacy CCS process and to minimize delays in care while avoiding unnecessary or unapproved DME from being ordered by another clinic without MTU knowledge.

Notes:

- Vendors are to submit the TAR.
- If the MTU DME Request form is used (see sample below), no "Certificate of Medical Necessity for DME" form 6181 is required.

Medical Therapy Unit (MTU)/ Durable Medical Equipment (DME) Request Form

Client Name		**CCS#**		**CIN#**	
DOB		**Program end date**			
Approved by		**Date of review**			

☐ 9K CCS ☒ MediCal ☒ Partnership ☐ 9N M/C ONLY ☐OTLICP ☐ MTP only ☐ HMO

Requested Item(s)				
Vendor				
Vendor Mailing address				
Vendor Physical address				
Vendor contact	**Phone**		**Fax**	
Provider Number				

☐ Signed prescription attached

☐ Therapist assessment complete

☐ CCS Numbered Letter 09-0703 or 09-0514 criteria reviewed and met

☐ Quote reviewed

☐ The following codes/items are not approved:

Vendor to submit this form along with TAR/eTAR, prescription and quote from DME provider (including CCS approved HCPCS codes) to Partnership HealthPlan of California for payment.

MTU Approval Date:

Sample Form

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MCUP3119 (previously under QI - MCQP1020, QP100120)			**Lead Department: Health Services** **Business Unit**: Utilization Management	
Policy/Procedure Title: Sterilization Consent Protocol			☒ **External Policy** ☐ **Internal Policy**	
Original Date: QI Medi-Cal-4/25/1994 UM Medi-Cal-10/17/2012		**Next Review Date:** ~~09/11/2025~~10/08/2026 **Last Review Date:** ~~09/11/2024~~10/08/2025		
Applies to:	☒ **Medi-Cal**		☐ **Employees**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~09/11/2024~~10/08/2025	

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MPUP3078 – Second Medical Opinions
C. MCUP3064 – Communication Services
D. MPQP1022 – Site Review Requirements and Guidelines

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. DHCS Form 8469– *Previously known as Form PM330*, this form entitled "Consent for Sterilization" has been renamed by the California Department of Health Care Services (DHCS) as of 04/2025.~~form entitled "Consent Form"~~
B. Mentally Incompetent: A mentally incompetent individual is a person who has been declared mentally incompetent by the federal, state or local court of competent jurisdiction for any purposes which include the ability to consent to sterilization.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe the requisite consent procedures and delineate the conditions under which sterilization procedures (tubal sterilization, vasectomy and hysterectomy) are authorized under the Medi-Cal program in conformance with federal regulations.

VI. POLICY / PROCEDURE:

A. Member Consent
   1. Members who have procedures performed for the purpose of tubal sterilization or vasectomy shall receive adequate information to make an informed decision. This decision shall be reflected by a properly executed DHCS Consent Form 8469.
   2. A physician may perform or arrange for a (non-emergency) hysterectomy only if:
      a. The person who secures the authorization to perform the hysterectomy has informed the individual and the individual's representative, if any, orally and in writing that the hysterectomy

will render the individual permanently sterile.

b. The individual (or representative) has signed a written acknowledgment of the receipt of the preceding information. The consent must be dated prior to the date of surgery.

c. The individual has been informed of the rights to consultation by a second physician. (see policy MPUP3078 – Second Medical Opinions).

d. A copy of the written acknowledgment signed by the patient must be:

1) Provided to the patient

2) Retained by the physician and the hospital in the patient's medical records, and

3) Attached to claims submitted by physicians, assistant surgeons, anesthesiologists, and hospitals

3. Informed consent is not required for a hysterectomy if it is performed in a life threatening emergency situation in which a physician determines that prior acknowledgment was not possible. In these cases, a handwritten statement of the nature of the emergency signed by the physician shall be attached to the claim.

4. Translation and interpretation services will be provided if the Member to be sterilized does not understand the language used on the consent form or the verbal language used to obtain consent. Linguistic services are provided by Partnership HealthPlan (Partnership) at no cost to monolingual, non-English speaking or Limited English Proficiency (LEP) Medi-Cal beneficiaries as well as eligible Members with sensory impairment. These services include written translations, qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters, use of California Relay Services for hearing impaired or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries.

5. Informed consent for sterilization is not required prior to a sterilizing or potentially sterilizing procedure if the Member has been previously sterilized as the result of a prior surgery, menopause, prior tubal ligation, pituitary or ovarian dysfunction, pelvic inflammatory disease, endometriosis or congenital sterility. In these cases, the provider must state the cause of sterility in the Remarks section of the claim form or as an attachment. This statement must be handwritten and signed by a physician. All assistant surgeon, anesthesiology and inpatient provider claims must include a copy of the primary physician's statement.

6. The HealthPlan is responsible for monitoring providers to assure compliance with their responsibilities as previously outlined.

B. Coverage Conditions

1. Some planned sterilization procedures require a Treatment Authorization Request (TAR). Providers should refer to the Medi-Cal Provider Manual/ Guidelines sections “Benefits: Family Planning” *(ben fam)* and “Sterilization” *(ster)* to determine if a TAR is required.

2. Sterilization shall be covered only if all of the following are true:

a. The Member to be sterilized is at least 21 years of age at the time the consent for sterilization is obtained.

b. The Member is mentally competent (refer to definition of mentally incompetent at III.B).

c. The Member is able to understand the content and nature of the informed consent process; a mentally ill or developmentally disabled Member may consent to the sterilization if a physician determines the Member is capable of understanding the nature and the significance of the sterilization procedure.

d. The Member is not institutionalized.

e. The Member has voluntarily given informed consent.

f. At least 30 calendar days, but not more than 180 calendar days, have passed between the date of the written and signed informed consent and the date of the sterilization. The calendar day after the date the informed consent was signed is the first day of the 30-days waiting period.

1) Tubal sterilization may be performed at the time of an emergency abdominal surgery if the

Member consented to the sterilization at least 30 calendar days before the intended date of sterilization AND at least 72 hours have passed after written informed consent was given and the performance of the emergency surgery.

2) Tubal sterilization may be performed at the time of premature delivery if the Member gave written informed consent for sterilization at least 30 calendar days before the expected date of delivery AND at least 72 hours have passed after written informed consent to be sterilized was given.

g. Title 22 regulations prohibit giving consent to a tubal sterilization at the same time a Member is seeking to obtain or is obtaining an abortion. "Seeking to obtain" means that period of time during which the abortion decision and the arrangements for the abortion are being made. "Obtaining an abortion" means that period of time during which an individual is undergoing the abortion procedure, including any period during which preoperative medication is administered. This does not mean, however, that the two procedures may never be performed at the same time. If a Member gives consent to sterilization, then later wishes to obtain an abortion, the procedures may be done concurrently. An elective abortion does not qualify as emergency abdominal surgery, and this procedure does not affect the 30-day minimum wait.

h. Sterilization is covered only if all applicable requirements are met at the time the operation is performed. If the Member obtains retroactive coverage, previously provided sterilization services cannot be covered by Partnership unless all applicable requirements including the timely signing of an approved sterilization consent form were observed.

i. Hysterectomy is not covered when performed solely for the purpose of rendering the Member permanently sterile. A hysterectomy shall also not be covered if there is more than one purpose for the procedure and the hysterectomy would not be performed except for the purpose of rendering the Member permanently sterile.

C. Informed Consent Process Performed by the Provider:

The informed consent process shall be initiated by a physician or by the physician's designee (with an interpreter if needed), and then completed/confirmed by the physician performing the surgery. These activities are documented on the DHCS Consent Form ~~PM 3008~~469.

1. A Member has given informed consent only if:
   a. The provider who obtained consent for the sterilization procedure has completed the following requirements:
      1) Offered to answer any questions the Member may have had concerning the sterilization procedure;
      2) Provided the Member with a copy of the consent form and the booklet on sterilization published by the Department of Health Care Services;
      3) Provided orally[1] all of the following information to the Member to be sterilized:
         a) Advice that the Member is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the Member might be otherwise entitled;

[1] Translation and interpretation services will be provided if the Member to be sterilized does not understand the language used on the consent form or the verbal language used to obtain consent. Linguistic services are provided by Partnership HealthPlan of California at no cost to monolingual, non-English speaking or Limited English Proficiency (LEP) Medi-Cal beneficiaries as well as eligible Members with sensory impairment. These services include written translations, qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters, use of California Relay Services for hearing impaired or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries.

b) A full description of available alternative methods of family planning and birth control;
c) Advice that the sterilization procedure is considered to be irreversible;
d) A thorough explanation of the specific sterilization procedure to be performed;
e) A full description of the discomforts and risks that may accompany or follow the performance of the procedure, including an explanation of the type and possible side effects of any anesthetic to be used:
f) A full description of the benefits or advantages that may be expected as a result of the sterilization;
g) Approximate length of hospital stay;
h) Approximate length of time for recovery;
i) Explanation that there is no financial cost to the Member when they are eligible for Medi-Cal and have coverage with Partnership for the month the service is to be provided;
j) Information that the procedure is established or new;
k) Advice that the sterilization shall not be performed for at least 30 calendar days, except under the circumstances of premature delivery or emergency abdominal surgery as detailed above in VI.B.1.f.
l) The name of the physician performing the procedure; if another physician is to be substituted, the Member shall be notified prior to administering pre-anesthetic medication of the physician's name and the reason for the change in physicians.

b. Suitable arrangements were made to ensure that the information specified above was effectively communicated to any Member who is visually or hearing impaired or otherwise disabled[2].
c. An interpreter will be provided if the Member to be sterilized does not understand the language used on the consent form or the language used by the person obtaining consent.[2]
d. The Member to be sterilized was permitted to have a witness of the Member's choice present when consent was obtained.
e. The sterilization operation was requested without fraud, duress, or undue influence.
f. The appropriate consent form was properly completed and signed according to this policy.

2. The Member may withhold or withdraw consent for sterilization at any time prior to the procedure without adverse effect to his/her participation in the HealthPlan or right to future care.
3. Within 72 hours prior to the time the Member receives any pre-operative medication, the physician must advise the Member that federal benefits shall not be withheld or withdrawn if the Member chooses not to be sterilized. The physician certifies this action by signing the DHCS Consent Form 8469~~PM330~~.
4. Informed consent shall not be obtained while the Member to be sterilized is subject to the following:
   a. In labor or within 24 hours postpartum or post abortion
   b. Must not be within 30 calendar days of seeking to obtain or obtaining an abortion
   c. Under the influence of alcohol or other substances that affect the Member's state of awareness

D. Sterilization Consent Documentation
1. The fully completed and signed consent form, as delineated above, shall be included in the

[2] Translation and interpretation services will be provided if the Member to be sterilized does not understand the language used on the consent form or the verbal language used to obtain consent. Linguistic services are provided by Partnership HealthPlan of California at no cost to monolingual, non-English speaking or Limited English Proficiency (LEP) Medi-Cal beneficiaries as well as eligible Members with sensory impairment. These services include written translations, qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters, use of California Relay Services for hearing impaired or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries.

Member's medical record and include signature certifications as follows:
   a. The Member to be sterilized;
   b. The physician performing the sterilization;
   c. The interpreter, if required to obtain informed consent
2. The signature certifications assure the following:
   a. The Member is mentally competent and knowledgeably and voluntarily consented;
   b. The Member has received oral delivery of the requirements for informed consent;
   c. The Member understood, to the interpreter's best belief, the translation of the physician's oral statements and the written consent statement.

E. Partnership HealthPlan of California Monitoring Procedure
1. Claims submitted for procedures requiring informed consent are manually reviewed by the Claims Department for compliance.
2. Review criteria included in the Facility Site Review:
   a. Office staff have received training on informed consent requirements
   b. Informed consent is present in the medical record for all operative and invasive procedures
   c. A DHCS Consent Form 8469 (New 04/2025) is present for human sterilization
3. A Treatment Authorization Request (TAR) is required for hysterectomy and will be reviewed by the Partnership Utilization Management (UM) staff for information about the medical necessity of a hysterectomy.

VII. REFERENCES:

A. Title 22 California Code of Regulations § 51305.1
B. Medi-Cal Provider Manual/ Guidelines: Benefits: Family Planning *(ben fam),* Sterilization *(ster)*
C. DHCS Form 8469 (New 04/2025) – Consent for Sterilization form which can be found on this webpage: https://www.dhcs.ca.gov/Pages/permanentbirthcontrol.aspx~~https://mcweb.apps.prd.cammis.medi-cal.ca.gov/references/forms~~
~~D. PM 330 Sterilization Consent Form Tips & Reminders for Successful Billing~~
~~E.~~D. DHCS Sterilization Materials (booklets on sterilization provided with consent forms)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES: 12/21/94; 10/10/97 (name change only), 06/20/01, 10/16/02; 02/16/05; 03/15/06; 03/21/07; 02/20/08; 03/18/09; 03/17/10; 05/18/11;(changed to UM) 10/17/12; 03/18/15; 03/16/16; 03/15/17; *06/13/18; 04/10/19; 05/13/20; 05/12/21; 06/08/22; 08/09/23; 09/11/24; 10/08/25

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

PREVIOUSLY APPLIED TO:

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with

involvement from actively practicing health care providers and meets these provisions:

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

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

Partnership HealthPlan of California

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

MPUD3001

~~May~~ October 2025

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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 ~~six~~ seven (~~7~~6) teams including:

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

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

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

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
- Serves on the Quality/Utilization Advisory Committee, Pharmacy & Therapeutics Committee, Credentials Committee and Internal Quality Improvement 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
- Regularly attends 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)
- 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

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
-

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(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 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 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, 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.

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

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)

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 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, this position is responsible for the day-to-day implementation of Partnership's UM Program and 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 Associate Directors, 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
- Participates in 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
- Reports to the Q/UAC on UM activity
- Collaborates with providers and facilities
- Develops recommendations for program improvements
- Coordinates activities with Quality Improvement, Care Coordination, Population Health, Health Equity, Enhanced Health Services, 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 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 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 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
- 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.
- Carries out research and policy analyses on issues and opportunities related to state housing policy and low-income housing programs, gathers member 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 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 and reviews provider and member 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

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.

- 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

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 ~~mental~~ 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

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
- 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 Training & Education, 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 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 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 member's benefit package
- Work collaboratively with the Care Coordination, Population Health, Pharmacy and Quality Improvement staff on UM issues

Nurse Coordinator/ UM 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 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

[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.

- 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

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.

- 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.

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

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 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 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

Project Coordinator II - (EHS)
Under the direction of an Associate Director 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 an 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

Health Services Analyst I
Performs routine and ad-hoc reporting and data management for internal and external users; assists in maintaining reporting systems within the department. Prepares, analyzes, reports, and manages data used for both 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.

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.

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.

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 and/or other UM 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.

Health Services Administrative Assistant I – 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.

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

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. ~~A~~Three CAC member~~(s)~~ are~~is~~ 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, Medical Director for Quality, Regional Medical Director(s), ~~Clinical Director of~~ Behavioral

Health Clinical Director, Chief Health Services Officer and leadership from the Quality and Performance Improvement, Provider Relations, Utilization Management, ~~and~~ 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 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), ~~Clinical Director of~~ Behavioral Health Clinical Director, Director of Health Equity ~~Officer~~, Medical Director for Quality, Manager of ~~, Patient~~ Member Safety-Quality Investigations, Associate and Regional Medical Directors and leadership from the Health Services departments (e.g. Quality and Performance Improvement, ~~Provider Relations,~~ Utilization Management, Care Coordination, Pharmacy, Population Health, Health Equity, Enhanced Health Services), ~~Pharmacy, and~~ Grievance and Appeals, and Provider Relations d~~D~~epartments ~~-~~ 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 on a 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:

- Functioning as Partnership's UM Committee, r~~R~~eviews~~ing~~, makes~~ing~~ recommendations to, and approves~~ing~~ the *UM Program Description* and *UM Program Evaluation* annually
- 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

~~*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.~~

Quality Improvement and Health Equity Committee (QIHEC)

The Quality Improvement and Health Equity Committee (QIHEC) meets bimonthly~~is responsible~~ for analyzing and evaluating the results of Health Equity related Quality Improvement ~~(QI) and Health Equity~~ activities. This includes ~~ing~~ 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 follow-up of identified performance deficiencies.

The QIHEC provides recommendations ~~to the Internal Quality Improvement Committee (IQI) and~~ 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.

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 Substance Use Services 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 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.

~~*Community Advisory Committee (CAC)*~~
~~The CAC is composed of Partnership members who represent the diversity and geographic areas of Partnership's membership, including hard-to-reach populations. The CAC is a liaison group between members and Partnership, advocating for members by ensuring that the health plan is responsive to the health care and information needs of all members. 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. A CAC member(s) is selected to serve on the Board of Commissioners to provide member input and report back to the CAC.~~

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 (BHT)
- 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* "Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal RX" (12/30/2022)
- 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 ~~the delegated~~Partnership's toll-free ~~-~~Behavioral Health ~~Organization's toll-free~~ referral number~~s~~ (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 ~~delegated managed~~ behavioral healthcare department ~~organization (MBHO), Carelon Behavioral Health,~~which can be reached by calling ~~at~~ (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 ~~eligibility.~~residence. The administration of such referrals is addressed in the respective Memorandum of Understanding (MOU) with each respective County ~~Mental~~ 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 ~~delegated contractor(s)~~ 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, ~~'s delegated contractor, Carelon Behavioral Health,~~ for telephone consultation. For detailed referral and consultation procedures, PCPs can refer to Partnership Policy MPCP2017 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 ~~MCUP3028~~ 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 ~~(Partnership) or its delegated contractor, Carelon Behavioral Health~~, both parties will participate in a dispute resolution process as defined in Partnership Policy ~~ADM52~~ MPBP8005 Dispute Resolution Between Partnership and BM~~H~~Ps 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 ~~the~~ triage and referral protocols ~~for the delegated MBHO services provider(s)~~ to ~~assure~~ ensure they are appropriately implemented, monitored and ~~professionally~~ managed. Protocols utilized ~~employed by delegates must be~~are ~~clinically~~ based on sound clinical evidence and accepted industry practice~~s~~. ~~Protocols shall outline~~They must define the level of urgency and appropriateness of the care setting.

Triage and referrals ~~decisions~~ are performed by the Behavioral Health Access Line ~~the Care Coordination team of the delegated MBHO services provider~~ with oversight by Partnership's Senior Director of Behavioral Health and Behavioral Health Clinical Director. Partnership ~~and its delegate~~ works collaboratively with the respective County Behavioral Health Plans to coordinate and ensure M~~m~~embers 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. Partnership

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 MCUP3144 *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 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:
  - MPUP3126 *Behavioral Health Treatment (BHT) for Members Under the Age of 21*
  - MCCP2014 *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.

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 delivery system and availability of services 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/Removal of Benefits and 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 begins 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 service TAR requirements
- Identification of the Member population that (s) who would benefit
- R, relevant clinical information
- , and TAR requirements (e.g. Will whether a TAR would be required? Wor ill if TAR requirements would be removed?).

T The Chief Medical Officer (CMO) or Physician Designee reviews the request, along 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 the 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 that 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 Decisions

Partnership makes UM 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 members 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 days of receipt of request	24 hours of determination date[1]	May be extended *two (2)* times 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

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 MCUP3139 *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 MCUP3138 *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 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 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.

COMMUNICATION SERVICES

Partnership provides access to 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 health plan is in operation (Monday - Friday 8 a.m. - 5 p.m.).
- After normal business hours, Members and Providers may contact the Partnership voice mail service to leave a message which is communicated to the appropriate person on the next business day. Calls received after normal business hours are returned on the next business day and 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 voice mailbox is confidential and will accept messages after normal business hours. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
    - 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.
- 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 sensory impairment 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 alternative formats upon request. Alternative material formats include audio, large print and electronically for members with hearing and/or visual disabilities. Braille versions are available for members with visual disabilities. Auxiliary aids are also available upon request. Please refer to MCND9002 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 MCND9002 *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 Provider 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. 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 MCUP3042 *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 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 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 leadership including but not limited to:

- Chief Health Services Officer
- Director, Pharmacy 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 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, 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 (Effective July 1, 2025) 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

*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

	~~*04/16/2025*~~*09/17/2025*

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

	~~*05/14/2025*~~*10/08/2025*

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

	~~*06/25/2025*~~*10/22/2025*

Kim Tangermann — *Date Approved*
Board of Commissioners Chairperson

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: CGA024</td><td colspan="3">Lead Department: Grievance & Appeals</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Medi-Cal Member Grievance System</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 02/11/99 (MS 300)</td><td colspan="4">Next Review Date: 10/08/2026
Last Review Date: 10/08/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="3">☐ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="3">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="3">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 10/08/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCND9002 Cultural & Linguistic Program Description
~~A.~~B. MCND9004 Regulatory Required Notices
~~B.~~C. MPQP1016 Potential Quality Issue Investigation and Resolution
~~C.~~D. MCUP3037 Appeals of Utilization Management/Pharmacy Decisions
~~D.~~E. MPQP1022 Site Review Requirements and Guidelines
F. CGA022 Member Discrimination Grievance Procedure
~~E.~~G. CMP26 – Verification of Caller Identity and Release of Information

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Acknowledgment Letter is a written notification of receipt of a grievance or appeal that is sent to the member or the member's authorized representative.
B. Adverse Benefit Determination encompasses all previously existing elements of "Action" under federal regulations, with the addition of language that clarifies the inclusion of determination involving medical necessity, appropriateness, setting, covered benefits, and/or financial liability. An adverse benefit determination is defined to mean any of the following actions taken by a Managed Care Plan (MCP) (i.e., Partnership HealthPlan of California (Partnership)):
   1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
   2. The reduction, suspension, or termination of a previously authorized service.
   3. The denial, in whole or in part, of payment for a service.
   4. The failure to provide services in a timely manner.
   5. The failure to act within the required timeframes for standard resolution of grievances and appeals.
   6. The denial of the member's request to obtain services outside the network.
   7. The denial of a member's request to dispute financial liability.
C. Appeal is a member's request to Partnership for reconsideration of an adverse benefit determination resulting in the delay, modification, or denial of a service, benefit, or claim based on medical necessity, or a determination that the requested service was not a covered benefit.
D. Authorized Representative ~~is a relative, friend, attorney, or other person authorized by the member to represent them in matters regarding their healthcare.~~An adult member has the right to designate a friend,

family member, or other person to have access to certain Personal Health Information (PHI) to assist the member with making medical decisions. The member will need to provide appropriate legal documentation as defined in CMP26 Verification of Caller Identity and Release of Information and submit it to Partnership for review prior to releasing PHI. Until the form has been submitted and validated by Partnership staff, the member can give verbal consent to release non-sensitive PHI to a non-member. Verbal consent expires at close of business th following business day. The member can give additional verbal consent when the prior verbal consent window of time has expired.

E. Complaint is the same as a grievance. See grievance definition.
F. Deemed Exhaustion occurs if Partnership fails to adhere to the state and federal notice and timeframe requirements for either a Notice of Action (NOA) or a Notice of Appeal Resolution (NAR), including failure to provide a fully translated notice, or failure to provide timely and/or sufficient notice in the member's alternative format preferences. When deemed exhaustion occurs, the member may bypass Partnership's internal appeal process and initiate a state hearing.
G. Disputed Services means covered services that are the subject of a pending appeal or state hearing due to an adverse benefit determination by Partnership, or its subcontractors, to terminate, suspend, or reduce previously authorized covered services.
H. Expedited Review is the process by which a decision is rendered when a grievance involves an imminent and serious threat to the health of the member, including, but not limited to severe pain, potential loss oflife, limb, or major bodily function. Expedited reviews are approved by physician reviewers. An expedited review is also acknowledged verbally, whenever possible.
I. Grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination.
    1. Exempt Grievance is a grievance that is resolved by the end of the following business day. These grievances are handled by the Member Services Representatives or Grievance staff and are received over the telephone. These grievances are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment.
    2. Standard Grievance is a grievance that cannot be resolved by the end of the following business day.These grievances are handled by the designated Grievance staff.
J. Grievance Nurse Specialist (GNS) is the clinical staff member responsible for initiating and coordinating a multi-disciplinary team approach to handling ~~of~~ grievances with members, providers, plan Medical Directors, departmental directors and managers, and others to evaluate, monitor, and assure that medically necessary services are provided in a quality, efficient, and timely manner. Clinical support is provided to non-clinical staff as needed. The GNS may also provide input or participate in state hearings.
K. Grievance Case Analyst (GCA) is the staff member who is responsible for summarizing, analyzing, investigating, and issuing acknowledgments and resolutions to member grievances and appeals. The GCA also represents Partnership during state hearings.
L. Grievance system is the computer system that Partnership uses to log and track member grievances, appeals,and state hearing requests, which are logged by specific grievance types.
M. Inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include ~~but are not limited to:~~, but are not limited to, questions pertaining to eligibility, benefits, or other Partnership processes. Where Partnership is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.
N. Member is the Medi-Cal eligible individual receiving health care through Partnership to whom reference will be made as "member" in all protocols.
O. Member Grievance Review Committee (MGRC) is a forum to conduct a multidisciplinary review of member grievances (grievances and all level appeals). The committee is made up of representatives from Grievance & Appeals, Member Services, Provider Relations, Care

Coordination, Quality Improvement, Utilization Management, and Compliance.

P. Member Services Representatives (MSRs) are the Partnership staff members who assist members or their authorized representatives in learning about and understanding the services and benefits offered through Partnership, including the grievance, appeal, and state hearing procedures, and assist members in obtaining a resolution to their issues.

Q. Non-Contracting Provider or Practitioner is a health care provider who does not have a contract with Partnership, but may do business with Partnership for specific reasons, e.g., provision of emergency, out-of-state area, or one-time member care.

R. Notice of Action is a formal letter informing a member of an adverse benefit determination.

~~Q.~~S. Pending~~ing~~ Grievance is a member grievance that could not be fully resolved within 30 calendar days due to outstanding information needed to reach a final determination. These cases remain open beyond 30 days and are tracked until all relevant documentation is obtained and the grievance is adequately addressed and resolved.

~~R. Notice of Action is a formal letter informing a member of an adverse benefit determination.~~

~~S.~~T. Practitioner is a licensed individual who provides medical care.

~~T. Primary Care Provider (PCP) is a physician who has executed an agreement with Partnership to provide the services of a primary care physician.~~

U. Provider is an organization such as a hospital, residential treatment center, or rehabilitation facility.

V. Resolution Letter is a written notice of the outcome of a grievance or an appeal. This letter will include information regarding any applicable next steps and appeal rights.

~~V.~~W. Resolved is when the plan has reviewed all relevant documentation, conducted any necessary investigation, and reached a final determination with respect to each issue raised by the member

~~W.~~X. State Hearing is an appeal filed with the California Department of Social Services. The case is presented to an Administrative Law Judge (ALJ).

IV. ATTACHMENTS:

A. Your Rights Under Medi-Cal Managed Care Letter
B. Member Grievance Form

V. PURPOSE:

To ensure the thorough, appropriate, and timely resolution of member grievances, appeals, and state hearing requests, as well as to ensure Partnership's responsiveness to issues raised by Partnership members. The sections below outline the various components to the Grievance System as well as the process for each type of grievance. This policy is written in accordance with Partnership's contract with the Department of Health Care Services (DHCS) Exhibit A, Attachment 13, 14, All Plan Letter 21-011, Title 28 §1300.68 [except Subdivision §1300.68(c) g) and (h)], §1300.68.01[except Subdivision §1300.68.01(b) and (c)], Title 22 §53858, 42 CFR 438.420(a)(b) and (c) and 42 CFR 438.406(b)(3).

VI. POLICY / PROCEDURE:

A. Member Rights

Partnership takes member grievances, appeals, and state hearings seriously and strives to reach a fair resolution after a thorough evaluation of each issue. Partnership will address all grievances, appeals, and state hearings in a timely and efficient manner and ensure that members are given a reasonable opportunity to present evidence, facts, and laws in support of their grievance. This evidence can be provided in writing, in person, or by telephone. Members have the right to file a grievance or appeal regarding Partnership services. Our benefits and services are described in Partnership's Member Handbook, and include but are not limited to the following:

1. Medical Services
2. Durable Medical Equipment (DME)
3. Vision Services
4. Transportation
5. Enhanced Care Management (ECM)
6. Community Supports (CS)

The objectives of the grievance resolution process are as follows:

1. To protect the rights of members.
2. To ensure that there is no discrimination by Partnership against a member because the member filed a grievance, appeal, or state hearing.
3. To provide orderly and prompt responses.
4. To assist members in accessing medically necessary care on a timely basis.
5. To facilitate the investigation and resolution of medically related issues by the Medical Director and Health Services staff.
6. Submissions of a grievance are not construed as a waiver of the member's right to request a state hearing related to an adverse benefit determination.
7. To report and evaluate aggregate data on member grievances to determine areas requiring corrective action and/or opportunities for improvement. To develop and implement necessary corrective actions with the intent of achieving increased member satisfaction.
8. To ensure that all members have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translation of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems, and other devices that aid disabled individuals to communicate.
9. Ensure members are advised of their rights to submit evidence, facts, and law in support of their grievance and are given 10 calendar days to submit the documentation.

B. Cultural and Linguistic Requirements

1. At any point during the grievance process, a member has the right to language translation, including for all Partnership threshold languages and other non-English languages consistent with Partnership policy MCND9002 Cultural & Linguistic Program Description. This includes standard documents and correspondence. The procedure for review of member grievances ensures that all grievances are reviewed by GCAs for any cultural and linguistic issues. Training is provided on a yearly basis.
   a. Consistent with APL ~~21-004~~25-005, Partnership advises members of its nondiscrimination policy and availability of language assistance services by providing detailed enclosures with all grievances and appeals related member notices. The Nondiscrimination Notice is also available, upon request, in all threshold languages.
   b. Consistent with APL 22-002, Partnership will provide appropriate auxiliary aids and services to members with disabilities, including alternative formats, upon request.

C. How grievance processes are communicated to Partnership members

Members will be advised of their rights and access to grievance processes by the following means:

1. Written Materials – The Partnership member grievance process explaining how to file a grievance is printed in the Partnership Evidence of Coverage/Disclosure Form. It is included in the Partnership Member Newsletter at least once each year, mailed with all grievance and appeal acknowledgment and resolution letters, and on notifications of all treatment authorization request (TAR) denials.

2. Oral Communication – Telephone calls with Partnership staff and Partnership providers and/or practitioners.
3. Contracting Provider – Member grievance forms and a description of the grievance process is available at each contracting provider's office.
4. Partnership Website – Partnership maintains a website on the internet, which provides member grievance forms and information to members on how to file a grievance with Partnership and the expedited medical review process.
5. Items 1, 3 & 4 above all include the toll-free phone number, internet address, physical addresses, and the toll-free phone number for the hearing and speech impaired for Partnership.

D. Member Grievance Process

Grievances may be filed at any time following any incident or action that is the subject of the member's dissatisfaction. Grievances may address, but are not limited to the following issues:

1. Difficulty obtaining an appointment
2. Customer service at the provider's or practitioner's office
3. Billing issues
4. Appointment waiting times
5. Facility conditions
6. Confidentiality issues
7. Refusals of PCP to refer the member for care
8. (placeholder)

E. Grievances Filed

Members can receive assistance in filing a grievance or appeal from a patient advocate, a provider filing on behalf of the member, an ombuds person, or any other persons chosen by the member. There are five (5) methods members or a member's authorized representative may use to file a grievance:

1. By Telephone
   The member can contact Partnership's Member Services department to file a verbal grievance. Partnership used both bilingual staff and interpreter services for members who speak other languages (in accordance with Title 22 CCR 53858). An MSR will record the grievance into Partnership's grievance system.
2. In Writing
   The member may also submit their grievance in writing to Partnership. Upon request, members can request a member grievance form from Partnership or from a contracted provider office. The member grievance form contains information regarding the Partnership member grievance system. An authorized representative form is available upon request.
3. In Person
   Members may also visit Partnership's offices in Eureka, Fairfield, and Redding to request an in-person meeting with an MSR to express their grievance in person. Members can also request assistance in filing a grievance from the MSR or Grievance staff. If the member is under the age of 18, a parent or guardian may file a grievance on their behalf. Members may also fill out an Authorized Representative Form to authorize someone of their choice to represent them.

F. Contracted Provider

Members may file a grievance at one of Partnership's contracting providers' offices. The form titled "Member Grievance Form" is available at all contracted provider offices (in accordance with Title22 CCR 53858).

1. Partnership website
   Members can file a grievance by visiting Partnership's website at: http://www.partnershiphp.org/Members/Medi-Cal/Pages/Complaint,-Appeal-and-Hearing.aspxh and select "Online Grievance Form" to file their grievance electronically through Partnership's secure server. Members can contact Member Services for help navigating the website.

~~G. Delegation~~

~~a. Partnership delegates the grievance process, or portions thereof, Carelon Behavioral Health with the exception of Substance Use Disorder (SUD) related grievances pertaining to the Drug Medi-Cal Organized Delivery System (DMC ODS).~~

~~b. Partnership oversees the delegation of the grievance process conducted by these entities through quarterly reviews of the grievance logs and annual audits.~~

~~c. Partnership requires corrective action plans whenever Partnership designated staff identifies a problem in any of these entities' processes and assigns a deadline for receiving evidence that the problem has been resolved.~~

~~d.~~a. ~~Partnership provides our Grievance & Appeal policies and procedures to subcontractors/delegates and downstream subcontractors/delegates at the time that they enter into a subcontractor agreement. The policy is available via Partnership's Provider Manual, which if accessible via our external website, https://www.partnershipHP.org.~~

~~H.~~G. Resolving Member Grievances

The steps to resolve a member's grievance will occur as outlined below, which is established by the date Partnership receives the grievance.

1. The following documents are sent to the member by the grievance staff within five (5) calendar days of receipt of the member's grievance:
   a. Acknowledgment Letter- acknowledges the date the grievance was received and the name,address, and phone number of the GCA who may be contacted about the grievance or the appeal, and the toll-free phone number for hearing and speech-impaired members.
2. The GCA will conduct a preliminary investigation by contacting medical staff, Partnership's medical staff, or other appropriate individuals to gather information.
   a. If the grievance is about quality of care, diagnosis or treatment, or other medical quality issues,the GCA will consult with the GNS.
   b. As noted in sections I and J, below, the GNS classifies each grievance as clinical or non-clinical. The GNS works with the GCA to address all clinical issues identified in this grievance process. If a grievance is identified as containing both an appeal of a benefit denial and another grievance issue, each of these will be addressed separately, as noted below.
   c. Quality of Care Grievances: The GNS reviews all grievances for potential quality of care issues.If a potential quality of care issue is suspected, the GNS forwards the grievance with supporting documentation to the Chief Medical Officer (CMO) or physician designee for secondary review. If the CMO or physician designee confirms a potential quality issue (PQI), the case is referred to the Patient Safety team within the Partnership Quality Improvement (QI) department for further investigation as described in MPQP1016 Potential Quality Issue Investigation and Resolution. If the physician does not believe a PQI referral is warranted, but the GNS disagrees, the GNS may nonetheless make a PQI referral to the QI department. Quality of care grievances that are found to be without merit by the GNS and the Medical Director are tracked but not referred to the QI department for further investigation and action. Quality of care grievances must be investigated and resolved within 30 calendar days, even if they involve PQI concerns.

d. Other clinical issues identified by the GNS may include access issues, quality of service issues(including alleged discrimination), and quality of facility issues. As the GNS and GCA review incoming grievances, they may determine that the grievance is unfounded, or non-specific and not actionable, and thus not appropriate for referral to another department for investigation. If the non-quality of care grievance requires further investigation, it may be referred to a department within Partnership. Common referrals to other Partnership departments include:
   1) Provider Relations department to address some access issues (for example, phone access and waiting room access) and quality service issues (for example, staff rudeness or clinician miscommunication) with the individual provider or institution. In general, if sufficient and specific information is received in the grievance, such grievances are shared with the management of a site, and a response is requested, including self-identified corrective actions if applicable. If the response is judged to be insufficient by the Grievance or Provider Relations staff, the case may be referred to the CMO or physician designee for immediate review.
   2) Care Coordination department to address access issues, such as finding a specialist or getting in to see their assigned PCP. According to Care Coordination policy and the judgment of the Care Coordination nurses and managers, such cases may be escalated to department directors or a Partnership Medical Director if the resolution of the grievance is not possible through normal interventions by Care Coordination staff, and the member's health is at risk from this lack of resolution of the care coordination issue.
   3) QI's Member Safety-Quality Inspections Team to evaluate facility quality and safety through the Facility Site Review process. The severity and scope of issues are assessed to decide on appropriate follow-up actions.
   4) Health Equity department for accusations of discrimination, lack of translation, or cultural incompatibility. This procedure is described in policy CGA022.
   5) Member Services department management for problems with the initial member services response to grievances.
   6) Compliance department for alleged Health Insurance and Portability and Accountability Act (HIPAA) violations or alleged fraud, waste, or abuse.
   7) Partnership leadership for Partnership process issues identified.

~~e.~~b. Exempt and standard grievances are recorded and documented in the case management system (Everest).

~~f.~~c. Partnership receives grievances when a member is dissatisfied about non-covered services. For grievances involving a decision where the requested service is not a covered benefit, the member is offered the right to file an appeal. The resolution will specify the policy or Evidence of Coverage (EOC) that excludes the service. The resolution letter will identify the document and page number where the provision is found. The resolution letter will direct the member to the applicable section of the EOC containing the provision or provide a copy, if requested, of theapplicable policy. The resolution letter will explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested by the member.

~~I.~~H. Expedited Grievance Process

If a member or a treating physician requests an expedited review or if the MSR or other Partnership staff determines expedited review is needed, the issue will be immediately forwarded to Partnership's Medical Directors to render a determination as to whether an expedited review is appropriate. For expedited grievances regarding the denial of a request for

expedited resolution of an appeal, the Medical Director reviewing the expedited request must have the clinical expertise in treating the member's condition or disease. Resolutions on expedited reviews include an oral and written notification. The process is as follows:

1. Presentation of Evidence, Facts, and Law in Support of Member's Grievance
   Members are advised of their rights to submit evidence, facts, and law in support of their grievance.Members are also informed by the GCA of the limited time available to present evidence due to the nature of the expedited review request.
2. Expedited Review/Grievance Request Approved
   If Partnership's Medical Director determines that the grievance involves an imminent and serious threat to the health of the member, including, but not limited to severe pain, potential loss of life, limb, or major bodily function, the grievance will be handled as an expedited grievance. Grievance staff will notify members verbally that their request for an expedited review has been approved and their case will be processed within 72 hours.
3. Expedited Request Denied
   If Partnership's Medical Director determines the expedited review process is not necessary, the regular grievance process is followed. Members will be notified verbally by Grievance staff that their request for an expedited review has been denied within 72 hours of their request, and the grievance will be processed using the standard timeframe (30 calendar days).

~~J.~~I. Incoming Grievances

1. When a grievance is received into the Grievance unit, the Grievance Associate (GA) or designee will assign the grievance to a GCA using the Grievance Rotation Tracker.
2. Upon assigning the case, an email is generated to all Grievance staff, including the GNS. The GNS will log into the grievance system to evaluate if the case is a clinical or non-clinical grievance. An assessment note will be placed in the grievance system under the "Case Confirmed-Clinical" or "Case Confirmed-Non-Clinical" action by the GNS. Grievance staff will assess the grievance for other referrals to Partnership departments.
3. All clinical cases are reviewed by the GNS or designee to evaluate the need to forward the case to the QI department for a PQI and/or order records for evaluation. The GNS or designee will direct Grievance staff if a PQI referral is needed. The GNS or designee will also make recommendations for casework on any clinical cases.

~~K.~~J. Clinical Grievance

A clinical grievance is defined as any issue concerning the member experience provided by a clinic, hospital, or provider. The types of grievances considered to be clinical in nature include:

1. Quality of Service (by clinic/hospital/provider)
2. Access
3. Quality of Medical Care
4. Denials, Refusals (denial of service/treatment) by the provider, and not by Partnership
5. Cultural, Linguistic, and Health Education (by clinic/hospital/provider)
6. Transportation Related Grievances

~~L.~~K. Non-Clinical Grievance

A non-clinical grievance is defined as any issue concerning the services provided by Partnership and its non-clinical components. The types of grievances considered to be non-clinical in nature include:

1. Billing
2. Benefits/Coverage
3. Cultural, Linguistic, and Health Education (by Partnership staff, Partnership materials)
4. Quality of Service (by Partnership staff)

5. Enrollment (cancellation of coverage, premium increase, denial of enrollment)
6. Transportation Related Grievances

~~M.~~L. Quality of Medical Care Grievances

1. All quality of medical care grievances are reviewed by Partnership clinical staff to assess the member's concern for accuracy. For example, it is not unusual for a patient to feel their treatment was incorrect when in fact it was correct (medical records show that the treatment plan prescribed by the provider is clinically sound).
2. The designated Partnership clinical staff will base their determination on the review of information submitted by the member or their authorized representative. The review will also consist of a review of medical records and claims history.
3. All quality of care grievances are reviewed by a GNS and submitted to the CMO or physician designee for review within a timeframe which is appropriate for the nature of the member's condition. If there is a potential safety issue determined by the GNS or QI Nurse, documentation of the issue will be reviewed by the QI department.

~~N.~~M. Inter-Rater Reliability (IRR)

1. To ensure that grievances are appropriately designated by the GNS as clinical versus non-clinicaland referrals for PQIs are accurately being referred to the QI department, IRR studies will be conducted every quarter.
2. Sample will be prepared by the Grievance Manager or designee.
   a. PQI Referral Sample – A random selection of a minimum of 10 grievances will be pulled for review by the CMO or designee to determine whether the decision to not refer the case to QI as a PQI was appropriate.
   b. Clinical vs Non-Clinical Sample- A selection of a minimum of 10 grievances will be pulled for review by the CMO or designee to determine whether the categorization of a grievance, clinicalor non-clinical, was appropriate.
3. Timeframe – IRRs will be completed on a quarterly basis and reported to the Member Grievance Review Committee.
4. Results - A 90% IRR is required. Where a 90% score is not achieved, additional training will be provided to the GNS by the QI designated staff member, and subsequent IRR studies will be conducted until the passing score is achieved.

~~O.~~N. Grievances Involving Coverage For Terminally Ill Members

A member who has a terminal illness (incurable or irreversible condition that has a high probability of causing death within one (1) year or less) requires the following procedure for addressing a coverage denial.

1. Within five (5) business days of a denial of a benefit for treatment, services, or supplies deemed experimental as recommended by a participating plan provider, Partnership will provide to the member the following information.
   a. A statement setting forth the specific medical and scientific reasons for denying coverage.
   b. A description of alternative treatment services or supplies covered by the plan, if any. Compliance with this subdivision, Section 1368.1 of the Act, by a plan shall not be construed to mean that the plan is engaging in the unlawful practice of medicine.
   c. Copies of the plan's grievance procedures or grievance form. The grievance form shall provide an opportunity for the member to request a conference as part of the plan's grievance system provided under Section 1368.1.
2. If the member requests a conference, the conference will be held within five (5) business days if the treating participating physician determines, after consultation with the health plan Medical Director,based on standard medical practice, that the effectiveness of either the

proposed treatment, services,or supplies, or any alternative treatment, services, or supplies covered by the plan, would be materially reduced, if not provided at the earliest possible date. The member will also be given the option to extend the timeframe to request to participate in the conference up to 30 calendar days.

O. Grievances related to Transgender (Trans) inclusive care (See DHCS APL 24-017.)

A member has the right to file a grievance for the failure to provide Trans inclusive care. "Trans-inclusive health care" means comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex, (TGI), honors an individual's right to make their own choices about their body, does not make assumptions about an individual's gender, accepts gender fluidity and nontraditional gender presentation, and treats everyone with compassion, understanding, and respect.

1. Partnership's Grievance d~~D~~epartment will track and report the grievances to DHCS through the Monthly Managed Care Program Data (MCPD) submissions to DHCS under the "Gender Affirming Care" benefit type.
2. If a grievance is resolved in the member's favor, the Grievance d~~D~~epartment will report the need for refresher TGI training to the designated training department on the monthly basis. The report will include the case number, the case closed date, the individual(s), position title, and affiliation with Partnership.

P. Contacting Providers Regarding Grievances Filed Against Them

1. Members are notified at the time of the filing that their grievance may be sent to the provider they are grieving about to receive a response regarding their grievance. Members may request that any notification to their provider or practitioner regarding the grievance be delayed until a relationship with a new provider or practitioner is effective. Such a request is noted when the grievance is filed by the Partnership staff member. Partnership staff will assure the member that there will be no discrimination against them by Partnership or its providers or practitioners on the grounds that they have filed a grievance.

Q. Member Grievance Correspondence

1. There are two (2) types of member correspondence issued by grievance staff: the acknowledgment letter and the resolution letter. When translation is required, a fully translated version of these letters will be mailed. Of note, each member's correspondence includes Partnership's Nondiscrimination notice and the Your Rights under Medi-Cal Managed Care notice. For discrimination grievances,the member will be provided information on disputing or appealing the decision with the U.S. Department of Health and Human Services, Office of Civil Rights.
   a. Acknowledgment Letter
      1) An acknowledgment letter is issued within five (5) calendar days of receipt of a grievance. This letter will include the date of receipt, name, address, and phone number of the Partnership GCA who has been assigned to their case, and the phone number for the California Relay Service.
      2) Exception to sending the acknowledgment letter
         a) If a grievance is resolved within five (5) calendar days of receipt, the GCA will issue only the resolution letter.
   b. Resolution Letter
      1) The GCA mails a resolution letter within 30 calendar days of the date the grievance was received. The letter summarizes the grievance and describes the resolution. If the outcome of the grievance includes an adverse benefit decision, the member will be advised of how to appeal the decision in the resolution letter, and the "Your Rights" attachment will be included.

R. Time Frame - Grievance
1. Standard:
   a. Member grievances are resolved within 30 calendar days of the member's request for a grievance [Title 22 CCR 53858 (f) (1)]. In the event that resolution of a standard grievance is not reached within 30 calendar days~~,~~ the grievance will be placed in pending status to allow additional time to gather necessary documentation and conduct further investigation. Partnership will notify the member in writing of the status of the grievance and the estimated date of resolution.
2. Expedited:
   a. Grievance staff will process the case within 72 hours from the date of receipt of the grievance.

S. Grievance File Maintenance

Documentation for each grievance is maintained by the GCA. Documentation may include, but is not limited to, the following:

1. Memo outlining the grievance and the steps taken to resolve the issue;
   a. The date of the call
   b. The name of the complainant
   c. The complainant's member identification number
   d. The nature of the grievance
   e. The nature of the resolution
   f. The name of the plan representative who took the call and resolved the grievance
   g. Request for an Appeal or Grievance Form
   h. Acknowledgment Letter
   i. Additional written correspondence between Partnership, the member, providers and/or practitioners
   j. Billing and claims information (if appropriate)
   k. Medical Records Release Form (if appropriate)
   l. Medical records (if appropriate)
   m. Grievance resolution letter
   n. Notice of unresolved grievance (if appropriate)

Copies of grievances and responses shall be maintained by Partnership for ten (10) years.

VII. MEMBER APPEAL PROCESS

A. Time Frame – Appeal

Appeals must be filed within 60 calendar days following any denial action that is the subject of the member's dissatisfaction. Appeals can be filed by the member, their authorized representative, or a provider on behalf of a member either orally or in writing. If a member files an oral appeal, the MSR or Grievance staff will request the member to provide a written, signed appeal. The oral appeal establishes the filing date of the appeal. Partnership will proceed with the handling of the appeal if the written signed appeal is not received. There is only one level of appeal for members at the MCP level, per 42 CFR 438.402(b).

B. Resolving Member Appeals
1. Confirmation of member appeal
   a. Upon receipt of an appeal, Grievance staff conducts a preliminary investigation of the request byidentifying the substance and reason for the appeal and reviewing any additional clinical and/or other information submitted with the appeal. The Grievance staff will review any previous denials, the appeal history, and the timeline of activities leading up to

the current appeal, before contacting the treating provider, Partnership staff and any other appropriate individuals to gather information. Grievance staff will also contact the member to confirm the appeal and provide the member an opportunity to submit a statement for the reason for the appeal. When investigating the appeal, Partnership staff will not give deference to the denial decision.

2. Presentation of evidence, facts and law in support of member's grievance
   a. Members are advised of their rights to submit evidence, facts and law in support of their grievance and are given 10 calendar days to submit the documentation. Upon request, the member has the right to request reasonable access to their appeal case file, including medicalrecords and any other documents before and during the appeal process.
3. Continuation of benefits (also known as aid paid pending)
   a. Grievance staff will assess if the member's benefit/service can continue pending the outcome of the appeal decision.
      1) The ~~criterion~~ criteria for continuation of benefits are listed below per 42 CFR 438.420
         a) Requests must occur within 10 calendar days from the date the NOA was mailed to the member.
         b) The appeal must be filed timely.
         c) The appeal involves the termination, suspension, or reduction of a previouslyauthorized course of treatment.
         d) The service was ordered by an authorized provider.
         e) The original period covered by the original authorization has not expired.

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   b. Duration of continued or reinstated benefits
      1) If Partnership continues or reinstates the member's benefits while the appeal is pending, the benefits will be continued until one of the following occurs:
         a) The member withdraws the appeal.
         b) 10 days after Partnership mails the NAR, or, if the member requests a state hearing within the 10-day timeframe, the benefits will be continued until a state hearing decision is reached.
         c) The state hearing office issues a hearing decision adverse to the member.
         d) The time period or service limits of a previously authorized service has been met.
   c. Partnership must pay for disputed services if the member received the disputed services while the appeal or state hearing was pending. Consistent with 22 CCR § 51002 regarding prohibitions in collecting reimbursement from Medi-Cal beneficiaries, Partnership must ensure the member is not billed for disputed services even if the final resolution of the appeal or state hearing is adverse to the member, that is, upholds Partnership's adverse benefit determination.

C. Examples of Member Appeals
   1. An appeal is a member's request for reconsideration of an initial decision resulting in the denial ofservice, benefit or claim. Appeals may address, but are not limited to, the following issues:
      a. Appeals of denied TARs
      b. Appeals of level-of-care determinations
      c. Appeals of Partnership claims payment denials
      d. Appeals of primary care physician request for disenrollment
   2. Members filing grievance regarding their Medi-Cal eligibility are referred to their local county Health and Social Services Department or the Social Security Administration office for assistance.

D. Review of Appeals

1. Medically Related Appeals
   a. Grievance staff will refer medically related appeals and all documentation to the Medical Director for review who was not part of the original decision to deny, nor a subordinate of theoriginal decision maker, unless the final decision is in favor of the member (Contract Exhibit A,Attachment 14, 2, F). The "health care professional with appropriate expertise" is not determined by specialty, but by expertise and experience which varies with the career and experience of the particular Medical Director. In general, if the appeal is about a child, then a pediatrician or family physician Medical Director would be consulted. If the appeal is about an adult, then one of the internal medicine physicians or family physicians would be consulted. If the Medical Director reviewing the appeals feels that the particular clinical issue in question is outside their expertise or experience, they may refer the case to another Medical Director for review (who was not part of the original decision to deny, nor a subordinate of the original decision maker) or to an outside physician consultant with expertise in this area.
      1) Ordering Medical Records
         The Medical Director will direct grievance staff to order medical records from primary careproviders and/or other treating physicians if needed. Medical providers are expected to respond to requests for medical records within five (5) working days.
2. Other Appeals
   a. Appeals regarding claims, billing issues, special cases status and other non-medically related cases may be presented to the Member Grievance Review Committee for departmental review of the resolution as needed. The staff reviewing the appeal will be individuals who were not involved in the initial determination nor a subordinate of the original decision maker unless thefinal decision is in favor of the member.
3. Expedited Appeals
   a. Requests for expedited appeals will be immediately forwarded to a Medical Director for review. If the expedited review is deemed medically necessary, the appeal resolution will be provided within 72 hours. The GCA will make reasonable efforts to notify the member orally and provide written notice within 72 hours.

E. Member Correspondence
1. There are two (2) types of member correspondence that are issued by Grievance staff. When translation is required, a fully translated version of these letters will be mailed.
   a. Acknowledgment Letter
      1) An acknowledgment letter is issued within five (5) calendar days of receipt of an appeal.
      2) This letter will include the receipt date, name, address, and phone number of the GCA who has been assigned to their case and the phone number for the California Relay Service.
      3) Exception to sending the acknowledgment letter
         a) If an appeal decision is rendered within five (5) calendar days of receipt, the GCA will issue only the appeal decision letter.
      4) Denial of Expedited Review
         a) If a request for an expedited review has been denied by a Medical Director, grievance staff will also include in the acknowledgment notice that the request for an expedited review has been denied and the reason why the request was denied.
   b. Notice of Appeal Resolution Letter
      1) For preservice and post-service appeals, the GCA mails an appeal resolution letter within 30 calendar days from the date the appeal was received. The letter summarizes the appeal and describes the appeal decision. Appeal decisions to uphold the denial

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include the rationale specific to the member's condition or reason for the request so the member or their representative understand what is needed to file the next level of appeal. The letter is written in easy-to-understand language that includes the complete explanation of the grounds for the denial, without the use of abbreviations or acronyms that are not defined or health care procedure codes that are not explained. The appeal resolution letter will reference the benefit provision, guideline, protocol or criteria, which the appeal decision is based upon. Also, the letter will notify members that they have access to all copies and documents that are relevant to the appeal, free of charge. The appeal resolution letter will also list the titles and qualifications, including specialties of individuals participating in the appeal review. All appeal resolution letters will include state hearing rights when appropriate. If any appeal resolution timeframe is not met by Partnership (i.e., standard or expedited), the member is considered to have exhausted Partnership's appeals process and may proceed to a state hearing.

2) Partnership will authorize or provide services for overturned adverse benefit determinations (as theresult of an appeal determination) as expeditiously as the member's health condition requires, but no later than 72 hours after the decision.

c. Notification

Each notification template (i.e., Notice of Appeal Resolution, "Your Rights" attachments) when informing members of a denial or appeal resolution will either be DHCS templates or be submitted to DHCS for review and approval prior to use. Member correspondence includes Partnership's ~~Language Taglines~~Notice of Availability, Nondiscrimination notice, and "Your Rights Under Medi-Cal Managed Care." ~~(~~(See MCNP9004 Regulatory Required Notices Attachments C and D.) These notices provide the member information regarding Partnership's grievance process including the member's rights to file a state hearing.

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VIII. MEMBER STATE HEARING PROCESS

A. Member State Hearing Timeframe

State Hearings must be filed within 120 calendar days following the date of the NAR that is subject of the member's dissatisfaction. State hearings can be filed by the member or their authorized representative. For the purpose of this policy, the term "member" will be used to refer to the member and their authorized representative unless otherwise noted

B. Filing a State Hearing

1. Members have the right to file a state hearing after exhausting Partnership's appeal process or in instances of deemed exhaustion as defined in III.F above.
2. Members can file a state hearing with the California Department of Social Services. There are four ways to request a state hearing.
   a. By Phone

      Members can call the State Hearing Office at 1-800-743-8525. Hearing-impaired members mayuse TTY by calling 1-800-952-8349.

   b. By Mail

      Members can send a hearing request form or their own written request directly to:
      California Department of Social Services
      State Hearings Division
      P.O. Box 944243, Mail Station 9-17-433
      Sacramento, CA 94244-2430

   c. By Fax

Members can fax their hearing request form or their own written request directly to the state at 916-309-3487 or 833-281-0903.

d. In Person

Members can also turn in their hearing request form or their own written request at one of the local county offices.

3. Partnership will assist members with preparing for the State Hearing by providing the member with their case file, including medical records, other documents and records, guidelines, clinical criteria, and any new or additional evidence relied on for the initial or appeal denial.

C. Responding to State Hearing Requests

1. Notification of Hearing Request

Partnership receives ~~a~~ notice of the member's request for a state hearing from the SCOPE unit in theCalifornia State Department of Social Services and from the Office of the Ombudsman. Notifications include the case name, the request for hearing, and the filing date.

2. Review of Hearing Request

Upon receipt, grievance staff conduct~~s~~ a preliminary investigation of the request by contacting the treating provider, Partnership staff, and any other appropriate individuals to gather information. Grievance staff will also contact the member to confirm the state hearing and also to ~~also~~ provide the member an opportunity to submit a statement for the reason for the hearing. If the member has not opened an appeal with Partnership, staff will offer to open an appeal as well.

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3. Parties to State Hearings

The parties to the state hearings include Partnership, the member, and their representative or the representative of a deceased member's estate.

4. Continuation of Benefit

a. Upon request, the member's benefit/service can continue pending the outcome of the state hearing decision.

b. The criteria for continuation of benefits are listed below per 42 CFR 438.420.

1) Request must occur within 10 calendar days from the date the notice of action was mailed to the member.
2) The state hearing must be filed timely.
3) The state hearing involves the termination, suspension, or reduction of a previously authorized course of treatment.
4) The service was ordered by an authorized provider.
5) The original period covered by the original authorization has not expired.

c. Duration of continued or reinstated benefits

If Partnership continues or reinstates the member's benefit while the statehearing is pending, the benefits will be continued until one of the following occurs:

1) The member withdraws the state hearing
2) The state hearing office issues a hearing decision adverse to the member
3) The time period or service limits of a previously authorized service have been met

d. Disputes regarding continuation or reinstated benefits

In the event grievance staff finds that the member does not meet the criteria for continuation or reinstated benefits, the member will be referred back to the Office of the Ombudsman to reviewand render a decision if aid paid pending applies.

D. Creation of Statement of Position

Grievance staff, while working with clinical Partnership staff, will prepare the Statement of Position. The Statement of Position will state the following information:

1. The Issue
2. The Background
3. Pertinent Facts
4. Guidelines
5. History of TAR
6. Applicable Law
7. Conclusion

E. Submission of Statement of Position

Statements of Positions are submitted directly to the state hearing SCOPE office, the Office of the Ombudsman, and to the member, at least two (2) working days prior to the scheduled hearing. To ensure receipt prior to the hearing. Partnership will upload it to the Appeals Case Management System (ACMS). The ACMS is the online website used to manage State Hearings. Grievance staff will send the Statement of Position via FedEx to the member. FedEx envelopes will require direct signature for delivery. In the event a physical address cannot be obtained or is not available, Statement of Positions will be mailed via certified mail to the member's PO Box.

F. Representation during the State Hearing

1. Grievance staff will appear at the state hearings to represent Partnership and explain Partnership's position. Appropriate Partnership staff and/or other representatives may be asked to appear at the state hearings asdetermined necessary by the Medical Director.

G. Expedited State Hearings

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1. Within two (2) working days of being notified by the Department of Social Services (DSS) or the Office of the Ombudsman that a member has filed a request for a state hearing which meets the criteria for expedited resolution, Partnership will deliver directly to the designated/appropriate DSS Administrative Law Judge, all information and documents which either support, or which Partnership considered in connection with, the action which is the subject of the expedited state hearing. This includes, but is not limited to, copies of the relevant TAR, NOA, and NAR. If the NOA or NAR are not in English, fully translated copies shall be transmitted to DSS along with copies of the original NOA and NAR. One or more plan representatives with knowledge of the member's condition and the reason(s) for the action, which is the subject of the expedited state hearing, shall be available by phone during the scheduled state hearing.

H. State Hearing Decisions

1. Per 42 CFR 431.244(f)(1), the State must issue a final decision on the state hearing within 90 calendar days of the date of request for hearing. This timeframe is detailed in the "Medi-Cal Your Rights" document enclosed with NOA/NARs. The notice of the Administrative Law Judge's decision will provide members with information on how to request a rehearing of their issue if they disagree with the decision. A member may obtain judicial review of the decision by filing a petition in Superior Court under Code of Civil Procedure§1094.5 within one year after the date of the decision.
   a. Upheld Decisions
      Decisions favorable to Partnership will be noted in the grievance system case file and closed. A copy of the decision is forwarded to the department that rendered the adverse decision to the member.
   b. Overturned Decisions
      Adverse decisions to Partnership will be noted in the grievance system case file. A copy of the decision is forwarded to the department that rendered the adverse decision to the member and will be given 72 hours to overturn the decision; expedited hearings will require the denial be overturned within 24 hours. Once confirmation is received that the

decision is overturned, grievance staff will contact the member and the Office of the Ombudsman and verbally notify that the denial has been overturned. Interactions with the member and the Office of the Ombudsman are documented in the grievance system case file, and the case is closed once a copy of the overturned decision is available. Partnership will pay for disputed services if the member received the disputed services while the State Hearing was pending.

I. State Hearing File Maintenance

1. All documentation relating to a state hearing is scanned and uploaded into the grievance systemunder the member's case number. Documentation includes but is not limited to the following:
   a. Case Summary (produced out of grievance system) outlining the state hearing and the stepstaken to resolve the issue
   b. Notification of State Hearing
   c. All written correspondence between Partnership, the member, providers, and/or practitioners
   d. Billing and claims information (if applicable)
   e. Statement of Position
   f. Administrative Law Judge's decision on the hearing

IX. MONITORING AND REPORTING ~~of Timeliness of Grievances~~

A. Timeliness Monitoring and Risk Mitigation

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1. ~~All grievances, appeals, and state hearing requests with their resolutions are documented in the grievance system.~~ The department maintains a real-time tracker for all grievance and appeal cases that exceed regulatory timeframes. This tracker shall be reviewed weekly to identify trends, workload issues, or potential barriers to timely resolution. In the event of sustained non-compliant trends, such as a pattern of late cases over a tolling 30-day period, leadership shall conduct a resource capacity review to assess workload distribution and staffing levels. If staffing shortages or case volume exceed available capacity, the department shall:
   a. Temporarily reassign cases to balance workloads
   b. Notify executive leadership of staffing gaps that may require additional hiring or support
   c. Implement mitigation measures such as increased supervision, adjusted assignments, or telework restrictions to prioritize timely case resolution
2. All grievances, appeals, and state hearing requests with their resolutions are documented in the grievance system.
~~1.~~3. At the end of each month, the grievance system manager or their designee will review the grievance staff cases as part of their performance review. ~~In addition, all grievances and appeals pending and unresolved for 30 days or more are reviewed.~~
~~2.~~4. Monthly meetings, or more often if needed, are conducted with staff to ensure that member grievances and appeals are resolved within established timeframes as well as to review open member grievances and appeals and determine appropriate resolutions.

B. Reporting Grievances to HealthPlan Committees for Review

1. Under the direction and oversight of the CMO, individual and aggregate data on member grievances and appeals are reviewed by the Member Grievance Review Committee(MGRC), Internal Quality Improvement (IQI), and Quality/Utilization Advisory Committee (Q/UAC) no less than four (4) times per year. Each committee reviews the data for possible actions as determined appropriate according to Partnership Quality Assurance Protocol. On a quarterly basis, all grievances related to access to care, quality of care and denial of services will be

reviewed and analyzed by the committee to remedy any problems identified. On an annual basis, Partnership's ~~Consumer~~ Community Advisory Committee (CAC) will review the written record of Grievance ~~&~~and Appeals.

X. EXEMPT GRIEVANCE PROCESS

A. Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the end of the following business day, are categorized as exempt grievances and are exempt from the requirement to send a written acknowledgment and response. If the exempt grievance is resolved by theend of the following business day, the grievance will remain categorized as "exempt". If the exempt grievance is not resolved by the end of the following business day, it will be processed as a standard grievance, with the rights of the standard grievance timelines. All grievances are clearly listed on a universal grievance log.

B. All exempt grievances are reviewed by the GNS within three (3) days to determine whether the grievance has potential quality of medical care issues. The GNS will base their determination on the review of information submitted by the member or authorized representative. The review may also consist of a review of medical records already obtained by Partnership for utilization management purposes, care coordination notes, and claims history. If the GNS determines a clinical issue identified, they will submit the exempt grievance to the CMO or physician designee for review within a timeframe which is appropriate for the nature of the member's condition. Either the GNS or the CMO/physician designee may determine, based on their clinical judgement, that the exempt grievance warrants individual attention by a Partnership department, and refer the case for intervention (similar to interventions done for non-exempt grievances, summarized in section G.2.d, Resolving Member Grievances, above).

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XI. REPORTING REQUIREMENTS

A. Partnership maintains an inquiry log of all requests for information that do not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits,or other Partnership processes.

B. Partnership maintains and has available for DHCS' review, Partnership's grievance logs, including copies of the grievance logs of any subcontracting entity delegated with the responsibility to maintain and resolve grievances, and the Partnership exempt grievance log. Grievance logs are maintained based on the requirementsset forth in Title 22 CCR Section 53858 (e).
   1. Date and time the grievance was filed
   2. The name of the member filing the grievance
   3. Member identification number
   4. The name of the person receiving the grievance
   5. A description of the grievance
   6. A description of the action taken to resolve the grievance
   7. The proposed resolution by the plan
   8. The name of the person responsible for resolution
   9. The date of notification to the member

C. The information contained in this log shall be reviewed by Partnership's Board and Partnership's CMO or physician designee on an annual basis.

XII. MEDICAL RECORDS/DOCUMENT REQUESTS:

A. Members and providers may call to request materials and/or letters related to their

Grievance/Appeal/State Hearing to be sent to them by mail or by fax.

B. Members can request their case file free of charge by calling Partnership's Member Services department.

XIII. REFERENCES:

A. Partnership Contract 08-85215 A19
B. 22 CCR §53858
C. 22 CCR § 51002
D. 28 CCR §1300.68 [except subdivision §1300.68(c), (g) and (h)]
E. 28 CCR §1300.68.01[except subdivision §1300.68.01(b)and (c)]
F. 42 CFR 438.420(a)(b) and (c)
G. 42 CFR 438.406(b)(3)
H. California Department of Health Care Services (DHCS) All Plan Letter (APL 25-005 Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, and Alternative Formats (revised Feb. 12, 2025 supersedes APL 21-004)
I. DHCS APL 24-017 Transgender, Gender Diverse or Intersex Cultural Competency Training Program and Provider Directory Requirements (Dec. 5, 2024)
~~H.~~J. DHCS APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates (Aug. 31, 2021, supersedes APL17-006)
~~I.~~K. DHCS APL 22-002 Alternative Format Selection for Members with Visual Impairments (March 1~~4~~2, 2022)
~~J.~~L. NCQA -2025 Standards and Guidelines: Member Experience 7A-7B
~~K.~~M. NCQA 2025 Standards and Guidelines: Utilization Management 8A-9A-9B-9C-9D

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XIV. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

XV. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Grievance & Appeals Compliance Manager

XVI. REVISION DATES:

Medi-Cal
MS- 06/4/99; 04/25/00; 05/17/00; 06/19/00; 07/09/02; 10/25/02; 02/19/03; 02/23/04; 05/11/04; 01/17/06;01/16/08; 03/18/09; 07/21/10; 03/20/13; 11/18/15; 06/21/17; 03/13/19; 3/11/20; 5/12/21; 08/10/22; 10/11/23; 02/14/24; 2/12/25; 10/08/25

PREVIOUSLY APPLIED TO: N/A

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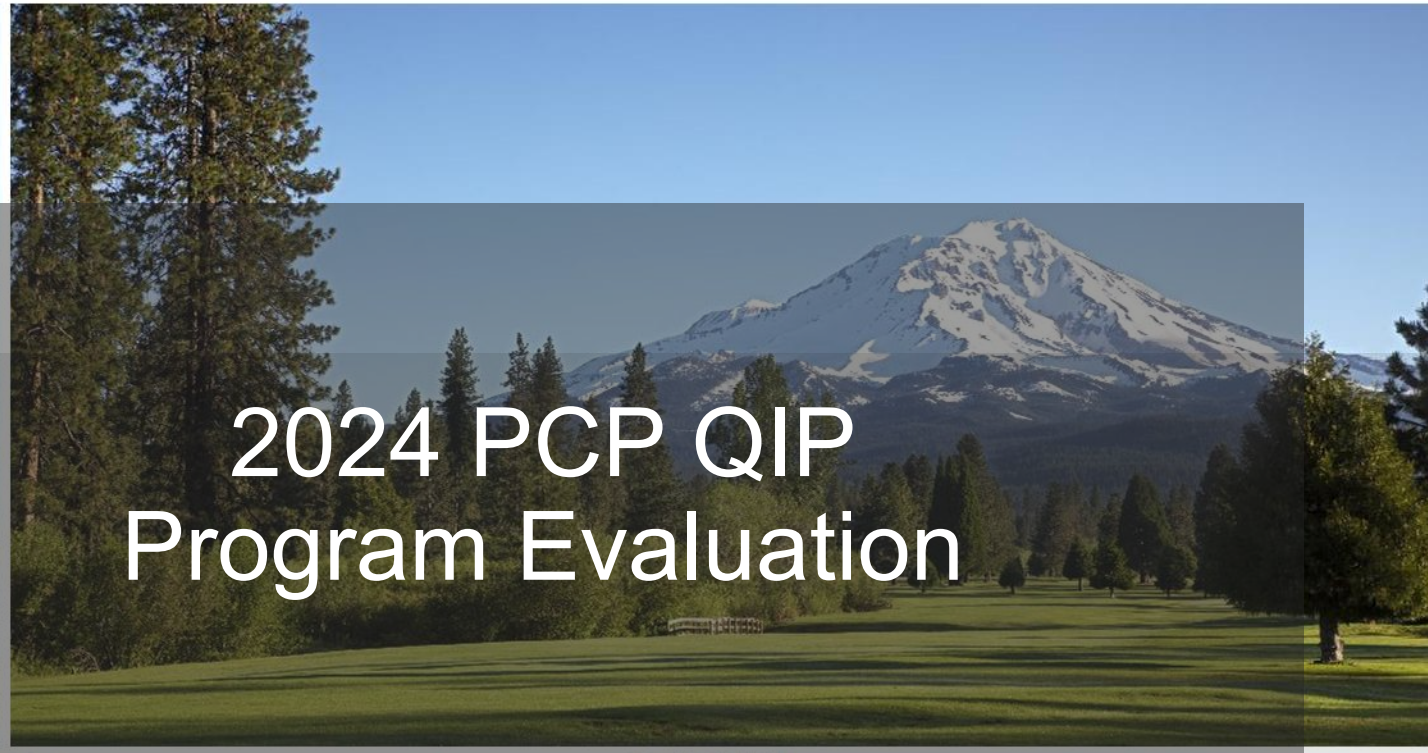
PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

ACCREDITED NCQA HEALTH PLAN



2024 PCP QIP Program Evaluation

Prepared by:
Athena Beltran-Nampraseut
September 2025

Contents

2024 Program Overview

2024 Program Adjustments and Changes

2024 PCP Program Performance

2024 Payout Overview

2024 Summary

2024 PCP QIP Overview

Clinical Core Measurement Set

PCP QIP is a Calendar Year program: January 1 – December 31

CLINICAL DOMAIN										
PRACTICE TYPE			MEASURE	MEASURE CATEGORY	AGE RANGE	TARGETS		FULL / PARTIAL POINTS		
FAMILY	INTERNAL	PEDS				FULL 90th	PARTIAL 50th	FAMILY	INTERNAL	PEDS
✓	✓		Comprehensive Diabetic Care - HbA1c Control	CHRONIC DISEASE MANAGEMENT	18 - 75 YRS	60.34%	52.31%	6 / 5	12 / 9	--
✓	✓		Comprehensive Diabetic Care - Retinal Eye Exams		18 - 75 YRS	63.33%	52.31%	5 / 4	6 / 4	--
✓	✓		Controlling High Blood Pressure		18 - 85 YRS	72.22%	61.31%	6 / 5	10 / 7	--
✓		✓	Immunization for Adolescents - Combination 2	PREVENTATION AND SCREENING	13 YRS	41.12%	35.04%	6 / 4	--	13 / 11
✓	✓		Breast Cancer Screening		50 - 74 YRS	63.37%	52.20%	6 / 5	15 / 11	--
✓	✓		Cervical Cancer Screening		21 - 64 YRS	66.48%	57.11%	6 / 5	15 / 11	--
✓		✓	Childhood Immunization Status - Combination 10		2 YRS	45.26%	30.90%	6 / 4	--	13 / 11
✓	✓		Colorectal Cancer Screening**		45 - 75 YRS	39.81%**	31.68%**	5 / 4	12 / 9	--
✓		✓	Lead Screening in Children*		2 YRS	*62.79%	--	6 / -	--	8 / -
✓		✓	Child and Adolescent Well Care Visit	PEDIATRIC ACCESS	3 - 17 YRS	61.15%	48.07%	9 / 7	--	21 / 17
✓		✓	Well Child Visits in the First 15 Months of Life		15 MONTHS	68.09%	58.38%	9 / 7	--	13 / 10

**Partial Points target set at 25th%ile & 50th%ile for Full Points

* New Measure: No Partial Points and Full Points set at 50th%ile target

Note: Expansion providers' Full Points targets were 50th%ile, No Partial Points

Non-Clinical & Patient Experience Measurement Set

PRACTICE TYPE			NON-CLINICAL			FULL / PARTIAL POINTS		
FAMILY	INTERNAL	PEDS				FAMILY	INTERNAL	PEDS
HOSPITAL UTILIZATION								
✓	✓		Ambulatory Care Sensitive Admissions	FULL POINT TARGET 8.86 (60th Percentile)	PARTIAL POINT TARGET 10.62 (70th Percentile)	5 / 4	5 / 4	--
✓	✓		Risk Adjusted Readmission Rate	FULL POINT TARGET **SCORE <1.0**	PARTIAL POINT TARGET **≥1.0 - 1.2**	5 / 4	5 / 4	--
PRIMARY CARE UTILIZATION								
✓	✓	✓	Avoidable ED Visits	FULL POINT TARGET 9.23 60th Percentile	PARTIAL POINT TARGET 11.43 70th Percentile	5 / 4	5 / 4	10 / 8
✓	✓	✓	PCP Office Visits	FULL POINT TARGET Greater than 1.9 visits per member per year on average	PARTIAL POINT TARGET Between 1.6 and 1.9 visits per member per year on average	5 / 4	5 / 4	10 / 8
PATIENT EXPERIENCE								
✓	✓	✓	Patient Experience	**CG-CAHPS**	**ACCESS**	**COMMUNICATIONS**	10 / 9	10 / 8	12 / 10
					FULL POINTS 50TH Percentile (41.97%)	FULL POINTS 50TH Percentile (70.31%)			
					PARTIAL POINTS 25TH Percentile (34.83%)	PARTIAL POINTS 25TH Percentile (65.12%)			
				SURVEY OPTION	**FULL POINTS**	**PARTIAL POINTS**			
					PARTS 1 AND 2	PARTS 1 OR 2			

Unit of Service Measurement Set

UNIT-OF-SERVICE				
PRACTICE TYPE			MEASURE	CRITERIA
FAMILY	INTERNAL	PEDS		
✓	✓		Advance Care Planning	Minimum 1/1000th (0.01%) of the sites assigned monthly membership 18 years and older for: • $100 per Attestation, maximum payment $10,000 per site. • $100 per Advance Directive/POLST, maximum payment $10,000 per site
✓	✓	✓	Extended Office Hours	For Capitated PCPs only. Quarterly 10% of capitation for PCP sites must be open for extended office hours the entire quarter an additional 8 hours per week or more beyond the normal business hours (reference measure specification). Non-capitated PCPs will have additional funding added to the Core measure set.
✓	✓	✓	PCMH Certification	$1,000 yearly per site, for achieving or maintaining PCMH accreditation.
✓	✓	✓	Peer-led Group Visits	$1,000 per group, either new or existing. (Maximum of 15 groups per parent organization).
✓	✓	✓	Health Information Exchange	One time $3000 incentive for signing on with a local or regional health information exchange; Annual $1500 incentive for showing continued participation with a local or regional health information exchange. The incentive is available at the parent organization level.
✓	✓	✓	Health Equity	$2000 per parent organization for submission of Health Equity implementation initiative or an annual updated Health Equity report.
✓		✓	Dental Fluoride Varnish	Two Part: 1) $1,000 per parent organization for submission of proposed plan to implement fluoride varnish application in the medical office. 2) $5 per application when the minimum of 2% of sites assigned members 6 months to 5 years old received DFV administered by a non-dental practitioner at least once in the measurement year.
✓	✓	✓	Tobacco Screening	$5.00 per tobacco use screening or counseling of members 11- 21 years of age after 3% threshold of assigned members screened.
✓	✓	✓	Electronic Clinical Data Systems (ECDS)	Maximum of $5,000 per parent organization. Allowance of data exchange from Provider Electronic Health Records to Datalink in order to capture clinical screenings, follow-up care and outcomes. Participation to include data collection of specific clinical components for all Partnership members within your organization. 1. $2,000 per Parent Organization who signs an agreement with DataLink to allow the extraction of HEDIS data by September 30, 2024. Agreements signed after September 30, 2024 will be eligible for half payment ($1,000) through December 31, 2024 2. An additional $3,000 per Parent Organization when DataLink receives HEDIS data abstraction successfully from EMR by October 31, 2024 and the Parent Organization responds timely to request for verification.
✓		✓	Early Administration of 1st HPV Dose	Administer the first HPV dose by the age of 12 in order to have the required 6-month pause between the first and 2nd dose and another 6 months to administer the 2nd HPV dose before the 13th birthday $50 per HPV dose given before age 12.
✓		✓	Early Administration of Initial Flu Vaccine Series (Two Doses)	Early administration of influenza and to complete administration of the 2nd dose within 60 calendar days of the 1st dose. $50 per two dose series completed by 15 months of age, with the 2 doses up to 60 days apart.

2024 PCP Program Adjustments/Changes

Core Measurement Sets Adjustment 2023 ➡ 2024

2023 Core Measurement Set
Clinical Measures
Asthma Medication Ratio
Breast Cancer Screening
Cervical Cancer Screening
Child & Adolescent Well Care Visits
Childhood Immunization Statue: Combo 10
Colorectal Cancer Screening
Comprehensive Diabetes Care: HbA1c Control
Comprehensive Diabetes Care: Retinal Eye Exams
Controlling High Blood Pressure
Immunization of Adolescents - Combo 2
Well-Child Visits in the First 15 Months of Life
Non-Clinical Measures
Ambulatory Care Sensitive Admissions
Risk Adjusted Readmissions
Aviodable ED Visits/1000 member per year
Patient Experience
PCP Office Visits
Monitoring Measures

2024 Core Measurement Set
Clinical Measures
~~Asthma Medication Ratio~~
Breast Cancer Screening
Cervical Cancer Screening
Child & Adolescent Well Care Visits
Childhood Immunization Statue: Combo 10
Colorectal Cancer Screening
Comprehensive Diabetes Care: HbA1c Control
Comprehensive Diabetes Care: Retinal Eye Exams
Controlling High Blood Pressure
Lead Screening in Children
Immunization of Adolescents - Combo 2
Well-Child Visits in the First 15 Months of Life
Non-Clinical Measures
Ambulatory Care Sensitive Admissions
Risk Adjusted Readmissions
Aviodable ED Visits/1000 member per year
Patient Experience
PCP Office Visits
Monitoring Measures

Key: New Measure & ~~Removed Measure~~

UOS Measurement Sets Adjustment 2023 ➡2024

2023 Unit of Service Measures
Advance Care Planning
Extended Office Hours
PCMH Certification
Peer-led Self-Management Support Groups
Health Information Exchange
Health Equity
Blood Lead Screening
Dental Fluoride Varnish
Tobacco Screening
Electronic Clinical Data Systems (ECDS)

2024 Unit of Service Measures
Advance Care Planning
Extended Office Hours
PCMH Certification
Peer-led Self-Management Support Groups
Health Information Exchange
Health Equity
~~Blood Lead Screening~~
Dental Fluoride Varnish
Tobacco Screening
Electronic Clinical Data Systems (ECDS)
Early Administration of 1st HPV Dose
Early Administration of Initial Flu Vaccine Series (Two Doses)

Key: New Measure & ~~Removed Measure~~

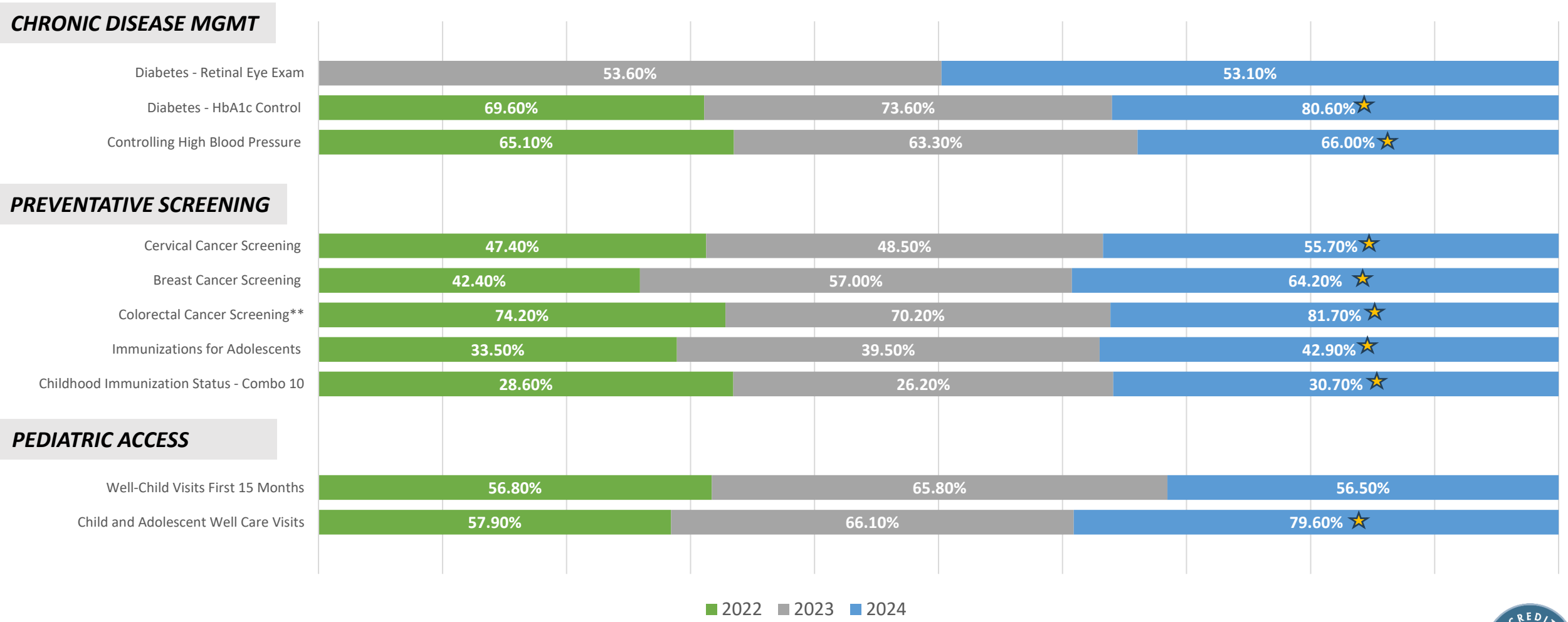
2024 PCP Program Performance

Plan-wide Performance
Clinical Domain YoY

PLANWIDE				
Clinical Core Measurement Set	**2022**	**2023**	**2024**	**23-24 Relative Change**
Breast Cancer Screening	52.74%	54.87%	54.20%	-1.22%
Cervical Cancer Screening	57.74%	56.96%	52.15%	-8.44%
Child and Adolescent Well Care Visits	51.30%	53.37%	55.48%	3.95%
Childhood Immunization Combo 10	30.35%	27.98%	24.11%	-13.83%
Colorectal Cancer Screening	39.93%	37.93%	38.30%	0.98%
Controlling High Blood Pressure	65.78%	64.70%	65.35%	1.00%
Diabetes - HbA1c Good Control (<=9.0%)	65.98%	69.04%	66.18%	-4.14%
Diabetes - Retinal Eye Exam	N/A	55.80%	54.59%	-2.17%
Lead Screening in Children	N/A	N/A	66.23%	N/A
Immunizations for Adolescents	37.06%	38.89%	35.42%	-8.92%
Well-Child Visits (1st 15 Months)	61.54%	63.95%	54.22%	-15.22%

GREEN – Increased Relative Change
RED – Decreased Relative Change
YELLOW – Not Applicable (No data to show Relative Change)

Percentage Providers Meeting Partial Points YoY (50th Percentile) - Clinical Domain (Plan-wide) Legacy Counties

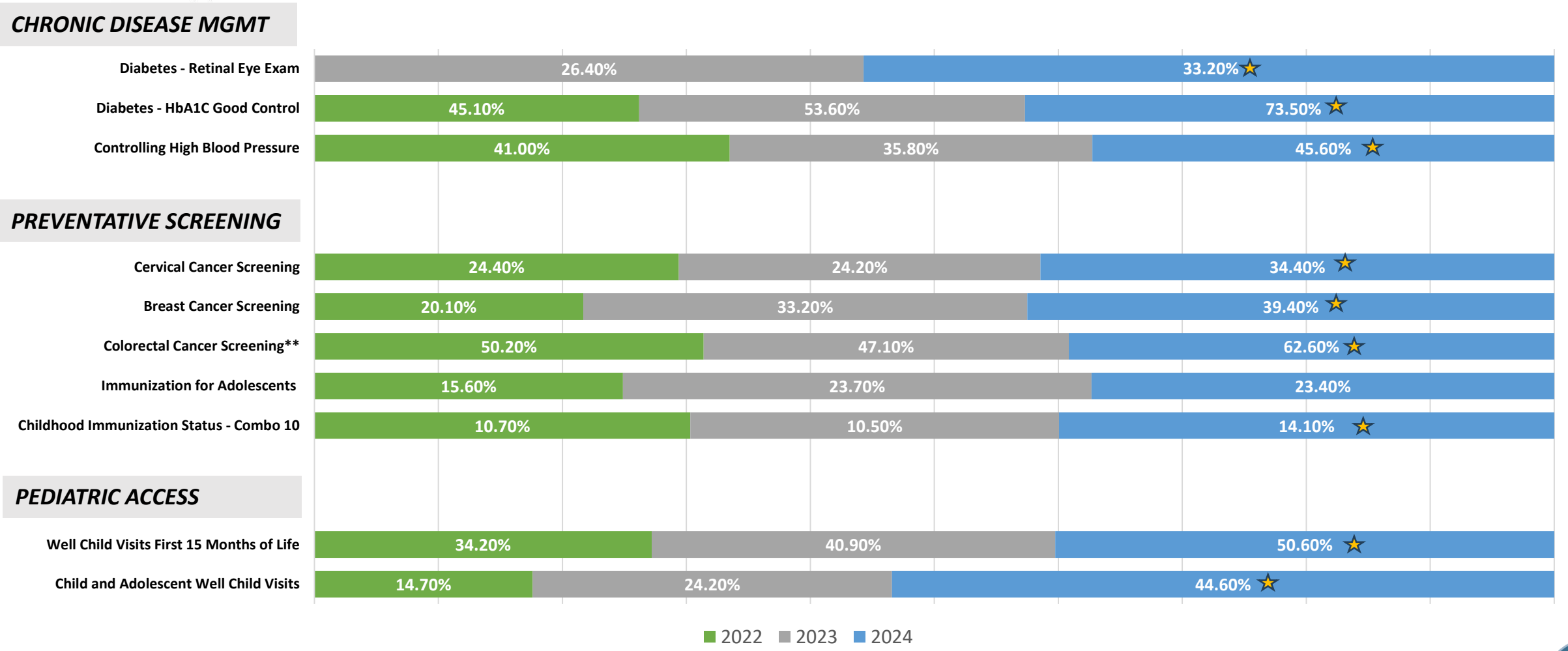


**Partial Points Target Set at the 25th Percentile

★ Outperformed prior measurement year

Note: Percentages do not include expansion counties

Percentage of Providers Meeting Full Points YoY (90th Percentile) – Clinical Domain (Plan-wide) Legacy Counties

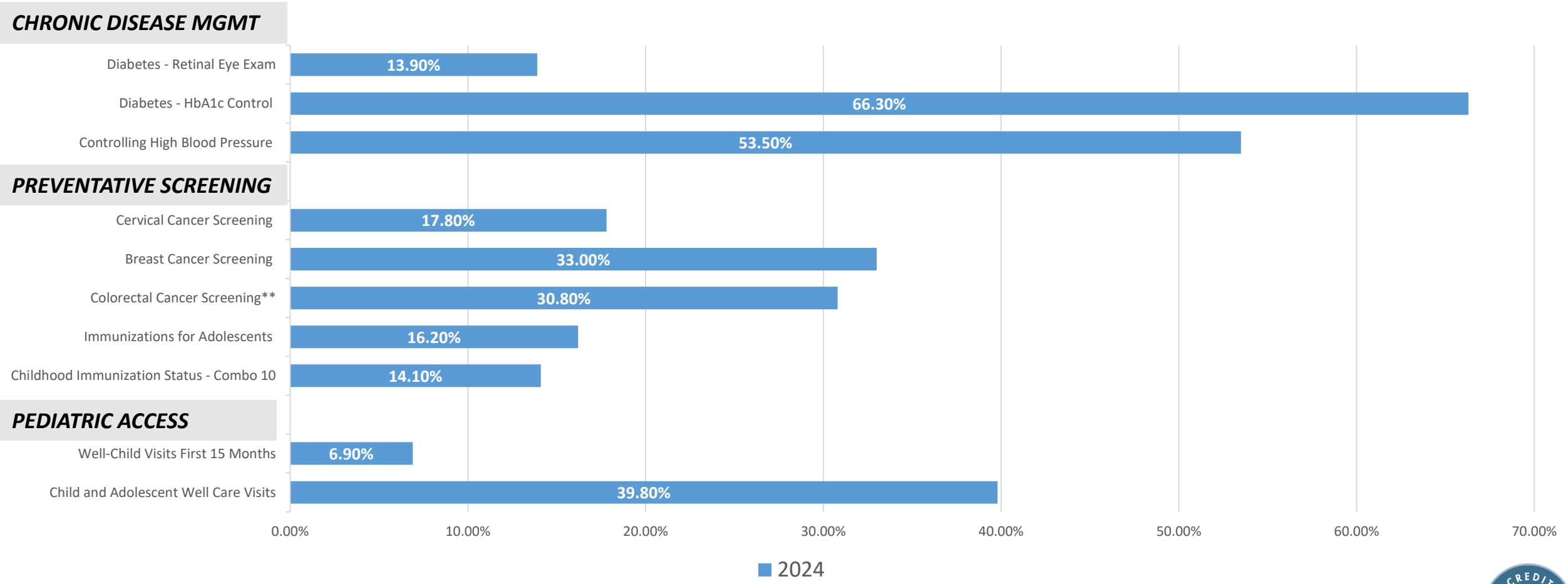


**Partial Points Target Set at the 50th Percentile

★ Outperformed prior measurement year

Note: Percentages do not include expansion counties

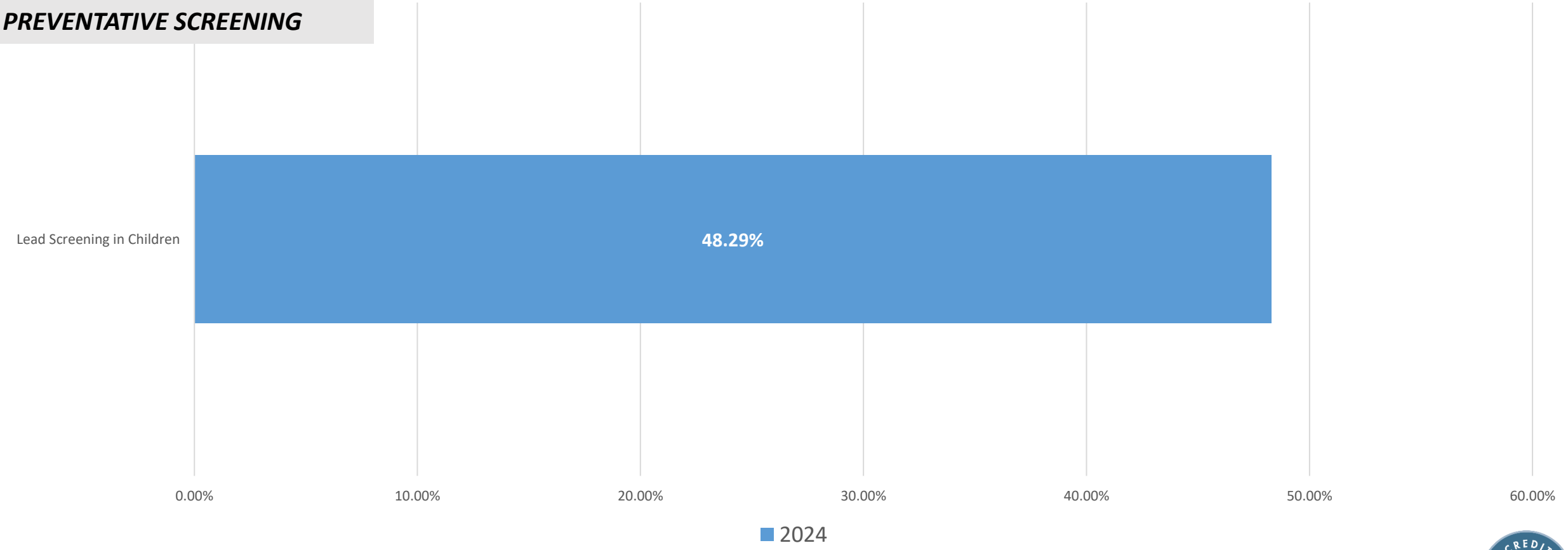
2024 Percentage Providers Meeting Full Points (50th Percentile)
Clinical Domain (Plan-wide)
Expansion Counties



Note: Percentages do not include legacy counties

2024 Percentage Providers Meeting Full Points (50th Percentile) – Clinical Domain (Plan-wide), ALL 24 Counties

PREVENTATIVE SCREENING



Relative Improvement (RI)

Available for most existing clinical measures where a provider site was eligible for scoring/payment in the previous measurement year

A site's performance on an existing clinical measure must:

- Meet the ***50th percentile target***

  AND

- Achieve an ***RI score of 15%*** or higher

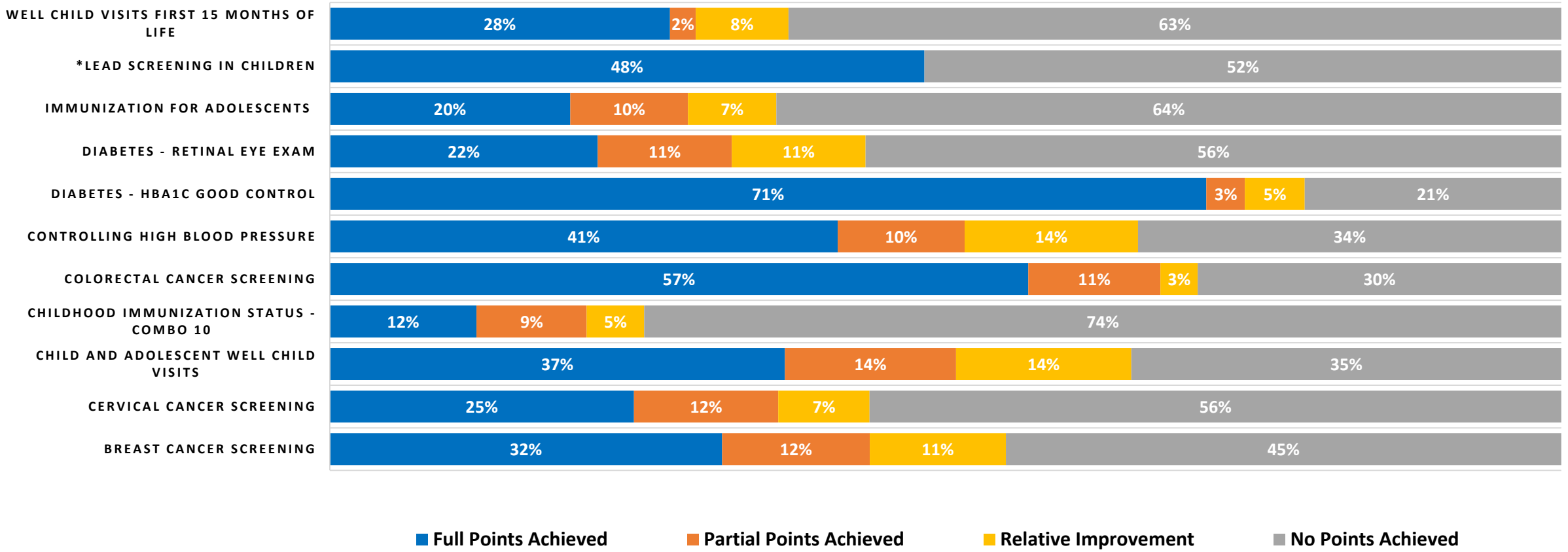
- Thereby achieving performance equal to or exceeding the 50th percentile and not exceeding the 90th percentile, **to earn full points**

$$\frac{\text{(Current year performance)} - \text{(previous year performance)}}{\text{(100} - \text{Previous year performance)}}$$

This method of calculating RI is based on a Journal of the American Medical Association article authored by Jencks et al in 2003. It is widely used by the Integrated Healthcare Association's commercial P4P program and CMS.

Disclaimer: RI is not applicable to expansion counties

2024 Points Earning Distribution for Clinical Measures (Plan-wide)



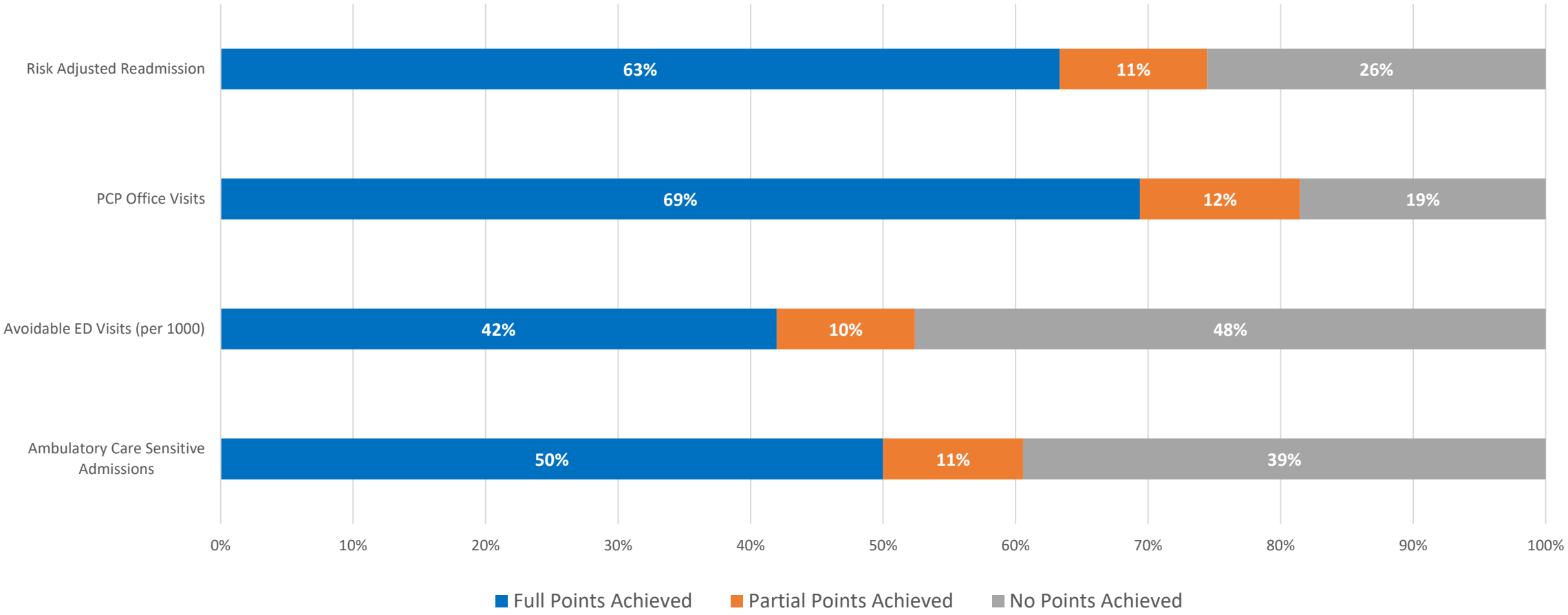
*New measure – No Partial Points & does not qualify for RI

Plan-wide Performance
Non-Clinical Domain YoY

PLANWIDE				
Non Clinical Core Measurement Set	**2022**	**2023**	**2024**	**23-24 Relative Change**
Ambulatory Care Sensitive Admissions	9.34	12.53	9.75	**-22.19%**
Avoidable ED Visits (per 1000)	8.33	10.87	14.27	**31.28%**
PCP Office Visits	1.98	2.00	2.26	**13.00%**
Risk Adjusted Readmission	0.75	0.80	0.88	**10.00%**

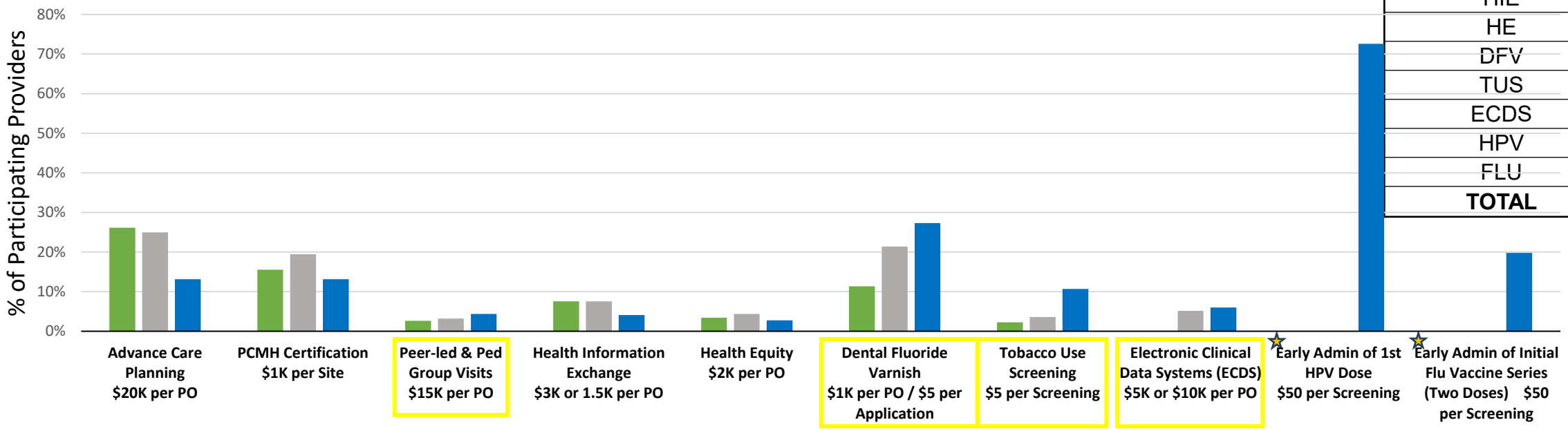
BLACK – Decreased Rate, Increased Performance
GREEN – Increased Rate, Increased Performance
RED - Increased Rate, Declined Performance

2024 Points Earning Distribution for Non-Clinical Measures (Plan-wide)



Unit of Service Participation YoY

2024 UOS Measures	2024 Total Payout
ACP	$497,100
PCMH	$48,000
Peer-led & Ped Groups	$39,000
HIE	$24,000
HE	$20,000
DFV	$46,680
TUS	$39,585
ECDS	$71,000
HPV	$273,050
FLU	$30,800
TOTAL	**$1,089,215**



2024 Unit of Service Measures and Potential Incentives

2022 2023 2024

Higher Participation from the prior year

2024 UOS Measures with highest payouts

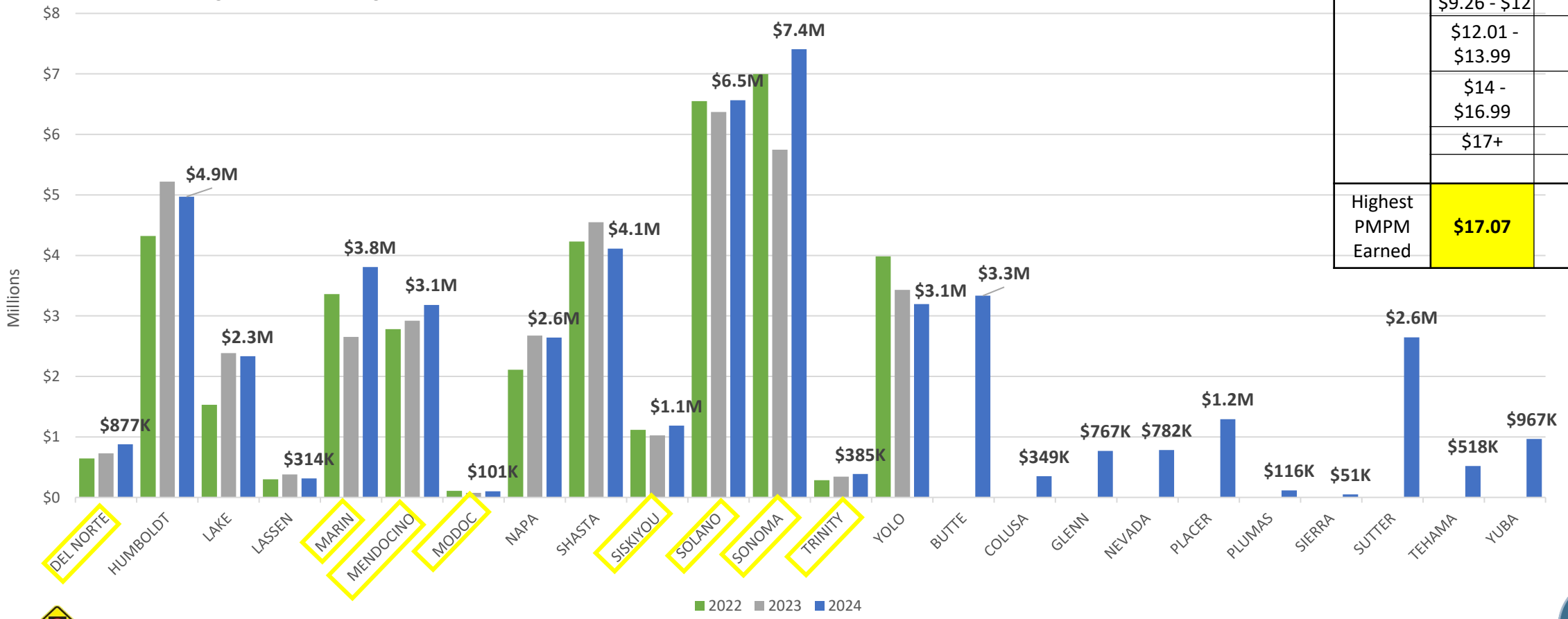
★ Only appliable to Family & Pediatric Practices only

2024 PCP Payout Overview

2024 PCP QIP Payment
County Y-o-Y Payouts

- 2024 Incentive Payout: $51.9M
- 2024 Weighted Average Earned PMPM Rate: $6.84

	PMPM Ranges	# of Providers
Base PMPM	$4.00	69
	$4 - $9.25	30
	$9.26 - $12	150
	$12.01 - $13.99	96
	$14 - $16.99	19
	$17+	1
Highest PMPM Earned	**$17.07**	



Higher Payout from the prior year

2024 Summary

PCP QIP Summary

Programmatic Changes	• Removed 1 Clinical Measure: Asthma Medication Ratio • Added 1 NEW Clinical Measure: Lead Screening in Children • Removed 1 UOS Measure: Blood Lead Screening • Added 2 NEW UOS Measures: 1) Early Administration of 1st HPV Dose & 2) Early Administration of Initial Flu Vaccine Series (Two Doses)
Program Performance	• Includes 10 additional counties from the prior year due to expansion • Increased QIP performance in 3 of 11 Clinical measures from the prior year • 5 Clinical measures ended above the 50th HEDIS Benchmark • 4 Clinical measures ended under the 50th HEDIS Benchmark
2026 Program Recommendations	• Add new clinical measure: Kidney Health Evaluation for Patients with Diabetes (KED) • Keep two separate measures for Breast Cancer Screening based on age range then implementing the 40-51yo measure as an active measure • Implement both the Chlamydia Screening & Well Child Visits in the First 15-30 Months of Life as active measures • Keep Topical Fluoride in Children as monitoring measure

Healthcare Effectiveness Data and Information Set (HEDIS®)

Measurement Year 2024 / Reporting Year 2025

NCQA HealthPlan Accreditation (HPA) Summary of Performance

Partnership – HPA Star Rating

August 2025

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1.0 Introduction

As a Medi-Cal Managed Care Plan, Partnership provides health care coverage for 24 counties in Northern California – the largest geographic footprint of any Medi-Cal Managed Care Plan in California. The health plan covers over 900,000 members who qualify for coverage based on low household income, and who make up a substantial portion of Northern California's total population. The annual measure performance analysis contained in this Annual Summary of Performance, centered on Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures selected by the National Committee for Quality Assurance (NCQA), supports Partnership's Health Plan Accreditation and is intended to give the best possible understanding of the status of quality outcomes for the low-income population served in these counties.

Partnership generates a detailed Annual Summary of Performance and distributes it widely so that stakeholders in Northern California – local governments, county public health, medical and behavioral health providers, hospitals, and community foundations - can use current, local, accurate, and audited data to prioritize activities to meet the health care needs of their communities. The Summary of Performance contains regional and county-level data that show local strengths and opportunities for preventative health care, based on national benchmarks. Behind each measure are many community members who were able to access the preventative services they needed to stay healthy, or who faced challenges or struggles to receive care.

In the end, it takes the entire health care delivery system working together to improve the health outcomes contained in this report. Partnership encourages everyone reading this report to review their local data closely, and look for a handful of ways their organization, alone or with others, can drive improvement on one or more measure that is important to them.

Partnership is always happy to connect organizations and community members within our network to resources and activities to help our members, and the communities we serve, be healthy. Please reach out to our Performance Improvement team at ImprovementAcademy@partnershiphp.org if you would like to learn more about activities in your area.

Thank you for your dedication to improving the health of our communities.

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2.0 Notable Changes to the MY2024 Annual Summary of Performance Report

MY2024 continued to host two required separate audits:

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

Partnership HEDIS Reporting Populations – MY2024

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

- Incoming counties added approximately 316,000 members to Partnership.
- Approximately 82,000 members assigned to Kaiser departed from Partnership. The decrease in membership primarily impacted Solano, Sonoma, Napa and Yolo Counties.

	Dec 2023	Dec 2024
Total Membership	**663,919**	**906,964**
10 Incoming Counties	**0**	**316,096**
New membership	0	316,096
14 Legacy Counties	**663,919**	**590,868**
Kaiser assigned Partnership members	82,033	0
Non-Kaiser membership	581,886	590,868

The addition of 10 incoming counties to Partnership's network changes Partnership's HEDIS Reporting Populations for NCQA's Health Plan Accreditation (HPA). Starting in MY2024, Partnership reported one Plan-Wide rate for all 24 counties in its network for the HPA measure set to its NCQA auditor, Advent Advisory.

Changes to NCQA HEDIS Measures – MY2024

NCQA released changes to several existing clinical measures used in NCQA HPA for MY2024:

Clinical Measure Changes for MY2024 HPA Required Reporting:

- New Measures:
  - Colorectal Cancer Screening (COL-E) is a new HPA measure
  - Language Diversity of Membership (LDM) is a new HPA measure
- Changed Measures:
  - The former Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD) measure was revised to Glycemic Status Assessment for Patients with Diabetes (GSD).

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  - Metabolic Monitoring for Children and Adolescents on Antipsychotics – Blood Glucose and Cholesterol Testing (APM-E) is now an Electronic Clinical Data Systems (ECDS) measure.
  - Follow-Up Care for Children Prescribed ADHD Medication – Continuation & Maintenance Phase (ADD-E) is now an Electronic Clinical Data Systems (ECDS) measure.

- Removed Clinical Measures:
  - Follow-up After Hospitalization for Mental Illness, 7 Days (FUH) was approved by the Advent Advisory auditor for removal from the HPA measure set as Not a Benefit, since psychiatric hospitalizations are not a Partnership benefit.

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

In July 2021, NCQA released the HealthPlan Rating Methodology: (Plan-wide):
As an NCQA Accredited plan, Partnership was required to report HEDIS and CAHPS annually, starting June 2022, for measurement year 2021 (MY2021). The overall Health Plan Rating (HPR) is the weighted average of a plan's HEDIS and CAHPS measure ratings, plus bonus points for plans with current Accreditation status. In MY2024 Partnership chose to be formally scored utilizing the Child CAHPS results.

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3.0 HPA Summary of Performance Plan-wide Relative to National All Lines of Business Benchmarks

3.1 HPA Plan-wide Performance Child CAHPS Results – Patient Experience:

This table shows the results of the MY2023 - MY2024 performance on the Patient Experience NCQA Accreditation measures relative to the MY2022 and MY2023 National All Lines of Business 10th, 33.33rd, 66.67th and 90th benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points

NCQA Accreditation Measures: Child CAHPS Survey Results MY2023-MY2024

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Patient Experience						
Getting Care						
MY 2023	***Getting Needed Care (Usually + Always)	77.06%	74.98%	79.83%	83.11%	86.50%
MY 2024		77.87%	76.79%	81.10%	85.70%	89.41%
MY 2023	Getting Care Quickly (Usually + Always)	78.92%	73.36%	77.73%	83.78%	86.94%
MY 2024		80.04%	78.92%	84.62%	89.35%	92.10%
Satisfaction with Plan Physicians						
MY 2023	Rating of Personal Doctor (9+10)	75.51%	61.79%	65.38%	70.59%	74.03%
MY 2024		78.64%	70.66%	74.42%	78.53%	82.63%
Satisfaction with Health Plan Services						
MY 2023	Rating of All Health Care (9+10)	68.13%	48.00%	53.48%	58.27%	62.50%
MY 2024		66.40%	62.29%	67.49%	71.90%	76.27%
MY 2023	***Rating of Health Plan (9+10)	58.89%	52.72%	59.30%	64.02%	68.70%
MY 2024		72.87%	64.03%	69.01%	73.76%	78.19%

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

3.2 HPA Plan-wide Performance Adult CAHPS Results – Patient Experience:

This table shows the results of the MY2023 - MY2024 baseline performance on the Patient Experience NCQA Accreditation measures relative to the MY2022 and MY2023 National All Lines of Business10th, 33.33rd, 66.67th and 90th benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points

NCQA Accreditation Measures: Adult CAHPS Survey Results MY2023-MY2024

NCQA Accreditation Measures - Planwide Performance w/Adults CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Patient Experience						
Getting Care						
MY 2023	***Getting Needed Care (Usually + Always)	73.98%	74.98%	79.83%	83.11%	86.50%
MY 2024		74.54%	75.52%	79.75%	83.73%	86.12%
MY 2023	Getting Care Quickly (Usually + Always)	68.09%	73.36%	77.73%	83.78%	86.94%
MY 2024		74.02%	73.26%	78.80%	82.98%	86.40%
Satisfaction with Plan Physicians						
MY 2023	Rating of Personal Doctor (9+10)	70.00%	61.79%	65.38%	70.59%	74.03%
MY 2024		65.75%	63.01%	67.32%	71.05%	74.42%
Satisfaction with Health Plan Services						
MY 2023	Rating of All Health Care (9+10)	54.49%	48.00%	53.48%	58.27%	62.50%
MY 2024		54.43%	50.00%	55.07%	59.47%	63.36%
MY 2023	***Rating of Health Plan (9+10)	46.62%	52.72%	59.30%	64.02%	68.70%
MY 2024		55.76%	53.41%	59.44%	64.05%	68.54%

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

3.3 HPA HEDIS Plan-wide Performance – Prevention and Population

This table shows the MY2023 – MY2024 baseline performance on the **Prevention and Population** NCQA Accreditation measures relative to the MY2022 and MY2023 National All Lines of Business10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures)

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Prevention and Population						
Children and Adolescent Well-Care						
MY 2023	***CIS - Childhood Immunization Status (Combination 10)	29.68%	20.68%	26.76%	35.04%	45.26%
MY 2024		28.22%	18.25%	24.39%	31.32%	42.34%
MY 2023	***IMA - Immunizations for Adolescents (Combination 2)	43.07%	24.82%	30.66%	38.93%	48.80%
MY 2024		39.66%	25.41%	31.39%	38.69%	48.66%
MY 2023	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	85.99%	62.77%	74.70%	83.21%	89.72%
MY 2024		76.16%	66.91%	76.89%	86.20%	91.24%
Women's Reproductive Health						
MY 2023	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	90.34%	73.48%	81.75%	86.86%	91.07%
MY 2024		84.43%	73.48%	81.94%	86.89%	91.85%
MY 2023	***PPC - Prenatal and Postpartum Care—Postpartum Care	86.96%	67.31%	75.18%	80.78%	84.59%
MY 2024		88.81%	68.63%	77.37%	82.48%	86.62%
MY 2023	PRS-E - Prenatal Immunization Status - Combination Rate	35.40%	7.94%	15.17%	25.81%	37.75%
MY 2024		29.36%	8.42%	15.96%	24.92%	35.60%
Cancer Screening						
MY 2023	BCS-E - Breast Cancer Screening	55.52%	42.98%	48.33%	54.94%	62.67%
MY 2024		56.29%	42.86%	49.24%	56.66%	63.48%
MY 2023	CCS - Cervical Cancer Screening	58.04%	43.50%	53.37%	59.85%	66.48%
MY 2024		58.64%	43.31%	52.07%	60.10%	67.46%
MY 2023	COL-E - Colorectal Cancer Screening	NR	NR	NR	NR	NR
MY 2024		32.99%	27.27%	34.30%	41.59%	49.35%
Description of Membership						
MY 2023	RDM - Race/Ethnicity Diversity of Membership (Reporting Only)	100.00%	63.20%	95.91%	100.00%	100.00%
MY 2024		100.00%	100.00%	100.00%	100.00%	100.00%
MY 2023	LDM - Language Diversity of Membership	NR	NR	NR	NR	NR
MY 2024		100.00%	0.00%	0.00%	13.07%	100.00%

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Prevention and Population						
Other Preventive Services						
MY 2023	**CHL - Chlamydia Screening in Women—Total**	56.00%	42.61%	51.39%	61.07%	67.39%
MY 2024		55.58%	43.53%	52.40%	61.46%	69.07%
MY 2023	AIS-E - Adult Immunization Status -- Influenza	17.61%	6.50%	10.82%	16.32%	21.05%
MY 2024	Immunizations for Adults	14.33%	7.39%	12.55%	17.91%	26.40%
MY 2023	AIS-E - Adult Immunization	49.15%	N/A	N/A	N/A	N/A
MY 2024	Status—Pneumococcal	44.03%	21.04%	38.73%	55.03%	68.07%
MY 2023	AIS-E - Adult Immunization Status—Td/Tdap	36.43%	18.67%	29.84%	41.54%	56.53%
MY 2024	Immunizations for Adults	32.96%	21.26%	33.40%	47.30%	57.67%
MY 2023	AIS-E - Adult Immunization Status—Zoster	14.63%	1.72%	4.42%	10.27%	14.54%
MY 2024	Immunizations for Adults	14.47%	2.23%	7.15%	13.49%	20.56%

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

3.4 HPA HEDIS Plan-wide Performance – Treatment: Respiratory, Diabetes, Heart Disease

This table shows the MY2024 baseline performance on the **Treatment** NCQA Accreditation measures relative to the MY2022 and MY2023 National All Lines of Business10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used f whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Treatment						
Respiratory						
MY 2023	**AMR - Asthma Medication Ratio- Total**	64.01%	55.09%	61.81%	69.41%	75.92%
MY 2024		64.71%	54.56%	62.35%	70.56%	76.65%
MY 2023	CWP - Appropriate Testing for	71.45%	57.41%	68.76%	77.56%	82.40%
MY 2024	Pharyngitis—Total	70.27%	61.35%	76.71%	85.11%	89.17%
MY 2023	**AAB - Avoidance of Antibiotic Treatment for	74.30%	50.05%	57.16%	66.19%	77.11%
MY 2024	Acute Bronchitis/Bronchiolitis—Total	56.00%	49.48%	56.76%	67.03%	77.66%
MY 2023	PCE - Pharmacotherapy Management of COPD	73.71%	56.05%	68.39%	75.79%	82.43%
MY 2024	Exacerbation - Systemic Corticosteroid	70.93%	55.28%	66.86%	74.78%	82.88%
MY 2023	PCE - Pharmacotherapy Management of COPD	88.15%	72.88%	82.35%	86.96%	90.53%
MY 2024	Exacerbation - Bronchodilator	86.18%	67.25%	80.19%	86.54%	89.96%
Diabetes						
MY 2023	EED - Eye Exams for Patients with Diabetes	52.59%	36.74%	46.96%	56.20%	63.33%
MY 2024		52.31%	40.39%	49.15%	57.09%	64.06%
MY 2023	BPD -Blood Pressure Control (<140/90) for	67.50%	52.07%	59.85%	68.61%	74.56%
MY 2024	Patients with Diabetes	70.56%	58.15%	65.32%	71.78%	77.37%
MY 2023	HBD -Hemoglobin A1c Control for Patients with Diabetes-- HbA1c Control (<8%)	54.81%	38.93%	49.39%	55.72%	60.34%
MY 2024	**GSD -Glycemic Status Assessment for Patients with Diabetes-- HbA1c Control (<8%)**	54.26%	44.25%	54.50%	59.64%	63.50%
MY 2023	SPD - Statin Therapy for Patients With	63.12%	54.15%	62.58%	67.07%	72.15%
MY 2024	Diabetes—Received Statin Therapy	64.93%	51.96%	62.66%	67.01%	71.41%
MY 2023	SPD - Statin Therapy for Patients With	94.76%	52.67%	62.50%	70.37%	77.97%
MY 2024	Diabetes—Statin Adherence 80%	67.90%	53.23%	64.18%	70.91%	79.73%
MY 2023	KED - Kidney Health Evaluation for Patients with	42.13%	22.73%	29.42%	38.80%	47.55%
MY 2024	Diabetes	40.88%	26.79%	33.00%	42.10%	49.72%

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Treatment						
Heart Disease						
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	81.90%	70.02%	78.80%	81.64%	85.04%
MY 2024		81.06%	66.64%	79.82%	83.00%	85.89%
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	95.45%	56.67%	66.48%	73.63%	80.95%
MY 2024		70.33%	59.20%	66.84%	73.75%	81.25%
MY 2023	***CBP - Controlling High Blood Pressure	70.57%	50.36%	57.66%	65.45%	72.22%
MY 2024		61.80%	54.61%	61.43%	67.40%	72.75%

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

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NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
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** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

3.5 HPA HEDIS Plan-wide Performance – Behavioral Health

This table shows the MY2024 baseline performance on the **Behavioral Health** NCQA Accreditation measures relative to the MY2022 and MY2023 National All Lines of Business10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Treatment						
Behavioral Health--Care Coordination						
MY 2023	FUH - Follow-Up After Hospitalization for Mental Illness-7 days	29.05%	21.77%	31.23%	41.03%	52.90%
MY 2024		NB	23.55%	32.71%	42.86%	57.69%
MY 2023	**FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total**	18.92%	23.74%	33.61%	46.35%	61.68%
MY 2024		13.39%	21.19%	33.01%	44.33%	59.95%
MY 2023	**FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total**	22.68%	13.83%	20.00%	27.73%	38.15%
MY 2024		22.88%	12.73%	18.76%	27.62%	37.47%
MY 2023	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	32.29%	15.16%	23.12%	37.31%	49.55%
MY 2024		29.83%	15.91%	26.90%	37.64%	50.80%
Behavioral Health--Medication Adherence						
MY 2023	AMM - Antidepressant Medication Management—Effective Continuation Phase Treatment	81.49%	31.59%	40.01%	46.74%	58.06%
MY 2024		48.04%	31.52%	41.00%	48.16%	61.06%
MY 2023	POD - Pharmacotherapy for Opioid Use Disorder—Total	41.53%	14.94%	23.38%	31.93%	40.34%
MY 2024		15.84%	12.05%	21.36%	29.01%	36.71%
MY 2023	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	73.46%	41.24%	57.79%	64.90%	72.61%
MY 2024		68.58%	44.65%	58.60%	66.15%	74.83%

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Treatment						
Behavioral Health-- Access, Monitoring and Safety						
MY 2023	APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	32.80%	26.36%	31.97%	40.50%	53.58%
MY 2024	APM-E - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (ECDS)	32.18%	25.86%	30.92%	41.41%	52.57%
MY 2023	ADD -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	31.45%	40.38%	50.98%	57.90%	63.92%
MY 2024	ADD-E -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase (ECDS)	40.36%	37.19%	48.94%	56.83%	63.49%
MY 2023	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.90%	72.83%	77.40%	80.86%	85.52%
MY 2024		83.85%	75.46%	79.51%	83.51%	87.27%
MY 2023	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	25.95%	36.65%	55.19%	63.89%	73.87%
MY 2024		41.38%	41.57%	54.55%	64.10%	74.14%
MY 2023	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	8.50%	7.05%	11.11%	16.94%	24.37%
MY 2024		7.63%	6.08%	10.51%	16.78%	26.72%

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

3.6 HPA HEDIS Plan-wide Performance – Risk Adjusted / Other

This table shows the MY2024 baseline performance on the **Risk Adjusted** / Other NCQA Accreditation measures relative to the MY2022 and MY2023 National All Lines of Business10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Risk-Adjusted Utilization						
MY 2023	PCR - Plan All-Cause Readmission - Observed to	0.8951	No Bench Marks Use for Scoring			
MY 2024	- Expected Ratio (18-64 years)	0.9944				
Other Treatment Measure						
MY 2023	**LBP - Use of Imaging Studies for Low Back	76.71%	67.72%	71.32%	75.44%	79.96%
MY 2024	Pain	73.67%	64.77%	67.84%	72.74%	78.72%

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA. NCQA calculates the Confidence Limits (CLs) for all health plans.

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

4.0 MY 2024 HPA HEDIS Rate Performance by County

The following tables show MY2024 county-level performance on HPA HEDIS measures in Partnership's six (6) Regions. For the fourteen (14) legacy counties in Partnership's Eureka, Fairfield, Redding and Santa Rosa Regions, MY2023 county-level performance is also included, showing year-over-year performance trends by county.

HPA measures not included in the county-level performance tables are:

- CAHPS Measures, which only have plan-wide rates;
- Description of Membership measures, which only have plan-wide rates

All tables show the MY2024 baseline performance on NCQA Accreditation measures relative to the MY2022 and MY2023 National All Lines of Business 10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4.1 HPA HEDIS Rate Performance by County, Auburn Region: Nevada, Placer, Plumas, Sierra Counties

4-5 points ○ 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).

Year	Measure	County Performance				National Medicaid Benchmarks			
		Nevada	Placer	Plumas	Sierra	10th	33.33rd	66.67th	90th
Prevention and Population									
Children and Adolescent Well-Care									
MY 2024	***CIS - Childhood Immunization Status (Combination 10)	100.00%	0.00%	0.00%	0.00%	18.25%	24.39%	31.32%	42.34%
MY 2024	***IMA - Immunizations for Adolescents (Combination 2)	0.00%	12.50%	0.00%	0.00%	25.41%	31.39%	38.69%	48.66%
MY 2024	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	73.33%	90.48%	0.00%	0.00%	66.91%	76.89%	86.20%	91.24%
Women's Reproductive Health									
MY 2024	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	100.00%	75.00%	100.00%	73.33%	73.48%	81.94%	86.89%	91.85%
MY 2024	***PPC - Prenatal and Postpartum Care—Postpartum Care	100.00%	83.33%	100.00%	86.67%	68.63%	77.37%	82.48%	86.62%
MY 2024	PRS-E - Prenatal Immunization Status - Combination Rate	11.28%	21.29%	31.11%	25.00%	8.42%	15.96%	24.92%	35.60%
Cancer Screening									
MY 2024	BCS-E- Breast Cancer Screening	66.67%	0.00%	0.00%	0.00%	42.86%	49.24%	56.66%	63.48%
MY 2024	CCS - Cervical Cancer Screening	62.50%	50.00%	33.33%	50.00%	43.31%	52.07%	60.10%	67.46%
MY 2024	COL-E - Colorectal Cancer Screening	18.18%	0.00%	33.33%	0.00%	27.27%	34.30%	41.59%	49.35%
Other Preventive Services									
MY 2024	CHL - Chlamydia Screening in Women—Total	48.06%	60.67%	23.26%	27.27%	43.53%	52.40%	61.46%	69.07%
MY 2024	AIS-E-Adult Immunization Status—Influenza - Total	8.48%	11.84%	10.38%	12.12%	7.39%	12.55%	17.91%	26.40%
MY 2024	AIS-E-Adult Immunization Status—Pneumococcal - 66+	35.21%	30.02%	31.25%	0.00%	21.04%	38.73%	55.03%	68.07%
MY 2024	AIS-E-Adult Immunization Status—Td/Tdap - Total	26.37%	24.48%	30.03%	37.12%	21.26%	33.40%	47.30%	57.67%
MY 2024	AIS-E-Adult Immunization Status—Zoster - Total	13.02%	14.60%	6.87%	8.60%	2.23%	7.15%	13.49%	20.56%

Year	Measure	County Performance				National Medicaid Benchmarks			
		Nevada	Placer	Plumas	Sierra	10th	33.33rd	66.67th	90th
		Treatment							
		Respiratory							
MY 2024	**AMR - Asthma Medication Ratio- Total**	0.00%	0.00%	100.00%	0.00%	54.56%	62.35%	70.56%	76.65%
MY 2024	CWP - Appropriate Testing for Pharyngitis—Total	77.18%	72.08%	80.74%	100.00%	61.35%	76.71%	85.11%	89.17%
MY 2024	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	76.67%	65.22%	57.69%	0.00%	49.48%	50.98%	67.03%	77.66%
MY 2024	PCE - Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	81.25%	62.00%	87.50%	100.00%	55.28%	66.86%	74.78%	82.88%
MY 2024	PCE - Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	75.00%	82.00%	87.50%	0.00%	67.25%	80.19%	86.54%	89.96%
		Diabetes							
MY 2024	EED - Eye Exams for Patients with Diabetes	20.00%	44.44%	0.00%	0.00%	40.39%	49.15%	57.09%	64.06%
MY 2024	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	70.00%	72.22%	0.00%	0.00%	58.15%	65.32%	71.78%	77.37%
MY 2024	GSD -Glycemic Status Assessment for Patients with Diabetes-- HbA1c Control (<8%)	50.00%	44.44%	0.00%	0.00%	44.25%	54.50%	59.64%	63.50%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	100.00%	0.00%	50.00%	0.00%	51.96%	62.66%	67.01%	71.41%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	0.00%	0.00%	100.00%	0.00%	53.23%	64.18%	70.91%	79.73%
MY 2024	KED - Kidney Health Evaluation for Patients with Diabetes	45.34%	49.73%	14.62%	0.00%	26.79%	33.00%	42.10%	49.72%
		Heart Disease							
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	100.00%	0.00%	0.00%	0.00%	66.64%	79.82%	83.00%	85.89%
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	100.00%	0.00%	0.00%	0.00%	59.95%	67.42%	74.07%	81.79%
MY 2024	***CBP - Controlling High Blood Pressure	71.43%	50.00%	0.00%	0.00%	54.61%	61.43%	67.40%	72.75%

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Year	Measure	County Performance				National Medicaid Benchmarks			
		Nevada	Placer	Plumas	Sierra	10th	33.33rd	66.67th	90th
Treatment									
Behavioral Health - Care Coordination									
MY 2024	**FUH - Follow-Up After Hospitalization for Mental Illness-7 days**	NB	NB	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2024	**FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total**	17.58%	9.04%	10.71%	0.00%	21.19%	33.01%	44.33%	59.95%
MY 2024	**FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total**	22.25%	22.72%	17.31%	87.50%	12.73%	18.76%	27.62%	37.47%
MY 2024	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	13.46%	12.05%	33.33%	50.00%	15.91%	26.90%	37.64%	50.80%
Behavioral Health - Medication Adherence									
MY 2024	AMM - Antidepressant Medication Management—Effective Continuation Phase Treatment	38.71%	46.34%	0.00%	100.00%	31.52%	41.00%	48.16%	61.06%
MY 2024	POD - Pharmacotherapy for Opioid Use Disorder—Total	9.76%	12.50%	0.00%	0.00%	12.05%	21.36%	29.01%	36.71%
MY 2024	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	65.45%	79.66%	72.73%	100.00%	44.65%	58.60%	66.15%	74.83%

Behavioral Health - Access, Monitoring and Safety									
MY 2024	APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	39.29%	35.92%	38.46%	0.00%	25.86%	30.92%	41.41%	52.57%
MY 2024	ADD -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	0.00%	0.00%	0.00%	0.00%	37.19%	48.94%	56.83%	63.49%
MY 2024	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	85.08%	85.07%	89.29%	80.00%	75.46%	79.51%	83.51%	87.27%
MY 2024	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	80.00%	6.25%	0.00%	0.00%	41.57%	54.55%	64.10%	74.14%
MY 2024	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	3.82%	5.83%	3.08%	14.29%	6.08%	10.51%	16.78%	26.72%
Risk-Adjusted Utilization									
MY 2024	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	2.0801	1.7290	0.0000	12.8852	No Bench Marks Use For Scoring			
Other Treatment Measures									
MY 2024	**LBP - Use of Imaging Studies for Low Back Pain	70.18%	71.43%	79.17%	40.00%	64.77%	67.84%	72.74%	78.72%

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA.
NCQA calculates the Confidence Limits (CLs) for all health plans.

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

4.2 HPA HEDIS Rate Performance by County, Chico Region: Butte, Colusa, Glenn, Sutter, Yuba Counties

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).

Year	Measure	County Performance					National Medicaid Benchmarks			
		Butte	Colusa	Glenn	Sutter	Yuba	10th	33.33rd	66.67th	90th
		Prevention and Population								
		Children and Adolescent Well-Care								
MY 2024	***CIS - Childhood Immunization Status (Combination 10)	0.00%	0.00%	0.00%	0.00%	0.00%	18.25%	24.39%	31.32%	42.34%
MY 2024	***IMA - Immunizations for Adolescents (Combination 2)	0.00%	0.00%	100.00%	40.00%	37.50%	25.41%	31.39%	38.69%	48.66%
MY 2024	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	64.52%	100.00%	77.78%	63.33%	58.82%	66.91%	76.89%	86.20%	91.24%
		Women's Reproductive Health								
MY 2024	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	93.33%	33.33%	83.33%	92.00%	90.00%	73.48%	81.94%	86.89%	91.85%
MY 2024	***PPC - Prenatal and Postpartum Care—Postpartum Care	96.67%	100.00%	100.00%	88.00%	80.00%	68.63%	77.37%	82.48%	86.62%
MY 2024	PRS-E - Prenatal Immunization Status - Combination Rate	19.02%	24.19%	25.82%	18.15%	17.99%	8.42%	15.96%	24.92%	35.60%
		Cancer Screening								
MY 2024	BCS-E- Breast Cancer Screening	26.32%	20.00%	0.00%	0.00%	100.00%	42.86%	49.24%	56.66%	63.48%
MY 2024	CCS - Cervical Cancer Screening	53.19%	75.00%	30.00%	55.56%	60.00%	43.31%	52.07%	60.10%	67.46%
MY 2024	COL-E - Colorectal Cancer Screening	26.67%	20.00%	25.00%	50.00%	50.00%	27.27%	34.30%	41.59%	49.35%
		Other Preventive Services								
MY 2024	CHL - Chlamydia Screening in Women—Total	55.64%	53.02%	51.47%	57.24%	57.89%	43.53%	52.40%	61.46%	69.07%
MY 2024	AIS-E-Adult Immunization Status—Influenza - Total	11.00%	17.54%	13.04%	12.57%	9.16%	7.39%	12.55%	17.91%	26.40%
MY 2024	AIS-E-Adult Immunization Status—Pneumococcal - 66+	39.50%	43.21%	32.31%	51.35%	36.51%	21.04%	38.73%	55.03%	68.07%
MY 2024	AIS-E-Adult Immunization Status—Td/Tdap - Total	28.86%	30.82%	32.27%	30.26%	27.31%	21.26%	33.40%	47.30%	57.67%
MY 2024	AIS-E-Adult Immunization Status—Zoster - Total	13.42%	15.10%	17.50%	14.44%	9.08%	2.23%	7.15%	13.49%	20.56%

Year	Measure	County Performance					National Medicaid Benchmarks			
		Butte	Colusa	Glenn	Sutter	Yuba	10th	33.33rd	66.67th	90th
		Treatment								
		Respiratory								
MY 2024	**AMR - Asthma Medication Ratio- Total**	66.67%	0.00%	100.00%	0.00%	0.00%	54.56%	62.35%	70.56%	76.65%
MY 2024	CWP - Appropriate Testing for Pharyngitis—Total	61.62%	46.31%	37.55%	38.27%	44.70%	61.35%	76.71%	85.11%	89.17%
MY 2024	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	20.23%	46.67%	24.29%	42.38%	31.59%	49.48%	50.98%	67.03%	77.66%
MY 2024	PCE - Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	71.58%	62.50%	75.00%	79.69%	55.00%	55.28%	66.86%	74.78%	82.88%
MY 2024	PCE - Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	83.68%	62.50%	93.75%	95.31%	84.00%	67.25%	80.19%	86.54%	89.96%
		Diabetes								
MY 2024	EED - Eye Exams for Patients with Diabetes	59.09%	100.00%	60.00%	39.13%	52.94%	40.39%	49.15%	57.09%	64.06%
MY 2024	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	79.55%	100.00%	60.00%	65.22%	70.59%	58.15%	65.32%	71.78%	77.37%
MY 2024	GSD -Glycemic Status Assessment for Patients with Diabetes-- HbA1c Control (<8%)	68.18%	50.00%	60.00%	56.52%	52.94%	44.25%	54.50%	59.64%	63.50%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	63.64%	75.00%	50.00%	0.00%	0.00%	51.96%	62.66%	67.01%	71.41%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	57.14%	0.00%	100.00%	0.00%	0.00%	53.23%	64.18%	70.91%	79.73%
MY 2024	KED - Kidney Health Evaluation for Patients with Diabetes	33.96%	37.39%	28.71%	32.35%	29.28%	26.79%	33.00%	42.10%	49.72%
		Heart Disease								
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	100.00%	100.00%	100.00%	0.00%	0.00%	66.64%	79.82%	83.00%	85.89%
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	100.00%	100.00%	100.00%	0.00%	0.00%	59.95%	67.42%	74.07%	81.79%
MY 2024	***CBP - Controlling High Blood Pressure	72.00%	75.00%	66.67%	61.11%	37.50%	54.61%	61.43%	67.40%	72.75%

Year	Measure	County Performance					National Medicaid Benchmarks			
		Butte	Colusa	Glenn	Sutter	Yuba	10th	33.33rd	66.67th	90th
Treatment										
Behavioral Health - Care Coordination										
MY 2024	FUH - Follow-Up After Hospitalization for Mental Illness-7 days	NB	NB	NB	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2024	FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total	10.45%	22.22%	10.71%	12.32%	10.11%	21.19%	33.01%	44.33%	59.95%
MY 2024	FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total	26.69%	15.38%	28.26%	23.38%	22.71%	12.73%	18.76%	27.62%	37.47%
MY 2024	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	15.91%	30.00%	33.33%	17.65%	16.67%	15.91%	26.90%	37.64%	50.80%
Behavioral Health - Medication Adherence										
MY 2024	AMM - Antidepressant Medication Management—Effective Continuation Phase Treatment	43.28%	28.57%	66.67%	36.84%	35.00%	31.52%	41.00%	48.16%	61.06%
MY 2024	POD - Pharmacotherapy for Opioid Use Disorder—Total	14.88%	0.00%	28.57%	25.00%	11.63%	12.05%	21.36%	29.01%	36.71%
MY 2024	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	67.83%	83.33%	87.50%	86.96%	69.81%	44.65%	58.60%	66.15%	74.83%
Behavioral Health - Access, Monitoring and Safety										
MY 2024	APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	35.56%	50.00%	25.81%	28.26%	34.44%	25.86%	30.92%	41.41%	52.57%
MY 2024	ADD -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	0.00%	0.00%	0.00%	0.00%	0.00%	37.19%	48.94%	56.83%	63.49%
MY 2024	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	86.90%	90.91%	86.36%	89.57%	85.26%	75.46%	79.51%	83.51%	87.27%
MY 2024	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	45.16%	100.00%	44.44%	33.33%	29.63%	41.57%	54.55%	64.10%	74.14%
MY 2024	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	4.59%	5.77%	3.28%	6.01%	5.12%	6.08%	10.51%	16.78%	26.72%

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Year	Measure	County Performance					National Medicaid Benchmarks			
		Butte	Colusa	Glenn	Sutter	Yuba	10th	33.33rd	66.67th	90th
Treatment										
Risk-Adjusted Utilization										
MY 2024	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	2.6863	1.3132	0.0000	1.5553	2.337	No Bench Marks Use For Scoring			
Other Treatment Measures										
MY 2024	**LBP - Use of Imaging Studies for Low Back Pain	72.62%	67.92%	75.58%	75.72%	77.56%	64.77%	67.84%	72.74%	78.72%

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA.
NCQA calculates the Confidence Limits (CLs) for all health plans.

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

4.3 HPA HEDIS Rate Performance by County, Eureka Region: Del Norte, Humboldt, Lake, Mendocino Counties

4-5 points ○ 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). Denominators less than 20 at the county level are suppressed.

Year	Measure	County Performance				National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Mendocino	10th	33.33rd	66.67th	90th
		Prevention and Population							
		Children and Adolescent Well-Care							
MY 2023	***CIS - Childhood Immunization Status (Combination 10)	10.00%	19.44%	18.75%	21.88%	20.68%	26.76%	35.04%	45.26%
MY 2024		0.00%	26.47%	26.09%	31.43%	18.25%	24.39%	31.32%	42.34%
MY 2023	***IMA - Immunizations for Adolescents (Combination 2)	50.00%	40.48%	28.57%	33.33%	24.82%	30.66%	38.93%	48.80%
MY 2024		16.67%	36.36%	50.00%	35.71%	25.41%	31.39%	38.69%	48.66%
MY 2023	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	100.00%	88.89%	92.86%	91.67%	62.77%	74.70%	83.21%	89.72%
MY 2024		85.71%	88.00%	100.00%	80.00%	66.91%	76.89%	86.20%	91.24%
		Women's Reproductive Health							
MY 2023	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	100.00%	80.00%	100.00%	92.31%	25.86%	30.92%	41.41%	52.57%
MY 2024		55.56%	76.00%	86.67%	90.91%	73.48%	81.94%	86.89%	91.85%
MY 2023	***PPC - Prenatal and Postpartum Care—Postpartum Care	100.00%	80.00%	85.71%	92.31%	67.31%	75.18%	80.78%	84.59%
MY 2024		44.44%	88.00%	93.33%	90.91%	68.63%	77.37%	82.48%	86.62%
MY 2023	PRS-E - Prenatal Immunization Status - Combination Rate	19.67%	19.46%	32.27%	38.89%	7.94%	15.17%	25.81%	37.75%
MY 2024		14.05%	20.24%	28.69%	37.32%	8.42%	15.96%	24.92%	35.60%
		Cancer Screening							
MY 2023	BCS-E- Breast Cancer Screening	38.88%	47.35%	47.56%	50.43%	42.98%	48.33%	54.94%	62.67%
MY 2024		46.83%	51.35%	48.55%	56.75%	42.86%	49.24%	56.66%	63.48%
MY 2023	CCS - Cervical Cancer Screening	30.00%	48.78%	65.52%	66.67%	43.50%	53.37%	59.85%	66.48%
MY 2024		50.00%	75.00%	30.00%	50.00%	43.31%	52.07%	60.10%	67.46%
MY 2023	COL- Colorectal Cancer Screening	NR	NR	NR	NR	NR	NR	NR	NR
MY 2024	COL-E - Colorectal Cancer Screening	25.14%	28.05%	33.41%	31.50%	27.27%	34.30%	41.59%	49.35%

Year	Measure	County Performance				National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Mendocino	10th	33.33rd	66.67th	90th
		Treatment							
		Respiratory							
MY 2023	**AMR - Asthma Medication Ratio- Total**	46.79%	60.64%	51.71%	60.71%	55.09%	61.81%	69.41%	75.92%
MY 2024		60.83%	63.41%	57.84%	62.50%	54.56%	62.35%	70.56%	76.65%
MY 2023	CWP - Appropriate Testing for Pharyngitis—Total	68.86%	72.81%	60.75%	69.21%	57.41%	68.76%	77.56%	82.40%
MY 2024		63.05%	78.86%	58.17%	80.02%	61.35%	76.71%	85.11%	89.17%
MY 2023	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	73.28%	71.76%	58.58%	68.16%	50.05%	57.16%	66.19%	77.11%
MY 2024		56.25%	56.86%	55.52%	62.08%	49.48%	50.98%	67.03%	77.66%
MY 2023	PCE - Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	75.76%	79.26%	75.20%	74.47%	56.05%	68.39%	75.79%	82.43%
MY 2024		62.75%	68.84%	74.82%	74.00%	55.28%	66.86%	74.78%	82.88%
MY 2023	PCE - Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	87.88%	88.89%	83.20%	87.94%	72.88%	82.35%	86.96%	90.53%
MY 2024		82.35%	84.06%	92.09%	88.00%	67.25%	80.19%	86.54%	89.96%

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Year	Measure	County Performance				National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Mendocino	10th	33.33rd	66.67th	90th
		Treatment							
		Diabetes							
MY 2023	EED - Eye Exams for Patients with Diabetes	22.22%	44.12%	56.52%	44.00%	36.74%	46.96%	56.20%	63.33%
MY 2024		0.00%	33.33%	50.00%	70.00%	40.39%	49.15%	57.09%	64.06%
MY 2023	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	75.00%	59.09%	68.00%	75.00%	52.07%	59.85%	68.61%	74.56%
MY 2024		66.67%	66.67%	92.86%	60.00%	58.15%	65.32%	71.78%	77.37%
MY 2023	HBD -Hemoglobin A1c Control for Patients with Diabetes-- HbA1c Control (<8%)	77.78%	55.88%	52.17%	44.00%	38.93%	49.39%	55.72%	60.34%
MY 2024	GSD -Glycemic Status Assessment for Patients with Diabetes-- HbA1c Control (<8%)	33.33%	59.26%	78.57%	60.00%	44.25%	54.50%	59.64%	63.50%
MY 2023	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	54.32%	54.86%	58.43%	53.94%	54.15%	62.58%	67.07%	72.15%
MY 2024		59.47%	59.20%	61.94%	55.91%	51.96%	62.66%	67.01%	71.41%
MY 2023	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	95.45%	96.36%	92.39%	92.45%	52.67%	62.50%	70.37%	77.97%
MY 2024		73.25%	70.16%	61.03%	65.32%	53.23%	64.18%	70.91%	79.73%
MY 2023	KED - Kidney Health Evaluation for Patients with Diabetes	25.32%	31.69%	19.91%	19.26%	22.73%	29.42%	38.80%	47.55%
MY 2024		29.02%	37.62%	35.38%	31.95%	26.79%	33.00%	42.10%	49.72%
		Heart Disease							
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	77.78%	83.72%	80.12%	83.33%	70.02%	78.80%	81.64%	85.04%
MY 2024		69.44%	75.83%	85.71%	77.78%	66.64%	79.82%	83.00%	85.89%
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	91.43%	95.37%	92.70%	96.25%	56.67%	66.48%	73.63%	80.95%
MY 2024		64.00%	74.73%	71.67%	61.04%	59.95%	67.42%	74.07%	81.79%
MY 2023	***CBP - Controlling High Blood Pressure	37.50%	78.13%	72.22%	74.07%	50.36%	57.66%	65.45%	72.22%
MY 2024		83.33%	48.00%	68.18%	78.95%	54.61%	61.43%	67.40%	72.75%

Year	Measure	County Performance				National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Mendocino	10th	33.33rd	66.67th	90th
Treatment									
Behavioral Health - Care Coordination									
MY 2023	**FUH[1] - Follow-Up After Hospitalization for Mental Illness-7 days**	0.00%	0.00%	0.00%	0.00%	23.74%	33.61%	46.35%	61.68%
MY 2024		NB	NB	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2023	**FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total**	10.89%	22.04%	10.78%	5.69%	23.74%	33.61%	46.35%	61.68%
MY 2024		11.61%	17.14%	10.36%	12.77%	21.19%	33.01%	44.33%	59.95%
MY 2023	**FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total**	14.97%	26.22%	19.35%	22.27%	13.83%	20.00%	27.73%	38.15%
MY 2024		18.24%	31.70%	13.33%	21.08%	12.73%	18.76%	27.62%	37.47%
MY 2023	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	20.00%	35.39%	8.00%	53.69%	15.16%	23.12%	37.31%	49.55%
MY 2024		15.79%	37.24%	6.67%	52.52%	15.91%	26.90%	37.64%	50.80%
Behavioral Health - Medication Adherence									
MY 2023	AMM - Antidepressant Medication Management—Effective Continuation Phase Treatment	86.96%	82.99%	73.58%	79.39%	31.59%	40.01%	46.74%	58.06%
MY 2024		53.62%	52.91%	40.89%	44.49%	31.52%	41.00%	48.16%	61.06%
MY 2023	POD - Pharmacotherapy for Opioid Use Disorder—Total	61.90%	40.96%	48.40%	47.30%	14.94%	23.38%	31.93%	40.34%
MY 2024		16.95%	20.75%	13.82%	17.47%	12.05%	21.36%	29.01%	36.71%
MY 2023	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	76.92%	73.83%	67.38%	71.65%	41.24%	57.79%	64.90%	72.61%
MY 2024		67.57%	68.39%	68.12%	62.81%	44.65%	58.60%	66.15%	74.83%

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Year	Measure	County Performance				National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Mendocino	10th	33.33rd	66.67th	90th
Treatment									
Behavioral Health - Access, Monitoring and Safety									
MY 2023	APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	54.05%	21.32%	29.52%	37.04%	26.36%	31.97%	40.50%	53.58%
MY 2024		45.95%	21.14%	26.47%	29.09%	25.86%	30.92%	41.41%	52.57%
MY 2023	ADD -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	55.00%	36.00%	25.00%	43.33%	40.38%	50.98%	57.90%	63.92%
MY 2024		18.18%	43.24%	50.00%	33.33%	37.19%	48.94%	56.83%	63.49%
MY 2023	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	88.76%	81.56%	78.73%	86.96%	72.83%	77.40%	80.86%	85.52%
MY 2024		81.11%	79.15%	80.07%	88.03%	75.46%	79.51%	83.51%	87.27%
MY 2023	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	40.00%	30.36%	16.67%	11.11%	36.65%	55.19%	63.89%	73.87%
MY 2024		0.00%	48.98%	33.33%	75.00%	41.57%	54.55%	64.10%	74.14%
MY 2023	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	6.85%	10.11%	8.55%	10.44%	7.05%	11.11%	16.94%	24.37%
MY 2024		5.94%	8.06%	3.82%	8.25%	6.08%	10.51%	16.78%	26.72%
Risk-Adjusted Utilization									
MY 2023	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	0.7160	0.8959	0.9614	0.7823	No Bench Marks Use For Scoring			
MY 2024		0.6596	0.9967	0.9747	0.9901				
Other Treatment Measures									
MY 2023	**LBP - Use of Imaging Studies for Low Back Pain	66.82%	82.27%	72.25%	79.77%	67.72%	71.32%	75.44%	79.96%
MY 2024		69.04%	78.28%	70.45%	74.30%	64.77%	67.84%	72.74%	78.72%

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA. NCQA calculates the Confidence Limits (CLs) for all health plans.

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

4.4 HPA HEDIS Rate Performance by County, Fairfield Region: Solano, Yolo, and Napa Counties

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). Denominators less than 20 at the county level are suppressed.

Year	Measure	County Performance			National Medicaid Benchmarks			
		Napa	Solano	Yolo	10th	33.33rd	66.67th	90th
Prevention and Population								
Children and Adolescent Well-Care								
MY 2023	***CIS - Childhood Immunization Status (Combination 10)	45.00%	33.33%	41.38%	20.68%	26.76%	35.04%	45.26%
MY 2024		47.06%	34.85%	21.62%	18.25%	24.39%	31.32%	42.34%
MY 2023	***IMA - Immunizations for Adolescents (Combination 2)	70.37%	39.13%	37.93%	24.82%	30.66%	38.93%	48.80%
MY 2024		50.00%	38.03%	55.56%	25.41%	31.39%	38.69%	48.66%
MY 2023	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	100.00%	97.22%	69.23%	62.77%	74.70%	83.21%	89.72%
MY 2024		100.00%	80.65%	45.00%	66.91%	76.89%	86.20%	91.24%
Women's Reproductive Health								
MY 2023	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	90.91%	90.70%	89.47%	25.86%	30.92%	41.41%	52.57%
MY 2024		88.24%	87.76%	76.00%	73.48%	81.94%	86.89%	91.85%
MY 2023	***PPC - Prenatal and Postpartum Care—Postpartum Care	81.82%	93.02%	94.74%	67.31%	75.18%	80.78%	84.59%
MY 2024		100.00%	85.71%	68.00%	68.63%	77.37%	82.48%	86.62%
MY 2023	PRS-E - Prenatal Immunization Status - Combination Rate	35.87%	41.85%	38.39%	7.94%	15.17%	25.81%	37.75%
MY 2024		38.62%	37.70%	40.00%	8.42%	15.96%	24.92%	35.60%
Cancer Screening								
MY 2023	BCS-E- Breast Cancer Screening	67.20%	58.12%	59.99%	42.98%	48.33%	54.94%	62.67%
MY 2024		66.84%	54.14%	60.29%	42.86%	49.24%	56.66%	63.48%
MY 2023	CCS - Cervical Cancer Screening	77.27%	66.07%	48.78%	43.50%	53.37%	59.85%	66.48%
MY 2024		75.00%	64.71%	47.62%	43.31%	52.07%	60.10%	67.46%
MY 2023	COL- Colorectal Cancer Screening	NR	NR	NR	NR	NR	NR	NR
MY 2024	COL-E - Colorectal Cancer Screening	38.24%	31.74%	32.50%	27.27%	34.30%	41.59%	49.35%

Year	Measure	County Performance			National Medicaid Benchmarks			
		Napa	Solano	Yolo	10th	33.33rd	66.67th	90th
Prevention and Population								
Other Preventive Services								
MY 2023	CHL - Chlamydia Screening in Women—Total	55.05%	62.67%	53.32%	42.61%	51.39%	61.07%	67.39%
MY 2024		49.58%	62.14%	51.37%	43.53%	52.40%	61.46%	69.07%
MY 2023	AIS-E-Adult Immunization Status—Influenza - Total	24.34%	19.23%	22.72%	6.50%	10.82%	16.32%	21.05%
MY 2024		21.99%	16.50%	21.83%	7.39%	12.55%	17.91%	26.40%
MY 2023	AIS-E-Adult Immunization Status—Pneumococcal - 66+	51.43%	56.30%	50.46%	N/A	N/A	N/A	N/A
MY 2024		51.67%	51.11%	47.74%	21.04%	38.73%	55.03%	68.07%
MY 2023	AIS-E-Adult Immunization Status—Td/Tdap - Total	39.23%	38.95%	41.62%	18.67%	29.84%	41.54%	56.53%
MY 2024		35.69%	34.58%	39.96%	21.26%	33.40%	47.30%	57.67%
MY 2023	AIS-E-Adult Immunization Status—Zoster - Total	21.55%	17.94%	18.53%	1.72%	4.42%	10.27%	14.54%
MY 2024		24.27%	17.30%	19.20%	2.23%	7.15%	13.49%	20.56%
Treatment								
Respiratory								
MY 2023	**AMR - Asthma Medication Ratio- Total**	78.34%	68.85%	65.93%	55.09%	61.81%	69.41%	75.92%
MY 2024		79.82%	65.79%	67.84%	54.56%	62.35%	70.56%	76.65%
MY 2023	CWP - Appropriate Testing for Pharyngitis—Total	65.48%	62.85%	89.19%	57.41%	68.76%	77.56%	82.40%
MY 2024		74.40%	71.69%	88.25%	61.35%	76.71%	85.11%	89.17%
MY 2023	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	76.10%	81.13%	78.71%	50.05%	57.16%	66.19%	77.11%
MY 2024		68.79%	80.34%	80.77%	49.48%	50.98%	67.03%	77.66%
MY 2023	PCE - Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	69.70%	74.00%	75.00%	56.05%	68.39%	75.79%	82.43%
MY 2024		78.26%	76.19%	68.35%	55.28%	66.86%	74.78%	82.88%
MY 2023	PCE - Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	100.00%	89.50%	84.52%	72.88%	82.35%	86.96%	90.53%
MY 2024		91.30%	87.07%	84.81%	67.25%	80.19%	86.54%	89.96%

Year	Measure	County Performance			National Medicaid Benchmarks			
		Napa	Solano	Yolo	10th	33.33rd	66.67th	90th
Treatment								
Diabetes								
MY 2023	EED - Eye Exams for Patients with Diabetes	69.57%	58.76%	43.24%	36.74%	46.96%	56.20%	63.33%
MY 2024		46.67%	59.65%	44.83%	40.39%	49.15%	57.09%	64.06%
MY 2023	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	66.67%	71.23%	67.86%	52.07%	59.85%	68.61%	74.56%
MY 2024		86.67%	84.21%	68.97%	58.15%	65.32%	71.78%	77.37%
MY 2023	HBD -Hemoglobin A1c Control for Patients with Diabetes-- HbA1c Control (<8%)	52.17%	56.70%	48.65%	38.93%	49.39%	55.72%	60.34%
MY 2024	GSD -Glycemic Status Assessment for Patients with Diabetes-- HbA1c Control (<8%)	66.67%	52.63%	55.17%	44.25%	54.50%	59.64%	63.50%
MY 2023	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	69.71%	69.35%	68.62%	54.15%	62.58%	67.07%	72.15%
MY 2024		67.58%	68.90%	69.47%	51.96%	62.66%	67.01%	71.41%
MY 2023	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	94.88%	96.63%	94.49%	52.67%	62.50%	70.37%	77.97%
MY 2024		65.16%	70.86%	71.09%	53.23%	64.18%	70.91%	79.73%
MY 2023	KED - Kidney Health Evaluation for Patients with Diabetes	59.81%	55.47%	47.04%	22.73%	29.42%	38.80%	47.55%
MY 2024		48.46%	50.53%	39.00%	26.79%	33.00%	42.10%	49.72%
Heart Disease								
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	85.26%	82.35%	84.31%	70.02%	78.80%	81.64%	85.04%
MY 2024		87.84%	77.89%	82.48%	66.64%	79.82%	83.00%	85.89%
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	97.53%	96.94%	93.80%	56.67%	66.48%	73.63%	80.95%
MY 2024		64.62%	69.87%	81.42%	59.95%	67.42%	74.07%	81.79%
MY 2023	***CBP - Controlling High Blood Pressure	86.67%	65.71%	63.64%	50.36%	57.66%	65.45%	72.22%
MY 2024		52.38%	62.75%	78.13%	54.61%	61.43%	67.40%	72.75%

Year	Measure	County Performance			National Medicaid Benchmarks			
		Napa	Solano	Yolo	10th	33.33rd	66.67th	90th
Treatment								
Behavioral Health - Care Coordination								
MY 2023	**FUH[1] - Follow-Up After Hospitalization for Mental Illness-7 days**	16.67%	58.10%	0.00%	23.74%	33.61%	46.35%	61.68%
MY 2024		NB	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2023	**FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total**	20.59%	19.43%	15.58%	23.74%	33.61%	46.35%	61.68%
MY 2024		13.04%	9.98%	10.69%	21.19%	33.01%	44.33%	59.95%
MY 2023	**FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total**	17.37%	24.81%	17.45%	13.83%	20.00%	27.73%	38.15%
MY 2024		10.83%	20.83%	17.30%	12.73%	18.76%	27.62%	37.47%
MY 2023	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	17.39%	36.08%	11.76%	15.16%	23.12%	37.31%	49.55%
MY 2024		12.90%	32.17%	15.07%	15.91%	26.90%	37.64%	50.80%
Behavioral Health - Medication Adherence								
MY 2023	AMM - Antidepressant Medication Management—Effective Continuation Phase Treatment	86.92%	84.74%	79.92%	31.59%	40.01%	46.74%	58.06%
MY 2024		49.62%	51.75%	50.22%	31.52%	41.00%	48.16%	61.06%
MY 2023	POD - Pharmacotherapy for Opioid Use Disorder—Total	38.46%	42.53%	39.68%	14.94%	23.38%	31.93%	40.34%
MY 2024		3.57%	13.07%	3.85%	12.05%	21.36%	29.01%	36.71%
MY 2023	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	78.02%	73.23%	67.11%	41.24%	57.79%	64.90%	72.61%
MY 2024		65.67%	65.96%	64.89%	44.65%	58.60%	66.15%	74.83%

Partnership HealthPlan of California
Measurement Year 2024 - Reporting Year 2025

Year	Measure	County Performance			National Medicaid Benchmarks			
		Napa	Solano	Yolo	10th	33.33rd	66.67th	90th
Treatment								
Behavioral Health - Access, Monitoring and Safety								
MY 2023	APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	47.73%	33.57%	21.18%	26.36%	31.97%	40.50%	53.58%
MY 2024		40.00%	41.57%	23.88%	25.86%	30.92%	41.41%	52.57%
MY 2023	ADD -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	37.50%	16.22%	38.78%	40.38%	50.98%	57.90%	63.92%
MY 2024		28.57%	25.00%	48.84%	37.19%	48.94%	56.83%	63.49%
MY 2023	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.55%	85.45%	83.85%	72.83%	77.40%	80.86%	85.52%
MY 2024		83.85%	87.32%	80.00%	75.46%	79.51%	83.51%	87.27%
MY 2023	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	28.00%	20.37%	17.39%	36.65%	55.19%	63.89%	73.87%
MY 2024		9.09%	58.33%	28.00%	41.57%	54.55%	64.10%	74.14%
MY 2023	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	6.32%	9.24%	4.34%	7.05%	11.11%	16.94%	24.37%
MY 2024		4.79%	8.85%	3.50%	6.08%	10.51%	16.78%	26.72%
Risk-Adjusted Utilization								
MY 2023	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	1.0566	0.8160	0.9892	No Bench Marks Use For Scoring			
MY 2024		0.8874	1.1087	1.0775				
Other Treatment Measures								
MY 2023	**LBP - Use of Imaging Studies for Low Back Pain	75.78%	77.01%	76.37%	67.72%	71.32%	75.44%	79.96%
MY 2024		65.19%	71.39%	74.62%	64.77%	67.84%	72.74%	78.72%

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA. NCQA calculates the Confidence Limits (CLs) for all health plans.

4.5 HPA HEDIS Rate Performance by County, Redding Region: Lassen, Modoc, Shasta, Siskiyou, Tehama, Trinity Counties

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). Denominators less than 20 at the county level are suppressed.

Year	Measure	County Performance						National Medicaid Benchmarks			
		Lassen	Modoc	Shasta	Siskiyou	Tehama	Trinity	10th	33.33rd	66.67th	90th
		Prevention and Population									
		Children and Adolescent Well-Care									
MY 2023	***CIS - Childhood Immunization Status (Combination 10)	10.00%	0.00%	13.95%	20.00%	N/A	0.00%	20.68%	26.76%	35.04%	45.26%
MY 2024		50.00%	0.00%	16.00%	18.18%	0.00%	25.00%	18.25%	24.39%	31.32%	42.34%
MY 2023	***IMA - Immunizations for Adolescents (Combination 2)	0.00%	50.00%	21.82%	18.18%	N/A	33.33%	24.82%	30.66%	38.93%	48.80%
MY 2024		12.50%	0.00%	21.57%	10.00%	0.00%	33.33%	25.41%	31.39%	38.69%	48.66%
MY 2023	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	66.67%	100.00%	86.67%	66.67%	N/A	66.67%	62.77%	74.70%	83.21%	89.72%
MY 2024		100.00%	100.00%	95.12%	66.67%	56.25%	0.00%	66.91%	76.89%	86.20%	91.24%
		Women's Reproductive Health									
MY 2023	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	100.00%	75.00%	93.75%	66.67%	N/A	0.00%	25.86%	30.92%	41.41%	52.57%
MY 2024		100.00%	100.00%	84.38%	100.00%	61.54%	50.00%	73.48%	81.94%	86.89%	91.85%
MY 2023	***PPC - Prenatal and Postpartum Care—Postpartum Care	100.00%	25.00%	83.38%	33.33%	N/A	0.00%	67.31%	75.18%	80.78%	84.59%
MY 2024		100.00%	50.00%	0.00%	100.00%	92.31%	75.00%	68.63%	77.37%	82.48%	86.62%
MY 2023	PRS-E - Prenatal Immunization Status - Combination Rate	11.70%	15.63%	14.29%	20.00%	N/A	8.51%	7.94%	15.17%	25.81%	37.75%
MY 2024		26.67%	17.14%	24.12%	27.33%	22.51%	15.38%	8.42%	15.96%	24.92%	35.60%
		Cancer Screening									
MY 2023	BCS-E- Breast Cancer Screening	45.98%	45.65%	50.90%	51.66%	N/A	43.46%	42.98%	48.33%	54.94%	62.67%
MY 2024		43.08%	48.52%	54.90%	52.64%	38.46%	49.39%	42.86%	49.24%	56.66%	63.48%
MY 2023	CCS - Cervical Cancer Screening	33.33%	0.00%	39.47%	66.67%	N/A	66.67%	43.50%	53.37%	59.85%	66.48%
MY 2024		50.00%	100.00%	53.85%	72.73%	36.84%	100.00%	43.31%	52.07%	60.10%	67.46%
MY 2023	COL- Colorectal Cancer Screening	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
MY 2024	COL-E - Colorectal Cancer Screening	23.17%	31.51%	32.16%	27.63%	25.00%	27.13%	27.27%	34.30%	41.59%	49.35%

Year	Measure	County Performance						National Medicaid Benchmarks			
		Lassen	Modoc	Shasta	Siskiyou	Tehama	Trinity	10th	33.33rd	66.67th	90th
Prevention and Population											
Other Preventive Services											
MY 2023	CHL - Chlamydia Screening in Women—Total	37.37%	30.39%	53.06%	46.15%	N/A	35.96%	42.61%	51.39%	61.07%	67.39%
MY 2024		41.55%	32.89%	52.12%	45.38%	54.34%	34.72%	43.53%	52.40%	61.46%	69.07%
MY 2023	AIS-E-Adult Immunization Status—Influenza - Total	7.70%	9.76%	9.31%	9.63%	N/A	7.89%	6.50%	10.82%	16.32%	21.05%
MY 2024		12.02%	10.14%	8.49%	10.20%	9.42%	8.18%	7.39%	12.55%	17.91%	26.40%
MY 2023	AIS-E-Adult Immunization Status—Pneumococcal - 66+	30.00%	25.00%	32.17%	33.33%	N/A	0.00%	N/A	N/A	N/A	N/A
MY 2024		30.00%	46.15%	36.81%	32.43%	27.00%	9.09%	21.04%	38.73%	55.03%	68.07%
MY 2023	AIS-E-Adult Immunization Status—Td/Tdap - Total	28.52%	29.97%	31.04%	29.73%	N/A	27.09%	18.67%	29.84%	41.54%	56.53%
MY 2024		28.42%	31.51%	33.87%	31.68%	29.20%	31.10%	21.26%	33.40%	47.30%	57.67%
MY 2023	AIS-E-Adult Immunization Status—Zoster - Total	3.76%	8.95%	9.25%	4.65%	N/A	5.99%	1.72%	4.42%	10.27%	14.54%
MY 2024		4.50%	10.87%	10.49%	5.84%	9.87%	6.96%	2.23%	7.15%	13.49%	20.56%

Year	Measure	County Performance						National Medicaid Benchmarks			
		Lassen	Modoc	Shasta	Siskiyou	Tehama	Trinity	10th	33.33rd	66.67th	90th
Treatment											
Respiratory											
MY 2023	**AMR - Asthma Medication Ratio- Total**	54.64%	46.88%	49.94%	49.05%	N/A	48.00%	55.09%	61.81%	69.41%	75.92%
MY 2024		58.70%	63.16%	57.28%	59.62%	0.00%	50.00%	54.56%	62.35%	70.56%	76.65%
MY 2023	CWP - Appropriate Testing for Pharyngitis—Total	83.33%	74.39%	60.26%	52.12%	N/A	47.44%	57.41%	68.76%	77.56%	82.40%
MY 2024		77.47%	75.18%	63.34%	64.94%	50.37%	43.96%	61.35%	76.71%	85.11%	89.17%
MY 2023	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	71.01%	46.67%	69.48%	67.18%	N/A	72.41%	50.05%	57.16%	66.19%	77.11%
MY 2024		59.62%	60.00%	61.78%	65.66%	53.05%	64.71%	49.48%	50.98%	67.03%	77.66%
MY 2023	PCE - Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	90.48%	75.00%	66.06%	61.11%	N/A	77.78%	56.05%	68.39%	75.79%	82.43%
MY 2024		58.62%	30.77%	74.31%	70.83%	77.00%	81.82%	55.28%	66.86%	74.78%	82.88%
MY 2023	PCE - Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	95.24%	75.00%	87.27%	86.11%	N/A	88.89%	72.88%	82.35%	86.96%	90.53%
MY 2024		86.21%	84.62%	85.42%	83.33%	90.00%	81.82%	67.25%	80.19%	86.54%	89.96%
Diabetes											
MY 2023	EED - Eye Exams for Patients with Diabetes	100.00%	100.00%	68.42%	85.71%	N/A	50.00%	36.74%	46.96%	56.20%	63.33%
MY 2024		20.00%	100.00%	58.33%	71.43%	30.77%	0.00%	40.39%	49.15%	57.09%	64.06%
MY 2023	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	66.67%	80.00%	73.81%	70.00%	N/A	66.67%	52.07%	59.85%	68.61%	74.56%
MY 2024		20.00%	0.00%	62.50%	57.14%	30.77%		58.15%	65.32%	71.78%	77.37%
MY 2023	HBD -Hemoglobin A1c Control for Patients with Diabetes-- HbA1c Control (<8%)	0.00%	100.00%	65.79%	42.86%	N/A	25.00%	38.93%	49.39%	55.72%	60.34%
MY 2024	GSD -Glycemic Status Assessment for Patients with Diabetes-- HbA1c Control (<8%)	60.00%	50.00%	54.17%	42.86%	38.46%	0.00%	44.25%	54.50%	59.64%	63.50%
MY 2023	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	55.29%	64.13%	54.82%	56.68%	N/A	47.73%	54.15%	62.58%	67.07%	72.15%
MY 2024		53.90%	60.61%	57.12%	61.60%	46.15%	51.09%	51.96%	62.66%	67.01%	71.41%
MY 2023	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	93.62%	98.31%	93.45%	93.50%	N/A	97.62%	52.67%	62.50%	70.37%	77.97%
MY 2024		67.47%	73.33%	71.68%	67.71%	66.67%	82.98%	53.23%	64.18%	70.91%	79.73%
MY 2023	KED - Kidney Health Evaluation for Patients with Diabetes	18.15%	25.00%	38.24%	26.56%	N/A	24.83%	22.73%	29.42%	38.80%	47.55%
MY 2024		17.08%	24.22%	42.26%	38.86%	37.70%	31.72%	26.79%	33.00%	42.10%	49.72%

Year	Measure	County Performance						National Medicaid Benchmarks			
		Lassen	Modoc	Shasta	Siskiyou	Tehama	Trinity	10th	33.33rd	66.67th	90th
Treatment											
Heart Disease											
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	72.73%	50.00%	75.22%	87.50%	N/A	78.57%	70.02%	78.80%	81.64%	85.04%
MY 2024		78.95%	100.00%	80.65%	76.67%	66.67%	78.95%	66.64%	79.82%	83.00%	85.89%
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	100.00%	100.00%	96.46%	91.43%	N/A	100.00%	56.67%	66.48%	73.63%	80.95%
MY 2024		60.00%	57.14%	68.00%	60.87%	50.00%	73.33%	59.95%	67.42%	74.07%	81.79%
MY 2023	***CBP - Controlling High Blood Pressure	100.00%	75.00%	80.65%	80.00%	N/A	100.00%	50.36%	57.66%	65.45%	72.22%
MY 2024		54.55%	0.00%	51.52%	50.00%	33.33%		54.61%	61.43%	67.40%	72.75%
Behavioral Health - Care Coordination											
MY 2023	**FUH[1] - Follow-Up After Hospitalization for Mental Illness-7 days**	0.00%	0.00%	0.00%	0.00%	N/A	0.00%	23.74%	33.61%	46.35%	61.68%
MY 2024		NB	NB	NB	NB	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2023	**FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total**	10.00%	0.00%	17.44%	13.58%	N/A	21.05%	23.74%	33.61%	46.35%	61.68%
MY 2024		9.38%	5.88%	18.90%	23.61%	6.67%	6.25%	21.19%	33.01%	44.33%	59.95%
MY 2023	**FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total**	6.67%	35.29%	34.58%	18.37%	N/A	21.05%	13.83%	20.00%	27.73%	38.15%
MY 2024		14.52%	27.27%	34.01%	22.29%	22.94%	20.93%	12.73%	18.76%	27.62%	37.47%
MY 2023	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	26.09%	40.00%	31.27%	40.00%	N/A	0.00%	15.16%	23.12%	37.31%	49.55%
MY 2024		37.04%	31.25%	36.40%	39.29%	25.00%	0.00%	15.91%	26.90%	37.64%	50.80%

Year	Measure	County Performance						National Medicaid Benchmarks			
		Lassen	Modoc	Shasta	Siskiyou	Tehama	Trinity	10th	33.33rd	66.67th	90th
Treatment											
Behavioral Health - Medication Adherence											
MY 2023	AMM - Antidepressant Medication Management—Effective Continuation Phase Treatment	81.05%	72.41%	81.78%	86.41%	N/A	86.36%	31.59%	40.01%	46.74%	58.06%
MY 2024		54.29%	22.22%	46.21%	44.66%	44.00%	55.56%	31.52%	41.00%	48.16%	61.06%
MY 2023	POD - Pharmacotherapy for Opioid Use Disorder—Total	52.94%	66.67%	33.63%	37.63%	N/A	46.15%	14.94%	23.38%	31.93%	40.34%
MY 2024		5.56%	55.56%	16.40%	27.83%	4.00%	10.00%	12.05%	21.36%	29.01%	36.71%
MY 2023	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	75.00%	73.68%	72.43%	84.38%	N/A	50.00%	41.24%	57.79%	64.90%	72.61%
MY 2024		73.91%	46.15%	66.19%	57.58%	60.53%	70.00%	44.65%	58.60%	66.15%	74.83%
Behavioral Health - Access, Monitoring and Safety											
MY 2023	APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	30.43%	11.11%	29.11%	34.78%	N/A	37.50%	26.36%	31.97%	40.50%	53.58%
MY 2024		31.03%	0.00%	29.56%	29.73%	29.52%	50.00%	25.86%	30.92%	41.41%	52.57%
MY 2023	ADD -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	15.38%	25.00%	32.43%	37.50%	N/A	37.50%	40.38%	50.98%	57.90%	63.92%
MY 2024		20.00%	50.00%	48.53%	53.85%	0.00%	40.00%	37.19%	48.94%	56.83%	63.49%
MY 2023	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	67.92%	96.15%	78.12%	87.62%	N/A	76.47%	72.83%	77.40%	80.86%	85.52%
MY 2024		80.43%	90.48%	81.42%	82.76%	84.08%	88.89%	75.46%	79.51%	83.51%	87.27%
MY 2023	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	20.83%	14.29%	31.97%	18.18%	N/A	20.00%	36.65%	55.19%	63.89%	73.87%
MY 2024		6.25%	33.33%	54.55%	50.00%	20.69%	50.00%	41.57%	54.55%	64.10%	74.14%
MY 2023	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	6.51%	2.59%	9.95%	11.13%	N/A	5.00%	7.05%	11.11%	16.94%	24.37%
MY 2024		9.57%	8.94%	12.24%	11.41%	4.96%	2.87%	6.08%	10.51%	16.78%	26.72%

Partnership HealthPlan of California
Measurement Year 2024 - Reporting Year 2025

		Risk-Adjusted Utilization									
MY 2023	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	0.7435	1.2776	0.8396	0.9745	N/A	0.8752	No Bench Marks Use For Scoring			
MY 2024		0.9224	0.9456	0.8900	0.4606	2.7723	0.6961				
		Other Treatment Measures									
MY 2023	**LBP - Use of Imaging Studies for Low Back Pain	68.93%	73.91%	76.68%	61.90%	N/A	75.76%	67.72%	71.32%	75.44%	79.96%
MY 2024		71.59%	57.78%	75.10%	63.19%	76.58%	64.44%	64.77%	67.84%	72.74%	78.72%

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA.
NCQA calculates the Confidence Limits (CLs) for all health plans.

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

4.6 HPA HEDIS Rate Performance by County, Santa Rosa Region: Marin, Sonoma Counties

Note: CAHPS is not captured by County

4-5 points ○ 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). Denominators less than 20 at the county level are suppressed.

Year	Measure	County Performance		National Medicaid Benchmarks			
		Marin	Sonoma	10th	33.33rd	66.67th	90th
Prevention and Population							
Children and Adolescent Well-Care							
MY 2023	***CIS - Childhood Immunization Status (Combination 10)	28.13%	44.74%	20.68%	26.76%	35.04%	45.26%
MY 2024		35.14%	34.25%	18.25%	24.39%	31.32%	42.34%
MY 2023	***IMA - Immunizations for Adolescents (Combination 2)	64.29%	65.43%	24.82%	30.66%	38.93%	48.80%
MY 2024		57.14%	53.85%	25.41%	31.39%	38.69%	48.66%
MY 2023	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	89.47%	77.50%	62.77%	74.70%	83.21%	89.72%
MY 2024		90.91%	69.49%	66.91%	76.89%	86.20%	91.24%
Women's Reproductive Health							
MY 2023	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.89%	91.67%	25.86%	30.92%	41.41%	52.57%
MY 2024		100.00%	90.00%	73.48%	81.94%	86.89%	91.85%
MY 2023	***PPC - Prenatal and Postpartum Care—Postpartum Care	100.00%	88.89%	67.31%	75.18%	80.78%	84.59%
MY 2024		100.00%	96.67%	68.63%	77.37%	82.48%	86.62%
MY 2023	PRS-E - Prenatal Immunization Status - Combination Rate	57.21%	45.31%	7.94%	15.17%	25.81%	37.75%
MY 2024		46.87%	39.15%	8.42%	15.96%	24.92%	35.60%
Cancer Screening							
MY 2023	BCS-E- Breast Cancer Screening	58.02%	61.94%	42.98%	48.33%	54.94%	62.67%
MY 2024		63.44%	59.17%	42.86%	49.24%	56.66%	63.48%
MY 2023	CCS - Cervical Cancer Screening	75.00%	58.62%	43.50%	53.37%	59.85%	66.48%
MY 2024		71.43%	68.00%	43.31%	52.07%	60.10%	67.46%
MY 2023	COL- Colorectal Cancer Screening	NR	NR	NR	NR	NR	NR
MY 2024	COL-E - Colorectal Cancer Screening	34.44%	38.68%	27.27%	34.30%	41.59%	49.35%

Year	Measure	County Performance		National Medicaid Benchmarks			
		Marin	Sonoma	10th	33.33rd	66.67th	90th
Prevention and Population							
Other Preventive Services							
MY 2023	CHL - Chlamydia Screening in Women—Total	72.34%	54.05%	42.61%	51.39%	61.07%	67.39%
MY 2024		77.63%	51.89%	43.53%	52.40%	61.46%	69.07%
MY 2023	AIS-E-Adult Immunization Status—Influenza - Total	24.30%	23.75%	6.50%	10.82%	16.32%	21.05%
MY 2024		21.41%	18.25%	7.39%	12.55%	17.91%	26.40%
MY 2023	AIS-E-Adult Immunization Status—Pneumococcal - 66+	48.51%	44.70%	N/A	N/A	N/A	N/A
MY 2024		49.58%	40.21%	21.04%	38.73%	55.03%	68.07%
MY 2023	AIS-E-Adult Immunization Status—Td/Tdap - Total	41.23%	35.03%	18.67%	29.84%	41.54%	56.53%
MY 2024		40.27%	31.66%	21.26%	33.40%	47.30%	57.67%
MY 2023	AIS-E-Adult Immunization Status—Zoster - Total	22.92%	15.55%	1.72%	4.42%	10.27%	14.54%
MY 2024		27.44%	13.98%	2.23%	7.15%	13.49%	20.56%

Year	Measure	County Performance		National Medicaid Benchmarks			
		Marin	Sonoma	10th	33.33rd	66.67th	90th
Treatment							
Respiratory							
MY 2023	**AMR - Asthma Medication Ratio- Total**	65.65%	71.78%	55.09%	61.81%	69.41%	75.92%
MY 2024		61.27%	70.42%	54.56%	62.35%	70.56%	76.65%
MY 2023	CWP - Appropriate Testing for Pharyngitis—Total	77.41%	75.36%	57.41%	68.76%	77.56%	82.40%
MY 2024		80.68%	82.89%	61.35%	76.71%	85.11%	89.17%
MY 2023	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	87.50%	79.66%	50.05%	57.16%	66.19%	77.11%
MY 2024		88.02%	77.33%	49.48%	50.98%	67.03%	77.66%
MY 2023	PCE - Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	72.22%	75.00%	56.05%	68.39%	75.79%	82.43%
MY 2024		55.26%	71.52%	55.28%	66.86%	74.78%	82.88%
MY 2023	PCE - Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	86.11%	91.88%	72.88%	82.35%	86.96%	90.53%
MY 2024		86.84%	87.42%	67.25%	80.19%	86.54%	89.96%

		Diabetes					
MY 2023	EED - Eye Exams for Patients with Diabetes	50.00%	41.77%	36.74%	46.96%	56.20%	63.33%
MY 2024		63.16%	65.52%	40.39%	49.15%	57.09%	64.06%
MY 2023	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	66.67%	59.76%	52.07%	59.85%	68.61%	74.56%
MY 2024		89.47%	67.24%	58.15%	65.32%	71.78%	77.37%
MY 2023	HBD -Hemoglobin A1c Control for Patients with Diabetes-- HbA1c Control (<8%)	73.08%	49.37%	38.93%	49.39%	55.72%	60.34%
MY 2024	GSD -Glycemic Status Assessment for Patients with Diabetes-- HbA1c Control (<8%)	52.63%	44.83%	44.25%	54.50%	59.64%	63.50%
MY 2023	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	65.65%	65.80%	54.15%	62.58%	67.07%	72.15%
MY 2024		67.69%	68.61%	51.96%	62.66%	67.01%	71.41%
MY 2023	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	95.35%	93.54%	52.67%	62.50%	70.37%	77.97%
MY 2024		69.25%	62.65%	53.23%	64.18%	70.91%	79.73%
MY 2023	KED - Kidney Health Evaluation for Patients with Diabetes	43.55%	44.30%	22.73%	29.42%	38.80%	47.55%
MY 2024		50.23%	47.24%	26.79%	33.00%	42.10%	49.72%

Year	Measure	County Performance		National Medicaid Benchmarks			
		Marin	Sonoma	10th	33.33rd	66.67th	90th
		Treatment					
		Heart Disease					
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	87.74%	83.18%	70.02%	78.80%	81.64%	85.04%
MY 2024		89.01%	82.29%	66.64%	79.82%	83.00%	85.89%
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	100.00%	93.38%	56.67%	66.48%	73.63%	80.95%
MY 2024		72.84%	70.46%	59.95%	67.42%	74.07%	81.79%
MY 2023	***CBP - Controlling High Blood Pressure	62.07%	71.64%	50.36%	57.66%	65.45%	72.22%
MY 2024		62.07%	62.67%	54.61%	61.43%	67.40%	72.75%
		Behavioral Health - Care Coordination					
MY 2023	**FUH[1] - Follow-Up After Hospitalization for Mental Illness-7 days**	11.11%	15.79%	23.74%	33.61%	46.35%	61.68%
MY 2024		NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2023	**FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total**	28.49%	26.91%	23.74%	33.61%	46.35%	61.68%
MY 2024		20.50%	16.83%	21.19%	33.01%	44.33%	59.95%
MY 2023	**FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total**	22.95%	17.08%	13.83%	20.00%	27.73%	38.15%
MY 2024		21.33%	18.89%	12.73%	18.76%	27.62%	37.47%
MY 2023	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	17.81%	13.57%	15.16%	23.12%	37.31%	49.55%
MY 2024		10.53%	22.86%	15.91%	26.90%	37.64%	50.80%

Year	Measure	County Performance		National Medicaid Benchmarks			
		Marin	Sonoma	10th	33.33rd	66.67th	90th
Treatment							
Behavioral Health - Medication Adherence							
MY 2023	AMM - Antidepressant Medication Management—Effective Continuation Phase Treatment	82.33%	80.13%	31.59%	40.01%	46.74%	58.06%
MY 2024		49.81%	45.43%	31.52%	41.00%	48.16%	61.06%
MY 2023	POD - Pharmacotherapy for Opioid Use Disorder—Total	47.22%	46.89%	14.94%	23.38%	31.93%	40.34%
MY 2024		5.19%	12.62%	12.05%	21.36%	29.01%	36.71%
MY 2023	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	85.71%	73.57%	41.24%	57.79%	64.90%	72.61%
MY 2024		77.88%	68.80%	44.65%	58.60%	66.15%	74.83%
Behavioral Health - Access, Monitoring and Safety							
MY 2023	APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	40.00%	41.84%	26.36%	31.97%	40.50%	53.58%
MY 2024		51.72%	35.29%	25.86%	30.92%	41.41%	52.57%
MY 2023	ADD -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	27.03%	33.74%	40.38%	50.98%	57.90%	63.92%
MY 2024		50.00%	31.82%	37.19%	48.94%	56.83%	63.49%
MY 2023	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	79.34%	81.45%	72.83%	77.40%	80.86%	85.52%
MY 2024		78.61%	85.90%	75.46%	79.51%	83.51%	87.27%
MY 2023	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	22.73%	32.47%	36.65%	55.19%	63.89%	73.87%
MY 2024		77.78%	31.48%	41.57%	54.55%	64.10%	74.14%
MY 2023	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	6.69%	7.17%	7.05%	11.11%	16.94%	24.37%
MY 2024		5.39%	8.69%	6.08%	10.51%	16.78%	26.72%

Risk-Adjusted Utilization							
MY 2023	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	0.9021	0.9640	No Bench Marks Use For Scoring			
MY 2024		0.9704	0.8308				
Other Treatment Measures							
MY 2023	**LBP - Use of Imaging Studies for Low Back Pain	75.28%	78.80%	67.72%	71.32%	75.44%	79.96%
MY 2024		72.67%	77.55%	64.77%	67.84%	72.74%	78.72%

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA.
NCQA calculates the Confidence Limits (CLs) for all health plans.

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

5.0 HEDIS HealthPlan Accreditation (HPA) – Healthplan Rating Methodology

Health plans are rated in three categories: private/commercial plans in which people enroll through employers or on their own; plans that serve Medicare beneficiaries in the Medicare Advantage program (not supplemental plans); and plans that serve Medicaid beneficiaries.

NCQA ratings are based on three types of quality measures: 1) measures of clinical quality from NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®) and Health Outcomes Survey (HOS); 2) measures of patient experience using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®); and 3) results from NCQA's review of a health plan's health quality processes (NCQA Accreditation). NCQA rates health plans that choose to report measures publicly.

The overall rating is the weighted average of a plan's HEDIS, HOS and CAHPS measure ratings, plus Accreditation bonus points (if the plan is Accredited by NCQA), rounded to the nearest half point displayed as stars.

The overall rating is based on performance on dozens of measures of care and is calculated on a 0–5 scale in half points (5 is highest). Performance includes three subcategories:

1. **Patient Experience:** Patient-reported experience of care, including experience with doctors, services and customer service (measures in the Patient Experience category).

2. **Rates for Clinical Measures:** The proportion of eligible members who received preventive services (prevention measures) and the proportion of eligible members who received recommended care for certain conditions (treatment measures).

3. **NCQA Health Plan Accreditation:** For a plan with an Accredited or Provisional status, 0.5 bonus points are added to the overall rating before rounding to the nearest half point and displayed as stars.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

6.0 HEDIS/CAHPS Measures Required for HP Accreditation—Medicaid

Measure Name		Display Name	Weight
PATIENT EXPERIENCE			
Getting Care			
Getting Needed Care (Usually + Always)		Getting care easily	1.5
Getting Care Quickly (Usually + Always)		Getting care quickly	1.5
Satisfaction With Plan Physicians			
Rating of Personal Doctor (9 + 10)		Rating of primary care doctor	1.5
Satisfaction With Plan and Plan Services			
Rating of Health Plan (9 + 10)		Rating of health plan	1.5
Rating of All Health Care (9 + 10)		Rating of care	1.5
PREVENTION AND POPULATION			
Children and Adolescent Well-Care			
CIS	Childhood Immunization Status—Combination 10	Childhood immunizations	3
IMA	Immunizations for Adolescents—Combination 2	Adolescent immunizations	3
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	BMI percentile assessment	1
Women's Reproductive Health			
PPC	Prenatal and Postpartum Care—Timeliness of Prenatal Care	Prenatal checkups	1
	Prenatal and Postpartum Care—Postpartum Care	Postpartum care	1
PRS-E	Prenatal Immunization Status—Combination Rate	Prenatal immunizations	1
Cancer Screening			
BCS-E	Breast Cancer Screening	Breast cancer screening	1
COL-E	Colorectal Cancer Screening—Total *(NEW MEASURE)*	Colorectal cancer screening	1
CCS	Cervical Cancer Screening	Cervical cancer screening	1
Description of Membership			
RDM	Race/Ethnicity Diversity of Membership	Race and ethnicity of members	1
LDM	Language Diversity of Membership *(NEW MEASURE)*	Language preferences of members	0.5
Other Preventive Services			
CHL	Chlamydia Screening in Women—Total	Chlamydia screening	1
AIS-E	Adult Immunization Status—Influenza—Total	Influenza immunizations for adults	1
	Adult Immunization Status—Td/Tdap—Total	Td/Tdap immunizations for adults	1
	Adult Immunization Status—Zoster—Total	Zoster immunizations for adults	1
	Adult Immunization Status—Pneumococcal—66+	Pneumococcal immunizations for adults	1

TREATMENT			
Respiratory			
AMR	Asthma Medication Ratio—Total	Asthma control	1
CWP	Appropriate Testing for Pharyngitis—Total	Appropriate testing and care for a sore throat	1
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	Appropriate antibiotic use for acute bronchitis/bronchiolitis	1
PCE	Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	Steroid after hospitalization for acute COPD	1
	Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	Bronchodilator after hospitalization for acute COPD	1
Diabetes			
BPD	Blood Pressure Control for Patients With Diabetes	Patients with diabetes—blood pressure control (140/90)	3
EED	Eye Exam for Patients With Diabetes	Patients with diabetes—eye exams	1
GSD	Glycemic Status Assessment for Patients With Diabetes—Glycemic Status (<8%) ***(NEW MEASURE)***	Patients with diabetes—glycemic status	3
SPD	Statin Therapy for Patients With Diabetes—Received Statin Therapy	Patients with diabetes—received statin therapy	1
	Statin Therapy for Patients With Diabetes—Statin Adherence 80%	Patients with diabetes—statin adherence 80%	1
KED	Kidney Health Evaluation for Patients With Diabetes—Total	Patients with diabetes—kidney health evaluation	1
Heart Disease			
SPC	Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	Patients with cardiovascular disease—received statin therapy	1
	Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	Patients with cardiovascular disease—statin adherence 80%	1
CBP	Controlling High Blood Pressure	Controlling high blood pressure	3

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Measure Name		Display Name	Weight
Behavioral Health—Care Coordination			
FUM	Follow-Up After Emergency Department Visit for Mental Illness—7 days—Total	Follow-up after ED for mental illness	1
FUA	Follow-Up After Emergency Department Visit for Substance Use—7 days—Total	Follow-up after ED for substance use disorder	1
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	Follow-up after high-intensity care for substance use disorder	1
Behavioral Health—Medication Adherence			
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Adherence to antipsychotic medications for individuals with schizophrenia	1
AMM	Antidepressant Medication Management—Effective Continuation Phase Treatment	Patients with a new episode of depression—medication adherence for 6 months	1
POD	Pharmacotherapy for Opioid Use Disorder—Total	Patients with opioid use disorder—medication adherence for 6 months	1
Behavioral Health—Access, Monitoring and Safety			
APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total ***(NEW REPORTING METHOD)***	Cholesterol and blood sugar testing for youth on antipsychotic medications	1
ADD-E	Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase ***(NEW REPORTING METHOD)***	Continued follow-up after ADHD diagnosis	1
SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Diabetes screening for individuals with schizophrenia or bipolar disorder	1
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	First-line psychosocial care for youth on antipsychotic medications	1
IET	Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total	Substance use disorder treatment engagement	1
Risk-Adjusted Utilization			
PCR	Plan All-Cause Readmissions—Observed-to-Expected Ratio—18-64	Plan all-cause readmissions	1
Other Treatment Measures			
LBP	Use of Imaging Studies for Low Back Pain—Total	Appropriate use of imaging studies for low back pain	1

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7.0 HEDIS/CAHPS MY2024 / RY2025 HPA Overall Star Rating Results: with Child CAHPS Survey Results (Projected)

On August 15, 2025, Partnership received NCQA's projected MY2024 HPA Star Rating of 3.0 Stars. This rating is calculated based on the MY2024 Child CAHPS® (regulated) survey results and plan-wide HEDIS rates per the NCQA Health Plan scoring methodology. Final scores will be published by NCQA in Fall of 2025. Because NCQA's scoring methodology uses rates that are proprietary to NCQA and will not be published until Fall 2025, Partnership's scoring calculations are not published in the MY2024 Annual Summary of Performance at this time.

As the MY2024 scoring summary below shows, Partnership's score was very close to a 3.5 Star Rating and missed the 3.5 Star Rating cut-point by 8/1000 of a point.

Rounding Rules	
0.000–0.249 → 0.0	2.750–3.249 → 3.0
0.250–0.749 → 0.5	3.250–3.749 →3.5
0.750–1.249 → 1.0	3.750–4.249 → 4.0
1.250–1.749 → 1.5	4.250–4.749 → 4.5
1.750–2.249 → 2.0	≥4.750 → 5.0
2.250–2.749 → 2.5	

Overall Rating Source	
Measure points	164.5
Overall Rating Not Rounded	2.741666667
Final Overall Rating +.5 Bonus	3.242
Final Score Rounded	3.0

7.1 Factors in MY2024 HPA Star Rating

Partnership's Star Rating declined from 3.5 Stars in MY2023 to 3.0 Stars in MY2024. The following factors were important drivers of Partnership's performance on the MY2024 HPA measures:

Improved Performance on CAHPS Surveys: Both the Child and Adult CAHPS survey scores

improved plan-wide between MY2023 and MY2024. Partnership saw significant improvements in year-over-year scores on the questions “Rating of Health Plan” and “Rating of Personal Doctor” on both surveys. This reflects Partnership’s sustained focus on improving the Partnership member experience in several key areas, including staff trainings to improve member benefits literacy; improvements in the transportation benefit; and digital platform enhancements such as the launch of a member texting platform. Partnership has also invested significant resources into a Healthcare Access Strategy and Tactical Plan, which includes provider recruitment and retention initiatives, network gap analyses, and telehealth integration strategies. All of these efforts combined led to survey results that show an improvement in reported member experience within the provider network.

Population Shifts within the Network: As described in Section 2, Partnership grew its membership by 36.7 percent in January, 2024, by adding ten additional counties to its network. Neither of the legacy Managed Care Plans departing these counties were NCQA Accredited Health Plans before 2024, so HPA HEDIS measures were less familiar and less prioritized for these incoming primary care providers. Additionally, incoming PCP’s were challenged by data completeness issues, which gave them limited historical data for multi-year measures. Incoming PCP’s also experienced significant member assignment mismatches at the beginning of 2024, which limited their ability to impact the members on their panels and impacted their HEDIS measure rates.

Approximately 82,000 Partnership members assigned to Kaiser also departed Partnership in January, 2024. These members have had high rates on the HPA HEDIS measures, and their departure impacted measure rates in Solano, Sonoma, Napa and Yolo Counties.

Finally, the disruption in Partnership’s contract with Dignity Health in early 2024 impacted members in Nevada, Shasta, Siskiyou, Tehama, and Yolo Counties. Though these 64,000 members were assigned to other PCP’s in their regions, the disruption in their primary care impacted many of the chronic condition and behavioral health management measures that make up the HPA measure set.

Resolution of Medi-Cal Rx Data Issues: In late 2024, Partnership identified and resolved several prescription duplication issues within the Medi-Cal Rx dataset, provided to Partnership by DHCS pharmacy benefit administrator Magellen. These issues had the effect of inflating the reported rates for several HPA measures centered on medication management during MY2022 and MY2023, including Antidepressant Medication Management—Effective Continuation Phase Treatment (AMM), Pharmacotherapy for Opioid Use Disorder (POD), Statin Therapy for Patients with Cardiovascular Disease – Adherence (SPC), and Statin Therapy for Patients with Diabetes – Adherence (SPD). The MY2024 measure rates reflects a more accurate Medi-Cal Rx prescription dataset, but also reflects a drop in reported rates between MY2023 – MY2024.

Annual Changes to NCQA HEDIS Benchmarks: Partnership uses the most recent NCQA published benchmarks available to project measure scores and calculate a Projected Star Rating. For

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MY2024, the most recently published benchmarks available are the Quality Compass MY2023 Medicaid National Benchmarks. NCQA, however, uses the MY2024 rates they receive from Medicaid plans nationwide in June 2025 to produce a more recent set of benchmarks based on MY2024 rates, that they then use to calculate the MY2024 Star Ratings for Medicaid plans. For MY2024, Partnership saw several measure benchmarks increase significantly, which resulted in a lower Star Rating projection than Partnership calculated internally using the MY2023 benchmarks. The HPA measures with benchmarks that increased most significantly in MY2024 include:

- Immunizations for Adolescents - Combination 2 (IMA-2)
- Prenatal and Postpartum Care - Timeliness of Prenatal Care (PPC-Pre)
- Adult Immunization Status - Zoster (Total) (AIS-E)
- Eye Exam for Patients With Diabetes (EED)
- Controlling High Blood Pressure (CBP)
- Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SSA)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) (APM-E)
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

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7.2 MY2024 HEDIS HealthPlan Accreditation (HPA) – HealthPlan Rating Score Child CAHPS - Change from Prior Year

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Rounding Rules	
0.000–0.249 → 0.0	2.750–3.249 → 3.0
0.250–0.749 → 0.5	3.250–3.749 →3.5
0.750–1.249 → 1.0	3.750–4.249 → 4.0
1.250–1.749 → 1.5	4.250–4.749 → 4.5
1.750–2.249 → 2.0	≥4.750 → 5.0
2.250–2.749 → 2.5	

MY2024 Projected Star Rating w/Child CAHPS survey results (submitted for HPA):

Final Overall Rating +.5 Bonus	3.24166667

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

MY2023 Star Rating w/Child CAHPS survey results (not submitted for HPA):

Final Overall Rating +.5 Bonus	3.752101

HEDIS HealthPlan Accreditation Star Rating Scoring MY2023 With Child CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2022	TOTAL ACCRD Score MY2023	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)	59.5	153	155	193.5	3.252101	4.0
Child CAHPS Rating	7.5	12	9	13.5		
Patient Experience	7.5	12	9	13.5	1.800	2
Prevention and Equity	18	39	52	66	3.667	3.5
Treatment	34	102	94	114	3.353	3.5

7.3 MY2024 HEDIS HealthPlan Accreditation (HPA) – HealthPlan Rating Score Adults CAHPS - Change from Prior Year

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Rounding Rules	
0.000–0.249 → 0.0	2.750–3.249 → 3.0
0.250–0.749 → 0.5	3.250–3.749 →3.5
0.750–1.249 → 1.0	3.750–4.249 → 4.0
1.250–1.749 → 1.5	4.250–4.749 → 4.5
1.750–2.249 → 2.0	≥4.750 → 5.0
2.250–2.749 → 2.5	

MY2024 Projected Star Rating w/Adult CAHPS survey results (not submitted for HPA):

Final Overall Rating +.5 Bonus	3.19166667

HEDIS HealthPlan Accreditation Star Rating Scoring MY2024 With Adult CAHPS Survey Results	MY 2024 Final Rate	TOTAL Weight	TOTAL ACCRD Score MY2024	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)		60	133	161.5	2.691666667	3.0
Patient Experience		7.5	10	15	2.000	2.0
Prevention and Population		19.5	52	61.5	3.154	3.0
Treatment		33	71	85	2.576	2.5

MY2023 Final Health Plan Rating w/Adult CAHPS survey results (submitted for HPA):

Final Overall Rating +.5 Bonus	3.62605042

HEDIS HealthPlan Accreditation Star Rating Scoring MY2023 With Adult CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2023	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)	59.5	148	186	3.12605042	3.5
Patient Experience	7.5	8	12	1.600	1.5
Prevention and Equity	18	50	64	3.556	3.5
Treatment	34	90	110	3.235	3.5

8.0 MY2024 HEDIS HealthPlan Accreditation (HPA) – Measurement Set Descriptions

HEDIS Measure	Measure Indicator	Measure Definition
Antidepressant Medication Management (AMM)	• Continuation Phase Treatment • Acute Phase Treatment	• The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. ○ Effective Acute Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). ○ Effective Continuation Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	• Total	• The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event. ***Note**: This measure is reported as an inverted rate [1–(numerator/eligible population)]. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (i.e., the proportion for episodes that did not result in an antibiotic dispensing event).*
Adult Immunization Status (AIS-E)	• Influenza immunizations for adults • Td/Tdap immunizations for adults • Zoster immunizations for adults • Pneumococcal immunizations for adults	• The percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.

HEDIS Measure	Measure Indicator	Measure Definition
Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase (ADD-E)	• Initiation Phase • Continuation and Maintenance (C&M) Phase	• The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. ○ Initiation Phase. The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. ○ Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.
Asthma Medication Ratio (AMR)	• 5–64 years • Total	• The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (APP)	• Total	• The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.
Breast Cancer Screening (BCS-E)	• Total	• The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

HEDIS Measure	Measure Indicator	Measure Definition
Cervical Cancer Screening (CCS)	• Total	• The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: ○ Women 21–64 years of age who had cervical cytology performed within the last 3 years ○ Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years ○ Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years
Childhood Immunization Status (CIS)	• Combination 10	• The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates. ○ Combination 10. Children who have had all ten indicators (DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV and Influenza).
Chlamydia Screening in Women (CHL)	• Total	• The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
Colorectal Cancer Screening (COL-E)	• Total	• The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.
Controlling High Blood Pressure (CBP)	• Total	• The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.

HEDIS Measure	Measure Indicator	Measure Definition
Appropriate Testing for Pharyngitis(CWP)	• Total	• The percentage of episodes for members 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	• Diabetes Screening	• The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	• 7 days • Total	• The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. ○ The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA)	• 7 days • Total	• The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. ○ The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	• 7 days • Total	• The percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. ○ The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.

HEDIS Measure	Measure Indicator	Measure Definition
Blood Pressure Control (<140/90) for Patients With Diabetes (BPD)	• Total	• The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.
Glycemic Status Assessment for Patients With Diabetes (GSD)	• HbA1c Control (<8%)	• The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: ○ HbA1c Control (<8%) ○ HbA1c poor control (>9.0%). ***Note:*** *Organizations must use the same data collection method (Administrative or Hybrid) to report these indicators.*
Eye Exam for Patients With Diabetes (EED)	• Eye Exam for Patients With Diabetes	• The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.
Kidney Health Evaluation for Patients with Diabetes (KED)	• Kidney Health Evaluation for Patients With Diabetes—Total	• The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.

HEDIS Measure	Measure Indicator	Measure Definition
Initiation and Engagement of Substance Use Disorder Treatment—(IET)	• Engagement of SUD Treatment • Total	• The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported: ○ Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visits or medication treatment within 14 days. ○ Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.
Use of Imaging Studies for Low Back Pain (LBP)	• Imaging for Low Back Pain	• The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis. ○ The measure is reported as an inverted rate [1–(numerator/eligible population)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).
Immunizations for Adolescents (IMA)	• Combination 2	• The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates. ○ Combination 2. Adolescents who have had all three indicators (meningococcal, Tdap and HPV).
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	• Total	• The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported, the percentage of children and adolescents on antipsychotics who received blood glucose testing, cholesterol testing, and both blood glucose and cholesterol testing. ○ Total. The sum of the age stratifications (1-17) as of December 31 of the measurement year.

HEDIS Measure	Measure Indicator	Measure Definition
Prenatal and Postpartum Care (PPC)	• Timeliness of Prenatal Care • Postpartum Care	• The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. ○ Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. ○ Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.
Prenatal Immunization Status (PRS-E)	• Combination Rate	• The percentage of deliveries in the Measurement Period in which women had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.
Pharmacotherapy Management of COPD Exacerbation (PCE)	• Systemic Corticosteroid • Bronchodilator	• The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported: 1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event. 2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event. ○ ***Note:*** *The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual.*
Pharmacotherapy for Opioid Use Disorder (POD)	• Total	• The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members age 16 and older with a diagnosis of OUD. ○ A 12-month period that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.

HEDIS Measure	Measure Indicator	Measure Definition
Plan All-Cause Readmissions— (PCR)	• Observed-to-Expected Ratio • 18-64 years • Total	• For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. ***Note**: For commercial and Medicaid, report only members 18–64 years of age.*
Race/Ethnicity Diversity of Membership- (RDM)	• Race/Ethnicity Direct	• An unduplicated count and percentage of members enrolled any time during the measurement year, by race and ethnicity.
Language Diversity of Membership (LDM)	• Spoken Language Preferred • Preferred Language for Written Materials	• An unduplicated count and percentage of members enrolled at any time during the measurement year by spoken language preferred for health care and preferred language for written materials.
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	• Non-Medicare 80% Coverage	• The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.
Statin Therapy for Patients With Cardiovascular Disease (SPC)	• Total. • Statin Therapy • Statin Adherence 80%	• The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported: ○ Received Statin Therapy. Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year. ○ Statin Adherence 80%. Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

HEDIS Measure	Measure Indicator	Measure Definition
Statin Therapy Statin Therapy for Patients With Diabetes (SPD)	• Received Statin Therapy • Statin Adherence 80%	• The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported: ○ Received Statin Therapy. Members who were dispensed at least one statin medication of any intensity during the measurement year. ○ Statin Adherence 80%. Members who remained on a statin medication of any intensity for at least 80% of the treatment period.
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	• BMI Percentile Documentation	• The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year. ○ BMI Percentile Documentation. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

Tactical Plan Update for 5-Star Quality Strategy

Status Update:

Close of Q4 FY2024/2025

Isaac Brown

Reported to IQI/QUAC in September 2025

NCQA Health Plan Ratings: 2024, Projected 2025

NCQA Projected HPR for MY2024

The *projected* HPR rating for MY2024 is **3.0 Stars, using the Child CAHPS Survey**.

	MY2022 – Final Used Child CAHPS	MY2023 – Final Used Adult CAHPS	MY2024 – Final Used Child CAHPS	MY2024 – Projected If we used Adult CAHPS
Patient Experience (CAHPS)	2.0	1.5	2.5	2.0
Prevention and Population (HEDIS domain)	3.5	3.5	3.0	3.0
Treatment (HEDIS domain)	3.5	3.5	2.5	2.5
Bonus for maintaining Accreditation	0.5	0.5	0.5	0.5
Overall HPR	**3.5**	**3.5**	**3.0**	**3.0**

- In the past 2 years, we have been pursuing but unable to attain 4.0 Stars.
- While we're celebrating a fantastic CAHPS improvement, we're also working to better understand declines in HEDIS measures under the Treatment domain.

2024 NCQA Health Plan Ratings

Health Plan Ratings (HPR) are assessed on a 0-5 point scale in ½ pts.

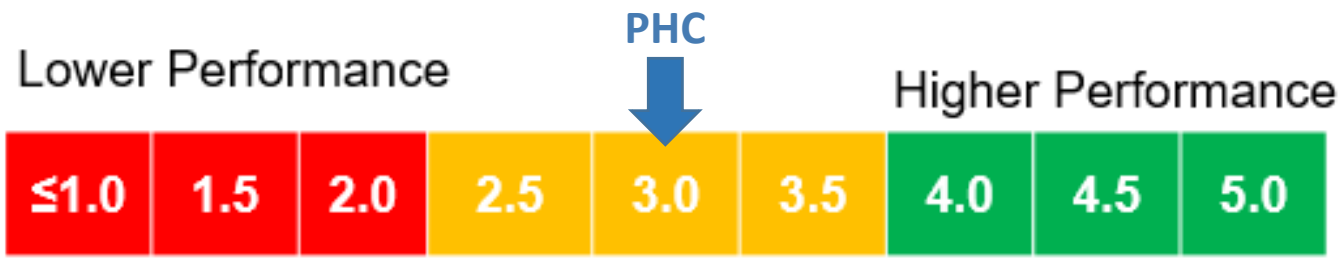
5-Star is the highest possible score (0/287 plans nationally)

4-Star or greater (59/287 plans)

- 4.5-Star CA plans (2): Contra Costa, San Mateo
- 4.0-Star CA plans (5): Alameda Alliance, Community Health Group, Inland Empire, SF HealthPlan, Blue Shield of CA-Promise

3.5-Star (88/287 plans)

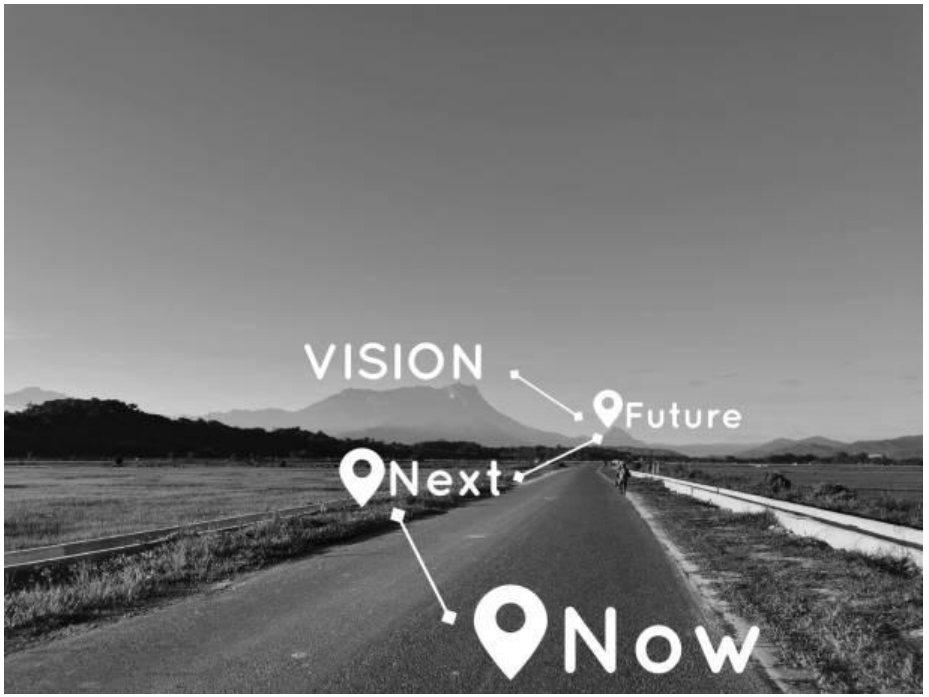
- 3.5-Star CA plans (6): **Partnership**, Cal Optima, LA Care, Santa Clara Family, Health Net of California, Molina Healthcare of CA



5-Star Quality Strategy

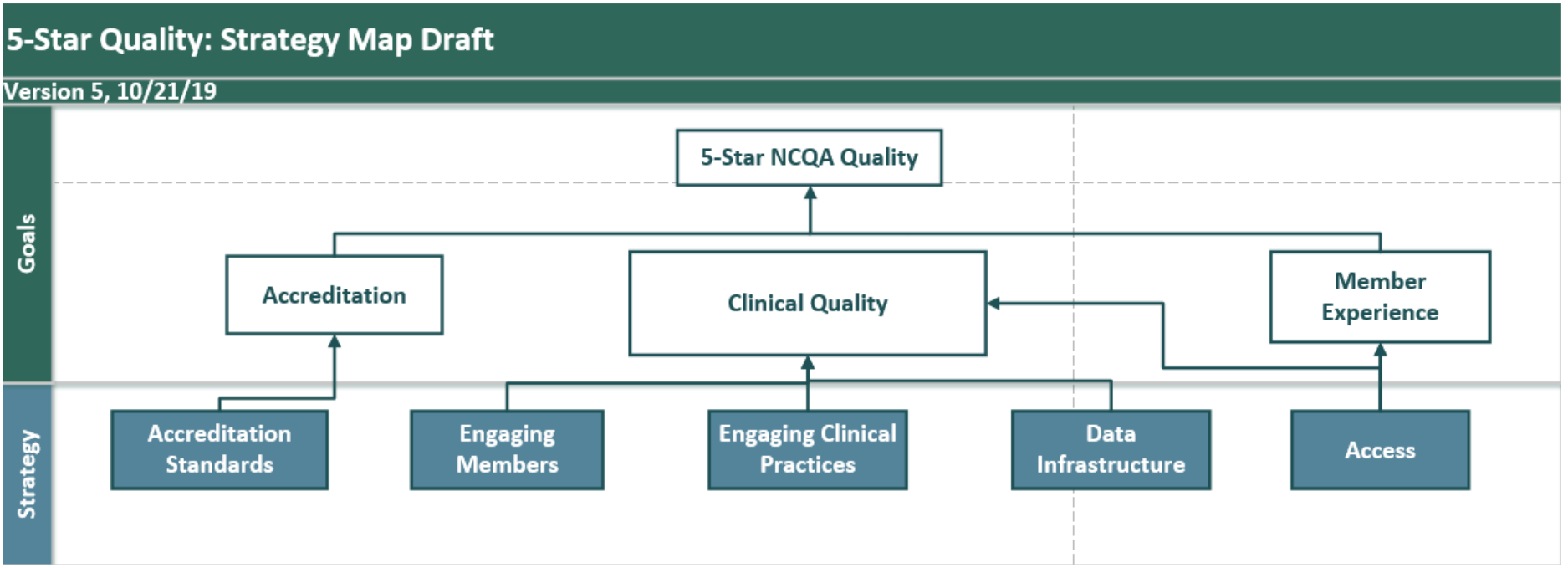
- Partnership aims to become an NCQA 5-Star rated health plan, while balancing increasing oversight and external pressures.

- Partnership's 5-Star Quality Strategy & Tactical Plan serve as the roadmap.



- In 2024-2025, Partnership continued its journey in becoming a highly rated health plan with a stated goal of maintaining **or exceeding** a 3.5 Star rating in 2024.

HEDIS Quality to 5-Star Quality



72 Tactics

HEDIS = Health Effectiveness Data and Information Set®
NCQA = National Committee for Quality Assurance

Performance Priorities in 2024-2025

- Enhance provider engagement in measure improvement initiatives with focus on
  - Lowest performing PCP orgs in PCP QIP
  - Advancing health equity & practice transformation
- Invest further to improve Patient Experience
- Continue adapting Access tactics
  - Locum Tenens Grants
- Engage new providers and community partners in expansion region and integrate with 5-Star Quality Strategy & Tactics
  - Establishing Quality expectations and engagement

Tactical Plan: Focus Areas

Engaging Clinical Practices	Engaging Members	Data Infrastructure	Accreditation	Access
Supply Actionable Care Gap Data to PCPs	Supply Care Gap Data to PHC Staff, Providers and Members	Provide Actionable Care Gap Data	Pass "Must Pass" Elements	Recruitment
Technical Assistance to Support Provider QI Capacity	Increase PHC Member Engagement Capacity	Data Quality, Access, Completeness	Maintain Grand Analyses	Retention
Pay for Performance Programs	Specific Member Engagement Activities	Supportive Analytics	Prepare for Health Equity Accreditation	Alternative Access
Work with Community Partners to Improve Quality		Pathway to Excellence	Prepare for Medicare	Learning about Optimizing Access

Engaging Clinical Practices

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Goal #	Goal Description	Objective #	Objective Description	Anticipated Action in 2024-2025	Anticipated Action in 2025-2026	Status
1.A	Supply Actionable Care Gap Data to PCPs	1.A.1	eReports	*Optimize*	*Optimize*	Some Risk
		1.A.2	PQD	*Optimize*	*Optimize*	Some Risk
		1.A.3	ePrompts logic integration into Provider Online Services	*Promote*	*Promote*	Established
		1.A.4	Unblinded quality data reporting	*Optimize*	*Sustain*	Established
		1.A.5	EMR workflow optimization	*Update*	*Pause*	Paused
		1.A.6	DataLink (previously known as ECDS measures)	*Update*	*Adapt*	In progress
1.B	Technical Assistance to Support Provider QI Capacity	1.B.1	Leverage other quality mandates: State mandated PDSAs, PIPs, Site Reviews, Prop 56	*Optimize*	*Optimize*	On Time
		1.B.2	Execute Tribal Health engagement strategy and tactical plan	*Optimize*	*Optimize*	On going
		1.B.3	Execute a plan-wide ***Enhanced Provider Engagement Strategy*** for provider organizations to increase capacity for QI work	*Optimize*	*Optimize*	In progress
		1.B.4	General QI Training (ABCs of QI)	*Sustain*	*Optimize*	Established
		1.B.5	Measure-specific trainings and webinars	*Optimize*	*Optimize*	Established
		1.B.6	Diversity Training to promote Health Equity	*Adapt*	*Adapt*	Implementation
		1.B.7	JLI activities	*Optimize*	*Optimize*	Established
1.C	Pay for Performance Programs	1.C.1	PCP QIP	*Optimize*	*Optimize*	Established
		1.C.2	Modified PCP QIP for low performing PO's	*Optimize*	*Optimize*	In progress
		1.C.3	Perinatal QIP	*Optimize*	*Optimize*	Established
		1.C.4	Hospital QIP	*Optimize*	*Optimize*	Established
1.D	Work with Community Partners to Improve Quality	1.D.1	Support CHA and CHIP within counties	*Optimize*	*Optimize*	In Development

Status Legend:

Problems	Needs Attention	Planning/Development	Progressing	Stable/Maintenance
Red	Orange	Light Green	Dark Green	Blue

ACCREDITED NCQA HEALTH PLAN

Engaging Clinical Practices

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Key Changes in Tactical Activity Status or New Tactics:

- 1 Tactic (1.A.5) updated from **Established** → **Paused**
  - EMR Optimization : A number of providers are in the process of shifting over from legacy EHRs to more updated options. To assist in these efforts, Partnership is providing grants to help the updates move along.
- 1 Tactic (1.A.6) updated from **Early Pilots** → **In Progress**
  - Datalink: We've begun expansion and scaling of early pilots to include additional providers and to increase the data sharing, allowing us to move toward ECDS goals.
- 1 Tactic (1.B.6) updated from **Planning in Progress** → **Implementation On Time**
  - Diversity Training: Training is being provided to target groups and is being tailored to meet current demands.
- 1 Tactic (1.B.7) updated from **In Development** → **Established**
  - JLI Activities: JLI has been shown to be a success programmatic effort and is now being utilized in the Auburn/Chico Regions as well.

ACCREDITED NCQA HEALTH PLAN

Engaging Members

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Goal #	Goal Description	Objective #	Objective Description	Anticipated Action in 2024-2025	Anticipated Action in 2025-2026	Status
2.A	Supply Care Gap Data to Partnership Staff, Providers and Members	2.A.1	Call Center ePrompts	*Optimize*	*Optimize*	Established
		2.A.2	Member Portal ePrompts	*Optimize*	*Optimize*	Early pilots
2.B	Increase PHC Member Engagement Capacity	2.B.1	Member Outreach for Care Gaps and Other	*Expand*	*Optimize*	In progress
		2.B.2	Member Services Reminders (on hold messaging)	*Optimize*	*Optimize*	Established
		2.B.3	Train PHC staff on targeted quality metrics	*Adapt*	*Adapt*	Established
		2.B.4	Member Incentive Programs	*Adapt*	*Adapt*	In progress
		2.B.5	Monitor Member Input to inform QI Engagements	*Adapt*	*Pilot*	In Development
		2.B.6	Member media campaigns	*Expand*	*Expand*	In progress
2.C	Specific Member Engagement Activities	2.C.1	Leverage new CHW benefit to support Quality strategies/goals	*Adapt*	*Adapt*	In progress
		2.C.2	Engagement in ED and Inpatient settings	*Adapt*	*Adapt*	Small delay
		2.C.3	Outreach to unestablished members	*Adapt*	*Adapt*	On hold
		2.C.4	Sponsorship of Mobile Mammography events	*Expand*	*Expand*	Established
		2.C.5	Increase Members having In Home Monitoring Devices (integrated)	*Optimize*	*Optimize*	Established

Status Legend:

Problems	Needs Attention	Planning/Development	Progressing	Stable/Maintenance
Red	Orange	Light Green	Dark Green	Blue

ACCREDITED NCQA HEALTH PLAN

Engaging Members

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Key Changes in Tactical Activity Status

- 1 Tactic (2.C.1) updated from **Early Pilots** → **In Progress**
  - CHW Benefit: We're currently seeing providers throughout the footprint utilizing the CHW model in working toward their quality goals.
- 1 Tactic (2.C.2) changed from **Implementation On time** → **Small Delay**
  - Engagement in ED and Inpatient Settings: Some work is being done here to understand who is going into the hospital and not getting preventative services at PCP. Member Engagement Dashboard and data dependent on HRP
- 1 Tactic (2.C.4) updated from **On Going** → **Established**
  - Mobile Mammography: This has become programmatic with over 70 events days planned each year. Looking at expansion to large health day events when appropriate.
- 1 Tactic (2.C.5) updated from **On Hold** → **Established**
  - In home monitoring services: Our PMEDs program is now well establish providing BP cuffs and other devices to help members and their providers monitor status.

ACCREDITED NCQA HEALTH PLAN

Data Infrastructure

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Goal #	Goal Description	Objective #	Objective Description	Anticipated Action in 2024-2025	Anticipated Action in 2025-2026	Status
3.A	Provide Actionable Care Gap Data	3.A.1	Improve member Contact Information (Unestablished Members; Moved Member-work with County; Mass reassignment)	*Optimize*	*Optimize*	On hold
		3.A.2	Health Education tools aligned with quality measures	*Adapt*	*Sustain*	Established
3.B	Data Quality, Accuracy Completeness	3.B.1	New core claims system	*Optimize*	*Optimize*	Some Risk
		3.B.2	Master Provider Data Management	*Optimize*	*Optimize*	In progress
		3.B.3	Data Dictionaries	*Optimize*	*Optimize*	In progress
		3.B.4	Data Stewardship Program	*Optimize*	*Adapt*	In progress
		3.B.5	Meaningful Use of HIE Across Systems	*Optimize*	*Optimize*	Optimize
		3.B.6	PHC Data Governance Structure	*Optimize*	*Adapt*	In progress
		3.B.7	Data Quality Monitoring and Expanding via the Data Quality Dashboard	*Optimize*	*Optimize*	Established
3.C	Supportive Analytics	3.C.1	Data Marts	*Optimize*	*Optimize*	In progress
		3.C.2	Analysis and Presentation of Annual quality measurement results	*Optimize*	*Update*	Established
		3.C.3	Monthly HEDIS data	*Optimize*	*Optimize*	Established
		3.C.4	Equity Analysis and related improvement activities	*Optimize*	*Optimize*	In progress
3.D	Pathway to Excellence	3.D.1	Knowledge Management Infrastructure	*Optimize*	*Optimize*	In progress
		3.D.2	Standardized scientific approach to small tests of change	*Optimize*	*Optimize*	On going
		3.D.3	Optimize data validation in all settings	*Update*	*Adapt*	In Development
		3.D.4	Standardized approach to scaling up/implementation	*Operationalize*	*Operationalize*	On going

Status Legend:

Problems	Needs Attention	Planning/Development	Progressing	Stable/Maintenance
Red	Orange	Light Green	Dark Green	Blue

ACCREDITED NCQA HEALTH PLAN

Data Infrastructure

Key ***Highlights**** on Tactical Activity Status:

**No major status changes since update in February 2024.*

- 1 Tactic (3.A.1) remains **Needs Attention**
  - Due to redetermination, 18-20% of our members are not actually our members.
  - Once redetermination is complete, the completeness and accuracy of member contact information can be assessed and better addressed through local efforts.
  - Current changes in legislation may drive attention to this effort
- 1 Tactic (3.B.1) remains **Some Risk**
  - HRP (i.e., new core claims system).
  - Validation activities for QI systems are ongoing.
  - Expected to go live in 2026
- 1 Tactic (3.D.2) updated from **In Development** → **On Going**
  - Finalized framework defining Partnership's standardized scientific approach to small tests of change. Now focusing on optimizing methods and quality controls key to reliable data validation.

NCQA Accreditation & D-SNP Prep

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Goal #	Goal Description	Objective #	Objective Description	Anticipated Action in 2024-2025	Anticipated Action in 2025-2026	Status
4.A	Pass "Must Pass" Elements	4.A.1	Internal File Review; Delegated file review; Delegation oversight to NCQA standards	*Optimize*	*Sustain*	Established
		4.A.2	Department goals related to NCQA	*Optimize*	*Sustain*	Stable
4.B	Maintain Grand Analyses	4.B.1	Ensure comprehensive and timely submission of grand analyses, including: UM, Member Experience, Network Adequacy/Availability, PHM/C&L, Continuity and Coordination of Care, and Behavioral Health	*Optimize*	*Sustain*	Stable
4.C	Prepare for Health Equity Accreditation	4.C.1	Conduct Gap Analysis, review resulting findings, and propose target HEA survey timeline	*Operationalize*	*Optimize*	In progress
4.D	Prepare for Medicare	4.D.1	Baseline HEDIS measure collection	*Optimize*	*Optimize*	In progress
		4.D.2	Address Medicare HEDIS gaps	*Operationalize*	*Operationalize*	In progress
		4.D.3	MediCare Incentive Programs for Members and Providers	*Operationalize*	*Operationalize*	In progress
		4.D.4	Overall quality oversight	*Operationalize*	*Operationalize*	In progress

Status Legend:

Problems	Needs Attention	Planning/Development	Progressing	Stable/Maintenance
Red	Orange	Light Green	Dark Green	Blue

ACCREDITED NCQA HEALTH PLAN

Key ***Highlights**** on Tactical Activity Status:

**No major status changes since last update in September 2024.*

- 1 Tactic (4.D.1) updated from **On Target** → **In Progress**
  - Medicare specific HEDIS® measures and specs are being evaluated as part of early quality strategy development under CMS Medicare STARS program. Baseline data collection and analysis are next steps.
- 1 Tactic (4.D.3) updated from **Initial Work Needed** → **In Progress**
  - Medicare specific provider incentive program (i.e., D-SNP PCP QIP) is in active development for 2026 launch.
- 1 Tactic (4.D.4) updated from **Initial Work Needed** → **In Progress**
  - Plan-wide collaboration is actively underway to finalize Partnership's Model of Care by end of 2025. In parallel, Partnership is developing infrastructure, collaborative workgroups, and quality committee structure to implement CMS Medicare STARS program.

Access

Goal #	Goal Description	Objective #	Objective Description	Anticipated Action in 2024-2025	Anticipated Action in 2025-2026	Status
5.A	Recruitment	5.A.1	Marketing to PCP Residents (Partnership Regions, CA and Out of State)	*Promote*	*Promote*	Deferred Prioritization
		5.A.2	Support J-1 Visa process	*Expand*	*Expand*	Deferred Prioritization
		5.A.3	Support the development, spread and quality of NP/PA residencies/fellowships in our region	*Operationalize*	*Operationalize*	In progress
		5.A.4	Partnership Recruitment Program	*Optimize*	*Sustain*	Established
		5.A.5	Contingency Firm Use Pilot Program	*Operationalize*	*Operationalize*	In progress
		5.A.6	Convene Regional Physician Residency Programs	*Operationalize*	*Operationalize*	Established
5.B	Retention	5.B.1	Provider Retention Initiative (PRI)	*Expand*	*Expand*	In progress
		5.B.2	Support local applicants with existing loan repayment programs	*Expand*	*Expand*	Deferred Prioritization
		5.B.3	Recruitment difficulty factor adjustment for QIP	*Adapt*	*Adapt*	In progress
		5.B.4	Virtual provider recruitment networking/mentoring	*Expand*	*Expand*	Deferred Prioritization
		5.B.5	PCP Organization Leadership Development	*Adapt*	*Adapt*	In Development
5.C	Alternative Access	5.C.1	Phone/Video visits in lieu of in person	*Optimize*	*Sustain*	Stable
		5.C.2	Advanced Access methodology	*Promote*	*Promote*	Some Risk
5.D	Learning about Optimizing Access	5.D.1	Clinician Entry/Exit interviews	*Expand*	*Expand*	Deferred Prioritization
		5.D.2	Capture best practices	*Expand*	*Expand*	In progress

Status Legend:

Problems	Needs Attention	Planning/Development	Progressing	Stable/Maintenance
Red	Orange	Light Green	Dark Green	Blue

Access

Key Changes in Tactical Activity Status or New Tactics:

- The Partnership Workforce Development team continues to work on new tactics and have deferred specific existing tactics to accommodate growing workload and priorities
- 5 Tactics flagged as **Deferred Prioritization**
  - 5.A.1: Marketing to PCP Residents (In/Out of State)
  - 5.A.2: Support J-1 Visa process
  - 5.B.2: Support applicants with existing loan repayment programs
  - 5.B.4: Virtual provider recruitment networking / mentoring – ***newly deferred as of June***
  - 5.D.1: Clinician Entry/Exit interviews
- 1 Tactic (5.B.5) updated from **Planning in Progress** → **In Development**
  - This tactic moved from the "Engaging Clinical Practices" goal under the "Technical Assistance to Support QI Capacity" objective to the "Access" goal under the "Retention" objective
  - Currently evaluating vendors and developing content expectations for Leadership Development cohorts.

Summary

- Partnership's 5-Star Quality Strategy was last updated in 2020 to align with our NCQA Accreditation goals.
  - Stretch goal: Being named a 5-Star NCQA Accredited plan by 2025
- Since the last 5-Star Strategy and Tactical Plan update :
  - Continued developing new tactics focused in enhanced community partnering and improving access
  - Consolidated or deferred existing tactics to better reflect ongoing work and to make space for promising new tactics
  - Invested more time and resources to prepare for Medicare (D-SNP)
  - Actively assessing progress and risks, adapting resource allocations
- Partnership continues to make progress under our 5-Star Quality Strategy/Tactical Plan in our continued journey to becoming a highly rated health plan, **with plans to create a new Strategy / Tactical plan in the 2025/2026 time period.**

CHA/CHIP Updates

DeLorean Ruffin, DrPH, MPH

August 7, 2025

Goal Status

Goal Status

1 updated goal & 3 new goals are pending PNA approval
4 goals drafted & pending county approval
13 Goals Approved to date
3 counties have an idea
2 counties have no goals

Updated Goal

Colusa

Goal:
Increase access to prenatal care among Partnership members in Colusa County.

SMART Objective:

Colusa County will increase PPC- Timeliness of Prenatal Care rate from 75.28% to meet the 50th percentile benchmark of 84.55% by August 30, 2026.

Strategy 1: Collaborative Partnerships with Local Prenatal Care Providers

1.1: Partnership HealthPlan will assist with warm introductions to local OB providers in the county by end of October 2025 to explain the goal of this initiative and invite them to engage in meaningful collaboration.

1.2: Colusa County's Public Health, Maternal, Child, and Adolescent Health Program (MCAH) and California Home Visiting Program (CHVP) will reach out to local organizations that offer pregnancy-related resources by end of October 2025 to explain the goal of this initiative and invite them to participate in meaningful collaboration.

1.3: Starting in November 2025, this collaborative partnership between local OB providers and pregnancy resource organizations will begin to work together to co-develop timely access solutions and discuss prenatal care referrals and track changes in utilization of services for timeliness of prenatal care.

1.4: In Q1 of 2026, Partnership HealthPlan will provide a presentation to this collaborative group on the Perinatal Quality Incentive Program (Perinatal QIP) covering participation in Partnership HealthPlan Perinatal Services to improve timely prenatal and postpartum care for Partnership members.

Colusa (Cont'd)

Strategy 2: Provider Mapping

2.1: Partnership HealthPlan, Colusa County Public Health, MCAH and CHVP program will develop a survey by the end of September 2025 for Colusa County's perinatal population. The goal is to gain a comprehensive understanding of where individuals seek services and the challenges, they face in accessing those services in a timely manner. The survey will be administered in October 2025 and will be results will be ready to share by December 2025 with the collaborative group in strategy 1.

2.2: The Colusa County MCAH and CHVP program will update their Pregnancy Resource Guide using information gathered from Strategy 1, which involves connecting with local providers and pregnancy resource organizations to create a comprehensive directory of perinatal care services by end of December 2025.

2.3: Partnership HealthPlan will support the Pregnancy Resource Guide efforts by sharing the resource on Partnership's external webpage, specifically on the Colusa County Resource Page by December 2025.

Strategy 3: Community Engagement

3.1: Partnership HealthPlan and the Colusa County MCAH and CHVP program will co-facilitate at least one informative session for members focused on perinatal care services to take place during Q1 of 2026. Partnership HealthPlan will present on topics such as the Growing Together Program (GTP), transportation services, and telehealth. The Colusa County MCAH and CHVP program will provide education to promote healthy pregnancies and births, and will share educational materials, including their Pregnancy Resource Guide.

3.2: Colusa County Public Health, MCAH and CHVP program and Partnership HealthPlan will collaborate in at least one community outreach event to take place in Q2 of 2026. (i.e. Colusa County Community Baby Shower) to engage the prenatal population and share resources such as the pregnancy resource guide, member benefits, including access to transportation and telehealth services for perinatal appointments, as well as the Growing Together Program.

New Goals

Plumas

Goal:
Reduction in opioid overdose related emergencies

SMART Objective:
Plumas County will decrease the number of annual opioid overdose related emergency department visits from 32 to 16 by December 31, 2026.

Strategy 1: Identification and Tracking of Increases in Opioid Overdose-Related Emergency Department (ED) Visits

1.1 – Establish Strategic Partnerships

The Plumas County Public Health Harm Reduction Program, in collaboration with the County Epidemiologist and Health Officer, will initiate and strengthen partnerships with local emergency response personnel, including emergency department staff and first responders. These relationships will serve as the foundation for ongoing collaboration in addressing opioid-related emergencies.

1.2 – Data Collection and Information Sharing

Plumas County Public Health will leverage the partnerships established in 1.1 to facilitate timely data collection on opioid-related ED visits and overdose incidents. Collaborate to identify emerging trends, share anonymized case reports, and gather frontline insights to inform public health strategies and improve response efforts. Partnership will provide support as needed, within the scope of the health plan's available resources.

Plumas (Cont'd)

Strategy 2: Implement an Anonymous SMS System for Real-Time Opioid Overdose Alerts

2.1 – Launch of Anonymous SMS Alert System

Plumas County Public Health will develop and implement a free, anonymous SMS alert system designed to notify individuals at risk of opioid overdose. The system will issue real-time alerts when a spike in overdose incidents indicates the presence of a potentially dangerous or contaminated opioid batch in the county.

2.2 – Ongoing Communication and Outreach

The Plumas County Public Health Harm Reduction Team will manage the SMS platform, sending timely alerts about high-risk opioid activity and promoting access to harm reduction services, such as naloxone distribution, syringe exchange, and local treatment resources.

Strategy 3: Harm Reduction Outreach and Community Engagement

3.1 – Educational Material Development and Dissemination

The Plumas County Harm Reduction Team will develop and distribute culturally appropriate, accessible educational materials focused on overdose prevention and harm reduction. Partnership will assist in the creation of educational material for community outreach events. These materials will be used at community outreach events and actively promoted on Partnership's social media platforms to maximize reach and engagement.

3.2 – Overdose Awareness Event

The Harm Reduction Team will organize and host Plumas County's first Overdose Awareness Day in 2025. Community partners will support the event by promoting it through their networks, distributing flyers, and maintaining a visible presence with informational booths on the day of the event.

Sierra

Goal:
Improve mental health and reduce tobacco use from 9th to 11th grade high school students in Sierra County.

SMART Objectives:
By December 31, 2026, reduce the percentage of 11th grade students in Sierra County who experience chronic sadness or hopeless feelings from 36% (2023-2024 CHKS) to 25% using the 2025-2026 CHKS.

By December 31, 2026, decrease the percentage of 11th grade students current use of vape products in Sierra County from 13% (2023-2024 CHKS) to 10% using the 2025-2026 CHKS.

Strategy 1: Peer Advocate Training

1.1: Sierra County Tobacco Use Reduction Program (SCTURP), Sierra County Tobacco Use Prevention Education (TUPE), and Partnership will collaborate with Loyalton High School to promote tobacco use prevention and address mental health challenges among teenagers.
1.2: SCTURP and TUPE will identify at least 2 students to be trained as peer advocates and receive the necessary health education and facilitation training.
1.3: Partnership's Health Educators will conduct 2 training sessions for the selected peer advocates. These sessions will focus on addressing feelings of hopelessness and strategies to reduce teen vaping.

Sierra (Cont'd)

Strategy 2: Peer-led Lunchtime Events

2.1: SCTURP and TUPE will work with the trained peer advocates to organize peer-led lunchtime events. These events will focus on topics such as stress management, coping with social pressures, and making informed decisions about mental health and vaping prevention.

Strategy 3: Resource Mobilization Campaign

3.1: The health education campaign will include the following resources:

a. Educational resources from a reputable website (e.g., kickitca.org, teen.smokefree.gov, American Lung Association, Empower Vape-Free Youth Campaign, etc.). Whenever possible, material will integrate mental health support alongside tobacco use prevention. All selected resources will be made available in both English and Spanish.

b. Unique material such as postcards, posters, or social media messages is another option that can be created by the Peer Advocates. Materials created can highlight the importance of stress management and coping mechanisms other than vaping, such as exercise, mindfulness, or talking to a trusted adult.

3.2: The resources identified or created in 3.1 will be distributed to all high school students at predetermined intervals between.

3.3: Posters created in 3.1b will be displayed at high schools and other popular teen gathering spots such as restaurants, arcades, and movie theaters. Additionally, social media messages and/or posters can be shared on local social media outlets.

Marin

Goal:
To improve preventative care measures for children ages 0-5 years of age in the Marin County Community Health Worker Hub by leveraging Community Health Worker Medi-Cal reimbursement benefit.

SMART Objective:
By December 31, 2026, Partnership Health Plan, Kaiser Permanente and Marin County Public Health will support implementation of the Marin County First 5 CHW Hub in serving 30 families and assessing impact of CHW services on early childhood preventive services (comparing year over year [MY24 to MY25] performance in (W30 2 & 6T, WCV) in Marin County and cross sectoral analysis among the total Medi-Cal population vs. the CHW served cohort of families.

Strategy 1: Strategy 1: Establish a high-quality, financially sustainable CHW Hub that serves children 0–5-year-olds and their families

1.1: CHWs will provide health education, health navigation, screening and assessments, and individual support and advocacy to 30 families in Marin with children under the age of 5 (specific with which kind of CHW's).

1.2: First 5 Marin will enroll as a Medi-Cal CHW supervising provider with Partnership Health Plan and Kaiser to lead billing and other administrative requirements on behalf of CHW Hub.

1.3: First 5 Marin will work with partner agencies to identify and certify CHWs.

1.4: First 5 Marin will lead CHW Hub convening, coordination, and communications with Hub partners and CHWs.

1.5: Partnership Health Plan and Kaiser will provide First 5 Marin with resources for a library of best practices from health plan county partners successfully implementing CHW billing.

Marin (Cont'd)

Strategy 2: Provide professional development and continuous learning opportunities for CHWs and CHW Network Administrators

2.1: First 5 Marin, in partnership with Marin County Public Health, will develop a peer networking and career development strategy for CHWs.

2.2: Marin County Public Health, in partnership with First 5 Marin, Partnership Health Plan and Kaiser, will develop and/or provide locally developed job aids and referral tools for CHWs.

2.3: Kaiser Permanente will share an Early Childhood Portfolio, a tool that helps parents and guardians track their child's well-child visits and immunizations.

2.4: Partnership Health Plan and Kaiser Permanente will support the creation of baseline data for the Year 2 for cohort of 30 families' performance data, including stratification of the Year 1 cohort to assess key performance indicators (e.g., race/ethnicity, location, and barriers to visits).

CHA/CHIP
Grant Funding Update

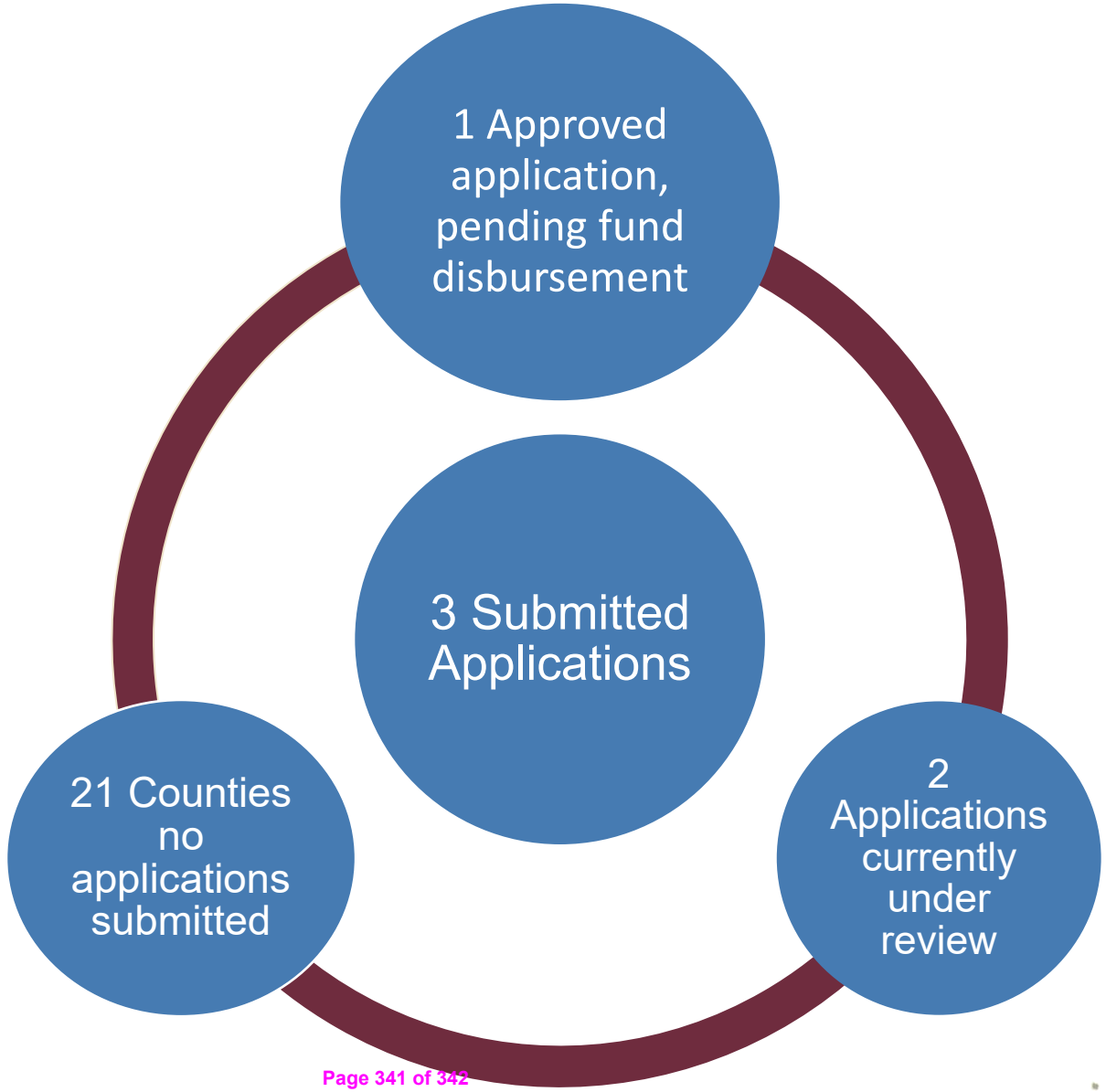
Application Status

Counties with applications under review:

- Lassen County
- Humboldt County

Counties with approved applications, & pending funding disbursement

- Sierra County



PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Questions?