PARTNERSHIP HEALTHPLAN OF CALIFORNIA
PHYSICIAN ADVISORY COMMITTEE ~ MEETING NOTICE

Members: (21)

Angela Brennan, D.O. (Chair)
Betzabel Kunkel, M.D.
Brian Montenegro, M.D.
Candy Stockton, M.D.
Chester Austin, M.D.
Chris Myers, D.O.
Christina Lasich, M.D.
Danielle Oryn, D.O.
Darrick Nelson, M.D.
Derice Seid, M.D.
John McDermott, FNP-PAC
Karen Sprague, MSN, CFNP
Karina Gookin, M.D.
Malia Honda, M.D.
Matthew Zavod, M.D.
Michele Herman, M.D.
Mills Matheson, M.D.
Teresa Shinder, D.O.
Steve Gwiazdowski, M.D.
Vanessa Walker, D.O.
Zoe Cappe, M.D.

Partnership Executive Staff:

Sonja Bjork, Chief Executive Officer
Jennifer Lopez, Chief Financial Officer
Wendi Davis, Chief Operating Officer
Amy Turnipseed, Chief Strategy & Government Affairs Officer
Robert Moore, MD, MPH, Chief Medical Officer
Katherine Barresi, RN, Chief Health Services Officer
Mark Bontrager, Sr. Director of Behavioral Health
Tina Buop, Chief Information Officer

Regional Medical Directors	Region	Region Directors
Jeffrey Ribordy, MD	Eureka - Del Norte, Humboldt, Mendocino & Lake	Vicky Klakken
Bradley Cox, DO	Redding - Siskiyou, Modoc, Shasta, Lassen, Trinity & Tehama	Vacant
Colleen Townsend	Fairfield - Napa, Yolo & Solano	Kathryn Power
Lisa Ward, MD	Santa Rosa - Marin & Sonoma	Leigha Andrews
R. Doug Matthews, MD	Chico - Glenn, Butte, Sutter, Colusa & Yuba	Rebecca Stark
Matthew Morris, MD	Auburn - Plumas, Sierra, Nevada & Placer	Jill Blake

Kermit Jones, MD, Deputy Chief Medical Officer
Jeffrey DeVido, MD, Behavioral Health Clinical Director
Mark Netherda, MD, Medical Director for Quality Improvement
Vacant, MD, Medical Director for Medicare Services

Directors / Managers / Associate Directors

Isaac Brown, Snr. Director, Quality & Performance Improvement
Aaron Brinkco, Senior Director, Provider Relations
Brigid Gast, RN, Senior Director, Care Management
Stan Leung, Pharm.D., Director., Pharmacy Services
Mohamed Jalloh, Pharm.D., Director of Health Equity
Lisa O'Connell, Director, Enhanced Health Services
DeLorean Ruffin, DrPH, Director, Population Health Management
Vacant, RN, Director of Utilization Management
Vacant, Director, Health Analytics
Kristine Gual, Director, Quality Measurement
Priscila Ayala, Director, Network Services
Irem Conery, Director, Member Experience
Dorian Roberts, Senior Manager, Provider Relations Reps.
Vacant, Manager, Quality Incentive Programs
Sue Quichocho, Manager, Quality Measurement
Kevin Jarrett-Lee, RN, Assoc. Dir. of Utilization Management
Marshall Kubota, Associate Medical Director
Bettina Spiller, MD, Associate Medical Director
Teresa Frankovich, MD, Associate Medical Director
Michael George, MD, Associate Medical Director

cc: Partnership Commission Chair
Dean Germano, Partnership Board Chair

FROM: PAC@partnershipHP.org
DATE: June 5, 2026

SUBJECT: PHYSICIAN ADVISORY COMMITTEE MEETING

The Physician Advisory Committee will meet as follows and will continue to meet the second Wednesday of every month (July and December are tentative.) Please review the Meeting Agenda and packet, as discussion time is limited.

DATE: Wednesday, June 10, 2026 **TIME: 7:30 a.m. – 9:00 a.m.**

HOSTING LOCATIONS

Partnership HealthPlan of California
4605 Business Center Drive
Fairfield, CA

Partnership – Santa Rosa
495 Tesconi Circle
Santa Rosa, CA

Partnership – Redding
2525 Airpark Drive
Redding, CA

Partnership – Eureka
1036 5th Street
Eureka, CA

Partnership - Auburn
281 Nevada St.
Auburn, CA 95603

Partnership - Chico
1000 Fortress St.
Chico, CA 95973

Aliados Health
1310 Redwood Way
Petaluma, CA 94999

Sutter-Lakeside
5176 Hill Rd. East
Lakeport, CA 95453

Tahoe Forest Health Systems
10976 Donner Pass Rd., Suite 9
Truckee, CA 96161

Office of Dr. Mills Matheson
1245 S. Main St.
Willits, CA 95490

Please contact Partnership's Executive Assistant to the Chief Medical Officer with additional questions at (800) 863-4155, or e-mail pac@partnershiphp.org.

REGULAR MEETING OF PARTNERSHIP HEALTHPLAN OF CALIFORNIA'S PHYSICIAN ADVISORY COMMITTEE (PAC) - AGENDA

Date: June 10, 2026 Time: 7:30 – 9:00 a.m. Location: Partnership

Partnership HealthPlan of California
4605 Business Center Drive
Fairfield, CA

Partnership – Santa Rosa Office
495 Tesconi Circle
Santa Rosa, CA

Partnership – Redding Office
2525 Airpark Drive
Redding, CA

Partnership – Eureka Office
1036 5th Street
Eureka, CA

Partnership - Auburn Office
281 Nevada St.
Auburn, CA 95603

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Truckee, CA 96161

Office of Dr. Mills Matheson
1245 S. Main St.
Willits, CA 95490

PUBLIC COMMENTS			Speaker		2 minutes
			Speaker		2 minutes
This Brown Act meeting may be recorded. Any audio or video tape record 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***					
I.		**EXECUTIVE OFFICE UPDATES**	**LEAD**		**TIME**
A.	**I**	**Chief Executive Officer Administration Updates**	**Ms. Bjork**		**7:35**
B.	**I**	**Chief Medical Officer Health Services Report**	**Dr. Moore**		**7:45**
II.	**A**	**MOTIONS FOR APPROVAL**	**LEAD**	**PG**	**TIME**
A.	**A**	**Review of May 13, 2026, PAC Minutes**	**Dr. Brennan**	**5**	**7:55**
B.	**A**	**Consent Review: Agenda Items II. B.1, B.2, B.5, B.6, and B.7.** **Consent review allows multiple agenda items to be approved with one motion.*	**Dr. Brennan**	**14 - 305**	**7:58**

1	**C**	**Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – May 20, 2026**
		Acceptance of Meeting Materials
		• Internal Quality Improvement Meetings, May 12, 2026
		  • Agenda
		  • Minutes
		• Quality / Utilization Advisory Committee
		  • Agenda
		  • Motion Summary
		  • Resignation of Dr. Phong Luu
		  • Quality Improvement Update
		
		Special Presentations (not included in the packet, for reference only)
		• *Initial Health Appointment- Claims & Encounters Summary*
		• *Behavioral Health Overview and Grand Analysis of Member Experience*
		• *Quality Improvement Health Equity Committee (QIHEC) Charter*
			Dr. Brennan	**14**
				16
				
				25
				27
				32
				33
					7:58

II.B	C	Consent Review: Agenda Items II. B.1, B.2, B.5, B.6, and B.7. *Continued*	LEAD	PG	TIME
2	C	***Policies/Procedures/Guidelines for Action***	Dr. Brennan		7:58
		Behavioral Health			
		MPBP8003 — Mental Health Services			
		MPBP8005 — Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services			
		MPXG5003 — Major Depression in Adults Clinical Practice Guidelines			
		Care Coordination			
		MPCP2023 — New Member Needs Assessment			
		MPCP2026 — Diabetes Prevention Program			
		MPCP20234 — Transitional Care Services (TCS)			
		Enhanced Health Services			
		MPAP7004 — Community Health Worker (CHW) Services Benefit			
		MPAP7005 — Street Medicine			
		Network Services			
		MPNET101 — Wellness and Recovery Access Standards and Monitoring			
		Quality Improvement			
		MPQP1038 — Physician Orders for Life-Sustaining Treatment (POLST)			
		MPQP1047 — Advance Directives			
		MPQP1055 — Provider Preventable Condition (PPC) Reporting			
		Utilization Management			
		MCUP3104 — Transplant Authorization Process			
		MPUP3047 — Tuberculosis Related Treatment			
		MPUP3136 — Microbiota-Based Therapeutics (MBT)			
		MPUP3137 — Palliative Care: Intensive Program (Adult)			
		MPUP3144 — Residential Substance Use Disorder Treatment Authorization			
		• Policy Summary • Detailed Synopsis		**45** **47**	
3	*C*	*Pharmacy & Therapeutics Committee*	*Dr. Stan Leung*		*7:58*
4	*C*	*Provider Education & Networking (PEN) Meeting*	*Mr. Brincko*		*7:58*
5	**C**	**Credentials Committee Meeting** • Summary, April 8, 2026 • Credentialed List, April 8, 2026	**Dr. Netherda**	**274** **279**	**7:58**
6	**C**	**Pediatric Quality Committee** • Summary, May 5, 2026	**Dr. Ribordy**	**284**	**7.58**
7	**C**	**Quality Improvement Health Equity Committee** • Summary, May 19, 2026	**Dr. Jalloh**	**290**	**7:58**
C.	**A**	**Physician Advisory Committee Membership** • Resignation – Dr. Vanessa Walker, Sutter Roseville • Nomination – Dr. Leigh Vall-Spinosa, Santa Rosa Medical Center •	**Dr. Brennan**	**306** **307**	**8:00**

III.	I	COMMITTEE MEMBER INTRODUCTION	LEAD	PG	TIME
A.	I	**Dr. Leigh Vall-Spinosa, Santa Rosa Community Health Center – Dutton** Family Medicine Physician	Dr. Vall-Spinosa	308	8:05
IV.	**I**	**REGIONAL MEDICAL DIRECTOR REPORTS**	**LEAD**		**TIME**
A.	I	Napa, Yolo & Solano	Dr. Townsend		8:10
B.	I	Marin & Sonoma	Dr. Ward		8:13
C.	I	Del Norte, Humboldt, Mendocino & Lake	Dr. Ribordy		8:16
D.	I	Glenn, Butte, Sutter, Colusa & Yuba,	Dr. Matthews		8:19
E.	I	Siskiyou, Modoc, Shasta, Lassen, Trinity & Tehama	Dr. Matthews		8:22
F.	I	Plumas, Sierra, Nevada & Placer	Dr. Morris		8:25
V.	*I*	*Old Business*	*LEAD*	*PG*	*TIME*
VI.	**I**	**SPECIAL PRESENTATIONS**	**LEAD**	**PG**	**TIME**
A.	A	Proposed 2027 Perinatal Quality Improvement Program (PQIP) Measurement Set	Troy Foster	313	8:30
B.	I	Potentially Preventable Admissions	Dr. Moore	*N/A*	8:35
VII.	**I**	**ADJOURNMENT**	**LEAD**		**9:00**
		Next PAC on August 12, 2026 at 7:30 a.m.	**Dr. Brennan**		

This agenda contains a brief description of each topic for consideration. Except as provided by law, no action shall be taken on any topic not appearing on the agenda.

Government Code §54957.5 requires that public records related to items on the open session agenda for a regular committee meeting be made available for public inspection. Records distributed less than 72 hours prior to the meeting are available for public inspection at the same time they are distributed to all members, or a majority of the members of the committee. The committee has designated the Executive Assistant to the Chief Medical Officer as the contact for Partnership HealthPlan of California located at 4665 Business Center Drive, Fairfield, CA 94534, for the purpose of making those public records available for inspection.
The Physician Advisory Committee Agenda and supporting documentation is available for review from 8:00 AM to 5:00 PM, Monday through Friday at all Partnership regional offices (see locations under the Meeting Notice). It can also be found online at the Physician Advisory Committee webpage, linked below.

https://www.partnershiphp.org/Providers/HealthServices/Pages/Physician-Advisory-Committee.aspx

In compliance with the Americans with Disabilities Act (ADA), Partnership meeting rooms are accessible to people with disabilities. Individuals who need special assistance or a disability-related modification or accommodation (including auxiliary aids or services) to participate in this meeting, or who have a disability and wish to request an alternative format for the agenda, meeting notice, agenda packet or other writings that may be distributed at the meeting, should contact the Executive Assistant to the Chief Medical Officer at least two (2) working days before the meeting at (800) 863-4155 or by email at pac@partnershiphp.org. Notification in advance of the meeting will enable Partnership to make reasonable arrangements to ensure accessibility to this meeting and to materials related to it.

Land Acknowledgment: Partnership HealthPlan honors the ancestral stewards of the land on which we meet today and acknowledges the displacement and lost lives due to colonization and ongoing disparities among California Native Americans.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PARTNERSHIP)
MEETING MINUTES

Committee: **Physician Advisory Committee**
Date / Time: **May 13, 2026 - 7:30 to 9:00 a.m.**

Voting members are required to attend in-person at one of Partnership HealthPlan's posted locations.

Members Present:
Angela Brennan, DO *(FF)*
Betzabel Kunkel, MD *(FF)*
Brian Montenegro, MD *(FF)*
Karen Sprague, MSN, CFNP *(FF)*
Matthew Zavod, MD *(FF)*
Michelle Herman, MD *(FF)*
Steven Gwiazdowski, MD *(FF)*
Teresa Shinder, MD *(FF)*
Zoe Cappe, MD *(FF)*
Malia Honda, MD *(E)*
Chester Austin, MD *(C)*
John McDermott, FNP *(C)*
Karina Gookin, MD *(AU)*
Darrick Nelson, MD *(R)*
Derice Seid, MD *(MCC)*
Mills Matheson, MD *(OMM)*
Danielle Oryn, DO *(A)*

FF Fairfield
SR Santa Rosa
E Eureka
R Redding
C Chico
AU Auburn
MCC Marin Community Clinics
OMM Office of Dr. Matheson
SH Sutter Health Roseville
SL Sutter Health Lakeside
A Aliados Health

Members Excused:
Candy Stockton, MD
Chris Myers, MD
Christina Lasich, MD

Members Absent:
Vanessa Walker, DO

Partnership Staff:
Sonja Bjork, Chief Executive Officer
Jennifer Lopez, Chief Financial Officer
Wendi Davis, Chief Operating Officer
Leigha Andrews, Region Director
Vicky Klakken, Region Director
Brigid Gast, RN, Sr. Dir., Care Management
Aaron Brincko, Sr. Dir., Provider Relations
Lisa O'Connell, Dir. Enhanced Health Services
Doreen Crume, RN, Mgr. Care Coord.
Stephanie Nakatani, Supervisor Provider Relations Representatives
Katherine Barresi, RN, Chief Health Services Officer
Robert Moore, MD, Chief Medical Officer
Kermit Jones, MD, Deputy Chief Medical Officer
Colleen Townsend, MD, Region Medical Director
Jeffrey Ribordy, MD, Region Medical Director
Bradley Cox, MD, Region Medical Director
R. Doug Matthews, MD, Region Medical Director
Matthew Morris, MD, Region Medical Director
Lisa Ward, MD, Region Medical Director
Mark Netherda, MD, Medical Director for Quality
Jeffrey DeVido, MD, Behavioral Health Clinical Dir.
Stan Leung, Pharm.D., Director, Pharmacy Services
Marshall Kubota, MD, Associate Medical Director
DeLorean Ruffin, DrPH, Director, Population Health
Mohamed Jalloh, Pharm.D., Director, Health Equity
Isaac Brown, Sr. Dir., Quality & Performance Improvement
Vacant, Director, Quality Management
Kristine Gual, Director, Quality Measurement
Vacant, Manager of QI Programs
Sue Quichocho, Mgr., Quality Measurement
Megan Shelton, Project Manager, Quality Improvement
Heather Esget, RN, Director, Utilization Mgmt. (UM)
Kevin Jarret-Lee, RN, Assoc. Dir. of UM
Robby Potter, RN, Supervisor of Inpatient UM
David Lavine, Assoc. Dir. of Workforce Development

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	DATE RESOLVED
Public Comments	PAC Chairperson asked for any public comments. None presented.	N/A	N/A
Quorum	17/21 – PAC	Committee quorum requirements met (17).	05/13/26

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AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.

I.A. Chief Executive Officer (CEO) Report	**Partnership's Chief Executive Officer presented an administrative update.**
	
	• **State Budget / Medi-Cal Policy Outlook**
	  • Partnership is closely monitoring release of the State's May Revision and related Medi-Cal policy proposals, particularly any proposal affecting members with uncertain immigration status.
	  • There are concerns members with uncertain immigration status could be moved from Medi-Cal managed care into fee-for-service Medi-Cal, which would materially affect Partnership membership and provider operations.
	  • Keeping family members, including mixed-status families, within the same managed care system to promote continuity, ease of provider administration, and inclusion in quality improvement and support programs is essential.
	  • Although State leaders had not publicly confirmed final actions, Partnership is preparing for possible changes and actively reviewing the budget release as soon as it becomes available.
	• **Medi-Cal Fiscal Pressures**
	  • The State's budget outlook remains uncertain despite reports of improved revenue and additional available funds.
	  • Department of Health Care Services (DHCS) recently reported a substantial Medi-Cal shortfall driven by utilization levels that were higher than projected, creating additional concern regarding future health plan funding.
	  • Partnership also continues to watch whether counties will receive additional resources to support new eligibility processing and redetermination requirements.
	• **County Eligibility and Work Requirement Implementation**
	  • County eligibility operations face significant administrative burden related to more frequent eligibility checks and implementation of anticipated work requirement provisions.
	  • Required system changes include documentation intake, worker training, and workflows for exemption determination; however, Centers for Medicare and Medicaid Services (CMS) has not yet issued all detailed guidance.
	  • California is expected to pursue a more coverage-oriented implementation approach than some early states, but many operational details remain unknown.
	  • Potential exemptions for individuals who are medically frail remain undefined, creating concern that providers may experience increased administrative requests for attestations and supporting documentation.
	• **Future of Medi-Cal Commission**
	  • Partnership is monitoring the work of the Future of Medi-Cal Commission, a California health policy initiative convened to advise on long-term Medi-Cal transformation.
	  • The Commission recently released broad policy concepts and goals, which are now under further review and refinement through workgroups and advisory committees.
	  • Partnership leadership emphasized the importance of following these proposals closely because of their potential long-term effect on Medi-Cal managed care and provider networks.

I.B. Chief Medical Officer (CMO) Health Services Report	**Partnership's Chief Medical Officer presented the following Health Services report.**
	• **GLP-1 Prior Authorization / Appeals**
	  • Partnership continues to track State approval and denial patterns for GLP-1 medications.
	  • Partnership's pharmacy team is actively escalating concerns, particularly denials related to dose escalation and requirements appearing inconsistent with existing policy.
	  • Providers were encouraged to contact regional medical directors or Partnership's pharmacy team regarding problematic cases and, when appropriate, to pursue appeals on behalf of patients.

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AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.

I.B. Chief Medical Officer (CMO) Health Services Report, Continued	• **Partnership Clinic Leadership Academy**
	  • The inaugural cohort for the Partnership Clinic Leadership Academy has been selected, with 35 health care leaders and managers from across the network participating.
	  • The program is being delivered in collaboration with Healthforce UCSF and is designed to strengthen clinic leadership capacity across Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Tribal Health Centers.
	  • Kickoff activities are scheduled to begin in June.
	• **Blood Pressure Monitor Access / Partnership Medical Equipment Distribution Services (PMEDS)**
	  • Partnership reviewed its medical equipment distribution program and reiterated the importance of home blood pressure monitoring for members with hypertension.
	  • Two access paths remain available: obtaining a monitor through the State pharmacy benefit when honored by a pharmacy, or through Partnership's equipment distribution program.
	  • Community pharmacy fulfillment remains inconsistent, though CVS has generally been more likely than average to honor these prescriptions.
	  • Partnership encourages sites to make use of either option to improve blood pressure control, a high-impact HEDIS© measure affecting member outcomes and financial performance.
	• **Community Reinvestment Advocacy**
	  • Clinicians and medical leaders are encouraged to participate in local county advisory processes related to community reinvestment funding decisions.
	  • Reinvestment dollars may be used to strengthen recruitment and retention incentives and to expand medical education and workforce pipeline opportunities.
	• **Primary Care Provider Quality Program (PCP QIP) Update**
	  • Final payment notices and checks are expected to be distributed soon.
	  • The weighted average score increased from the prior year, reflecting overall improvement despite a more difficult scoring environment.
	  • Total anticipated payments are approximately $53.5 million.
	  • A record 39 sites scored above 90%; six sites achieved 100%; and two Tribal Health Centers reached 100%.
	  • Fifteen sites scored zero percent, reflecting continued variability across the network.

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AGENDA ITEM	MOTIONS FOR APPROVAL	RECOMMENDATIONS / ACTION	DATE RESOLVED
II.A.	**April 8, 2026, PAC minutes were presented for approval.**	**<u>MOTION</u>:** Dr. Zavod moved to approve Agenda II.A as presented, seconded by, seconded by Dr. Montenegro. **<u>ACTION SUMMARY</u>:** [16] yes, [0] no, [1] abstentions.	05/13/26 Motion carried.
II.B. II.B.1 II.B.2 II. B.4 II.B.5	**Consent Calendar Review** • Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – May 20, 2026 • Policies, Procedures, and Guidelines for Action Policy Summary May 13, 2026 • Provider Education & Networking (PEN) Summary, April 2, 2026 • Credentials Committee Meeting, April 8, 2026 Minutes Credentialed List	**<u>MOTION</u>:** Nurse Sprague moved to approve Agenda II.B.1, II.B.2, II.B.4, and II.B.5 as presented, seconded by Dr. Herman. **<u>ACTION SUMMARY:</u>** [17] yes, [0] no, [0] abstentions.	05/13/26 Motion carried.
VI.A	Proposed 2027 Palliative Care QIP Measure Set	**<u>MOTION</u>:** Dr. Montenegro moved to approve Agenda item VI.A as presented, seconded by Dr. Montenegro. **<u>ACTION SUMMARY:</u>** [17] yes, [0] no, [0] abstentions.	05/13/26 Motion carried
VI.B	Proposed 2026 Hospital QIP 6-month Bridge Measure Set	**<u>MOTION</u>:** Dr. Herman moved to approve Agenda item VI.B as presented, seconded by Dr. Montenegro. **<u>ACTION SUMMARY:</u>** [17] yes, [0] no, [0] abstentions.	05/13/26 Motion carried

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.

III.A
Status Update, Regional Medical
	Partnership's Deputy Chief Medical Officer presented a brief update on behalf of the Regional Medical Director for Napa, Solano, and Yolo Counties.
	• **Yolo County**
	  • The pertussis outbreak that began in Davis in March has expanded to approximately 30 pediatric cases, with spread also reported in Woodland and elsewhere in Yolo County.
	  • Most affected children were reportedly up to date on pertussis vaccination; however, waning immunity from acellular pertussis vaccines may contribute to infection risk. Vaccination remains protective against severe disease, hospitalization, and death.
	  • Recent confirmed cases in Woodland prompted coordination with the Woodland Joint Unified School District to notify families regarding possible exposure.
	  • Providers were encouraged to test symptomatic patients regardless of vaccination status, consider pertussis in patients with paroxysmal cough and associated vomiting or "whoop," use PCR testing within the first 21 days of symptoms, and maintain isolation until five days of antibiotics are completed.
	  • Solano and Yolo Counties are recruiting for a new Public Health Officer.
	• **Napa County**
	  • No major county updates were reported. Partnership continues to monitor the transfer of Queen of the Valley Medical Center from Providence to NorthBay Health. system.

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AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
III.B. Status Update, Regional Medical	**Partnership's Regional Medical Director for Marin and Sonoma Counties presented a brief update on activities.** Dr. Leigh Vall-Spinose was introduced as a family physician and community leader from Santa Rosa who is interested in joining the Physician Advisory Committee as a voting member. **Regional Highlights** • Alliance Medical Center in North Sonoma County was invited by DHCS to present best practices related to implementation of mobile mammography. • Marin City Health and Wellness received recognition for work to close blood pressure control gaps among Black patients and received support through the California Health Care Foundation's Pulse of Change initiative. • Planning is underway for a June regional quality meeting focused on Cologuard implementation and spread of best practices. • Planning is also underway for a September perinatal summit that will bring together hospitals, community-based organizations, ECM, midwifery, doula, and related stakeholders. • Academic detailing lectures supporting pharmacy and quality improvement work are being well received. • Regional networking meetings and the Santa Rosa Regional Medical Director Forum were well attended and productive. • Sonoma Valley Hospital hosted its annual Women's Health Symposium focused on education and empowerment, including midlife and menopause topics. • Member experience education is being shared locally with sites such as Santa Rosa Community Health. • Workforce updates included an expanding rural training track residency in Lake County connected to the Santa Rosa Family Medicine Residency and an advanced practice clinician residency recruitment fair serving Marin, Sonoma, and Humboldt. • Additional advocacy lectures remain scheduled regarding federal policy changes and H.R. 1 implications.
III.C. Status Update, Regional Medical	**Partnership's Regional Medical Director for Lake, Mendocino, Humboldt, and Del Norte Counties presented a brief update on activities.** • Mendocino Community Health Center experienced a leadership change following the departure of its long-standing Chief Executive Officer. An interim chief executive is in place while recruitment proceeds. • In Willits, Adventist Health recently opened an urgent care center but temporarily closed it due to staffing challenges. Reopening is planned once staffing stabilizes. • In Ukiah, a sports medicine/orthopedic clinic closed temporarily due to a facility water-related issue; patients are being redirected to other sites. • Sutter Lakeside Hospital experienced a temporary disruption after a transformer incident and generator failure; the issue has since been resolved. • The Better Birthing Project, previously developed in Humboldt, is being expanded to Lake County in collaboration with Lake County Tribal Health to strengthen birthing experiences and hospital relationships for Tribal members. • A maternity photo project focused on Black and Tribal mothers is also being planned for Humboldt later this summer. • Concern was expressed regarding public reports of layoffs and service reductions at Mad River Hospital, including the elimination of medical staff office functions. Partnership is seeking additional information.
III.D. Status Update, Regional Medical	**Partnership's Regional Medical Director for Glenn, Butte, Sutter, and Colusa Counties presented a brief update on activities.** • A candidate has been interviewed for the Redding Regional Medical Director position, and additional updates are expected as recruitment proceeds. • Warner Mountain Indian Health Clinic in Fort Bidwell, received a provisional pass on its site inspection and is expected to join the Partnership network following minor final adjustments. The clinic has expanded from 20 hours per month of clinical visits to 20 hours per week and continues efforts to recruit additional provider support. • Banner Lassen in Susanville, local family medicine obstetrics capacity remains limited, and recruitment continues for additional obstetric providers to sustain approximately 400 annual births. • Seneca Hospital in Chester reported that its expanded hospital project is nearing completion, with opening anticipated in July 2026.

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AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
III.E Status Update, Regional Medical	**Partnership's Regional Medical Director for Siskiyou, Modoc, Shasta, Lassen, Trinity, and Tehama Counties presented a brief update on activities.** • Partnership's North Regional Director has transitioned to the Director Provider Contracts leadership role, with recruitment underway for a replacement. • In Yreka, Madrone Hospice has a new Chief Medical Officer, Dr. Sean Molloy. • Local FQHCs are reportedly reassessing prescribing expectations for pain medications in response to provider recruitment concerns, which may contribute to member grievances. • Shasta Regional Medical Center was recently highlighted in local media as financially vulnerable because of Medicaid cut concerns. Partnership continues to meet regularly with hospital leadership to explore collaborative strategies for strengthening specialty, primary care, and urgent care access and improving hospital performance. • A Nourish and Flourish event is scheduled for May 30 at the farmer's market.
III.F Status Update, Regional Medical	**Partnership's Regional Medical Director for Plumas, Sierra, Nevada, Yuba, and Placer Counties presented a brief update on activities.** • Blue Stone Health and Wellness, a regional provider partner located in Weimar, CA, received a presentation focused on the Primary Care Provider Quality Incentive Program with emphasis on hypertension management. • Joint Leadership Initiatives were held with WellSpace and Western Sierra Medical Clinic and also centered on quality incentive measures related performance goals. • Western Sierra Medical Clinic recently opened a Family Justice Center in collaboration with the District Attorney's Office to provide local support and screening resources for victims of domestic violence and child abuse. • Plumas District Hospital reported progress with new services, including its newer skilled nursing facility, although storm damage temporarily affected one wing and repairs are underway. • Plumas District Hospital is also assuming responsibility for ground ambulance operations in Lassen county beginning July 1, 2026. • The region held its first Regional Medical Director Forum, which was fully attended and received very positive feedback.
IV. Introductions	*No additional introductions were presented.*
V. Old Business	*No old business was presented.*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS ACTION REQUIRED

VI.A
Proposed 2026 Hospital QIP 6-month Bridge Measure Set
	Partnership staff presented the proposed 2026 Hospital QIP six-month bridge measure set.
	• A six-month bridge period from July 1, 2026, through December 31, 2026, is necessary because a new federal requirement now mandates that QIP programs operate on a calendar-year basis. Partnership's Hospital QIP has historically operated on a fiscal-year basis and will transition to a calendar-year program beginning January 2027.
	• The bridge set is an abbreviated version of the full-year measure set.
	• **Measures proposed to continue during the bridge period:**
	    • Expanded Delivery Privileges: continue Phase 2 requirements rather than advancing to Phase 3 during the bridge period. Hospitals that have adopted bylaws and/or policies allowing midwives and family physicians to hold delivery privileges must now demonstrate active recruitment and/or provide privilege lists showing clinicians granted delivery privileges.
	    • Doula Support: continue Phase 1 of the measure during the bridge period to sustain progress supporting doulas in the labor and delivery environment.
	    • Vaccines for Children (VFC) Enrollment: continue the hospital birthing-site enrollment measure through December 31, 2026, after which the measure is expected to be removed for the 2027 program.
	• **Measures proposed for removal during the bridge period:**
	    • Quality Improvement Capacity: removal was recommended because the hospital quality symposium for the current fiscal year has already occurred, and repeating the requirement in the abbreviated bridge timeframe would be duplicative before the 2027 program resumes.
	    • Hospital Compare / Patient Experience Measure: removal was recommended because Hospital Compare data are updated on a limited annual cycle and do not align well with the bridge period scoring timeline.
	    • Health Equity Measure: removal was recommended because hospitals will have recently submitted the applicable CMS health equity attestation, making a repeated submission during the short bridge period unnecessary.
	
	Questions: None
	A motion was taken to approve the measure set and passed as presented.

VI.B
Proposed 2027 Palliative Care QIP Measure Set
	Partnership staff presented the proposed 2027 Palliative Care QIP measure set.
	• Staff reported that no changes are recommended for the 2027 measurement year; therefore, the presentation served as a review of the existing measure set.
	• **Utilization Measure**
	    • Avoiding hospitalization and emergency department visits: incentive of $240 per member per month when there are no inpatient or emergency department visits during the calendar month.
	• **Quality Measures**
	• **Completion of a POLST** incentive of $120 per member per month once a signed POLST is completed.
	    • Completion of a standardized patient symptom assessment: maximum incentive of $120 per member per month when two standardized symptom assessments are completed with required data elements.
	    • For the symptom assessment measure, full credit is available when 70 percent or more of required data elements are captured; partial credit of $60 per member per month is available when 50 to 69 percent of required data elements are captured.
	
	Questions: None
	A motion was taken to approve the measure set and passed as presented.

DRAFT

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.

VI.C
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Member Experience Survey
	Partnership's Chief Medical Officer presented an overview of Consumer Assessment of Healthcare Providers and Systems (CAHPS®) member experience survey findings and related improvement opportunities.
	• **Purpose / Framing**
	   • Multiple sources of information used to assess member experience, including the health plan CAHPS survey, member grievances, provider-level CG-CAHPS findings, focus groups, supplemental surveys, and a recent external consultant assessment.
	   • Member experience is a shared responsibility involving Partnership, contracted providers, and the broader delivery system.
	• **Plan-Level CAHPS Findings**
	   • Partnership's 2024 CAHPS results remained below average overall. Adult measures were reported at approximately two stars overall, and child measures at approximately 2.5 stars.
	   • Leadership reviewed historical trends, noting stronger performance during earlier years when Partnership served fewer counties, followed by declines after major geographic expansion and again during the COVID-19 period.
	   • Although overall scores remain below average, limited improvement was observed in some health plan-related ratings, suggesting early progress from internal improvement efforts.
	• **Why Scores Matter**
	   • Low CAHPS scores affect Partnership's publicly reported quality ratings and reduce overall star performance despite strong clinical quality results.
	   • The State now withholds significant funding tied in part to adult and pediatric CAHPS performance, creating material financial consequences if experience scores do not improve.
	• **Key Findings from Complaints, Focus Groups, and Supplemental Analysis**
	   • Access remains the strongest recurring concern across survey results and grievances.
	   • Transportation grievances remain high in volume and continue to be a major source of member dissatisfaction.
	   • Members often associate all aspects of Medi-Cal with Partnership, including benefits or services actually administered by counties or the State, such as dental, behavioral health, eligibility, and Medi-Cal Rx.
	   • Members reported frustration with navigation, confusion about benefits, and difficulty reaching the right resource.
	   • Telehealth was identified as a meaningful opportunity to improve convenience and member satisfaction when appropriately applied.
	   • Focus groups indicated that members' perceptions of quality are heavily influenced by interactions with providers, including feeling listened to, respected, included in care decisions, and able to trust continuity and follow-through.
	• **Provider-Level Observations**
	   • CG-CAHPS findings for larger primary care provider organizations generally mirrored the plan-level results, with access scoring lower than communication.
	   • Pediatric scores were generally stronger than adult scores, and substantial variation exists among provider organizations.
	   • Leadership noted that some smaller rural and Tribal providers achieved particularly strong performance, while larger FQHCs often demonstrated strong clinical quality but only average to slightly below-average member experience scores.
	• **External Consultant Findings**
	   • A recent external evaluation concluded that sustainable improvement will require moving beyond compliance-based grievance closure toward a more proactive member experience operating model.
	   • Recommendations included governance changes, stronger access improvement work, reducing provider variability, improving transportation performance, enhancing grievance governance, strengthening listening strategies, leveraging telehealth, and improving digital member experience.
	   • Leadership noted that Partnership is already taking steps in this direction, including recruitment of a director focused on member experience.

DRAFT

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.

VI.C
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Member Experience Survey, Continued
	• **Guidance for Leaders / Committee Discussion**
	  • Committee members were encouraged to observe their own organizations' access and communication systems directly, including calling front office lines, reviewing waiting room experience, shadowing staff, and following a patient journey through the system.
	  • The CEO emphasized that improving member experience is important both because it aligns with organizational mission and because it protects revenue at a time when health care resources are under pressure.
	  • Examples of high-performing organizations were noted, and Partnership offered to help spread successful practices.
	  • Committee discussion included caution against over-comparing pediatric and adult practice settings given their inherent differences; concern regarding time pressure, documentation burden, and financial structures that limit visit time; and interest in practical communication training approaches that improve patient perception without necessarily increasing visit length.
	
	No formal action was requested. The presentation was received for informational purposes only.

AGENDA ITEM	**ADJOURMENT**
PAC adjourned at 8:59 a.m.	**Next Physician Advisory Committee announced for June 10, 2026.**

For Signature Only

The foregoing minutes were APPROVED AS PRESENTED on ____________________ ______________________________

Date **Angela Brennan, D.O., Committee Chairperson**

The foregoing minutes were APPROVED WITH MODIFICATION on ____________________ ______________________________

Date **Angela Brennan, D.O., Committee Chairperson**

DRAFT

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE
MEETING AGENDA

Date: Tuesday, May 12, 2026 **Time: 1:30 - 3:30 p.m.**

Locations:
Napa/Solano (Fairfield West)
Trinity Alps (Redding – Airpark)

To Join by Webex:
https://partnershiphp.webex.com/meet/iqi
Meeting # 2631 319 6924

To Join by Telephone:
Toll Free: 844-621-3956
Access Code: 2631 319 6924

	Item	Lead	Time	Page #
I.	**Call to Order//New Staff Introduction(s)/Announcements/Approval of Minutes**			
1	Approval of Internal Quality Improvement (IQI) Committee Meeting Minutes of Apr. 7	Robert Moore, MD, MPH, MBA	1:30	6
2	Policy Review Updates			
II.	**Old Business**			
	None			--
III.	**New Business – Consent Calendar Policies**			
	Consent Calendar		1:37	25
Health Services Departments	**Care Coordination**			
	MPCP2026 – Diabetes Prevention Program			27
	MPCP2034 – Transitional Care Services			34
	Enhanced Health Services			
	MPAP7004 – Community Health Worker (CHW) Services Benefit			48
	MPAP7005 – Street Medicine			60
	Quality Improvement			
	MPQP1038 – Physician Orders for Life-Sustaining Treatment (POLST)			68
	MPQP1047 – Advance Directives			74
	MPQP1055 – Provider Preventable Condition (PPC) Reporting			78
	Utilization Management			
	MPUP3137 – Palliative Care: Intensive Program (Adult)			84
	MPUP3144 – Residential Substance Use Disorder Treatment Authorization			105
Non – HS Departments	**Behavioral Health**			
	MPBP8005 – Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health			112
	Member Services			
	MC341 – Distribution of Member Rights and Responsibilities – Wellness and Recovery Program			118
	Network Services			
	MPCR300 – Physician Credentialing and Re-credentialing Requirements			123
	MPCR302 – Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements			135

	Item	Lead	Time	Page #
	MPCR303 – Applied Behavioral Health and Substance Use Disorder Practitioner Credentialing and Recredentialing Requirements			142
	MPCR304 – Allied Health Practitioners Credentialing and Re-credentialing Requirements			148
	MPCR500 – Ongoing Monitoring of Sanctions			154
	MPPR208 – Provider Notification of Provider Termination, Site Closure or Change in Location Information			163
	MPNET101 – Wellness and Recovery Access Standards and Monitoring			170
	MPCR102 – Provider Directory Accuracy			174
	MPCR701 – Ancillary Care Services Provider Credentialing and Re-credentialing Requirements			177
	MPNET103 – DHCS Subcontractor Network Certification			187
IV.	**New Business – Discussion Policies**			
	Synopsis of Changes		--	217
Non-HS	**Behavioral Health**			
	MPBP 8003 – Mental Health Services	Jeffrey DeVido, MD	1:44	221
HS Policy	**Care Coordination**			
	MPCP2023 – New Members Needs Assessment	Aryana Cunnigham	1:49	240
	Quality Improvement			
	MPXG5003 – Major Depression in Adults Clinical Practice Guidelines	Jeffrey DeVido, MD	1:54	256
	Utilization Management			
	MPUP3047 – Tuberculosis Related Treatment	Mark Netherda, MD	1:59	261
	MPUP3136 – Fecal Microbiota Transplant (FMT)	Tony Hightower	2:04	267
	MCUP3104 – Transplant Authorization Process	Tony Hightower	2:09	271
V.	**Presentations**			
1	QI Update	Isaac Brown	2:14	278
2	IHA- Claims & Encounters Summary	Rachel Newman	2:19	291
3	Behavioral Health Overview and Grand Analysis: ME7 E&F Member Experience	Mark Bontrager Jeffrey DeVido, MD	2:29	303
4	Proposed CY 2027 Perinatal QIP Measure Set	Troy Foster	3:04	330
5	QIHEC Charter	Mohammed Jalloh, PharmD	3:14	335
FYI	**Adjournment by 3:30 p.m. to 1:30 p.m. Tuesday, June 9, 2026**			

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

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

Members Absent:
Davis, Wendi, Chief Operating Officer
Klakken, Vicky, Regional Director (NW-Eureka)
Matthews, R. Douglas, "Doug," MD, Regional Medical Director (Chico)
Ruffin, DeLorean, DrPH, Director of Population Health
Townsend, Colleen, MD, Regional Medical Director (SE-Fairfield)
Sharp, Tim, Regional Director (NE-Redding)
Vaisenberg, Liat, Director of Health Analytics

Guests:
Akintan, Folo, MBBS/MD, MPH, MBAm Epidemiologist, Pop Health
Allen, Angier, Sr. Data Scientist I, Finance
Arrazola, Kelcie, Lead Trainer, Provider Relations
Bikila, Dejene, Manager of Data Science, Finance
Chebolu, Radha, Sr. Data Scientist II, Finance
Clark, Kristen, Manager of Qlty. & Training, Member Services
Cunningham, Aryana, Policy Analyst, Care Coordination
Curreri, Nicole, MPH, CHES, Associate Director of Enhanced Health Services
Diaz, Alondra, Project Coordinator I, Care Coordination
Durst, Jennifer, Senior Manager of Performance Improvement, QI
Escobar, Nicole, Sr. Manager of Behavioral Health
Flournoy, Candi, Project Manager II, QI
Foster, Troy, Program Manager II, QI
Friedman, Greg Allen, Project Coordinator II, Population Health
Harris, Vander, Sr. Health Data Analyst I, Finance
Hendrix, Hillary, Executive Assistant, Behavioral Health
Horan, Kathleen, Facilities Business Management Specialist, Finance
Isola, Brandy, Manager of Performance Improvement, QI (Chico)
Kim, Amanda, Improvement Advisor, QI (Redding)
Kulkarni, Shreya, Policy Analyst, Regulatory Affairs & Compliance
Kubota, Marshall, Associate Medical Director
Kung, Jen, Sr. Health Data Analyst II, Finance
Lee, Donna, Manager of Claims, Claims
Leung, Paul, Sr. Health Data Analyst I, Finance
Ling, Samuel, Sr. Health Data Analyst I, Finance
Medric, Christy, Sr. Health Data Analyst I, Finance
Moore, Jordan, Education Specialist, Provider Relations
Morris, Matthew, MD, Regional Medical Director
Muncy, Kellie, Manager of Change Management & Configuration
Nguyen, Tom, Manager of Health Analytics., Finance
O'Leary, Hannah, Manager of Population Health
Quichocho, Sue, Manager of Quality Measurement, QI
Rathnayake, Rasitha, Sr. Health Data Analyst I, Finance
Rednic, Hanny, Program Manager I, UM
Roach, Erika, Program Manager I, Network Services
Seale, J'aime, PR Lead, Network Services
Sivasankar, Shivani, Sr. Data Scientist, Finance
Stites, Jaylyn, Program Manager II, Provider Relations (Redding)
Vance, Brooke, Program Manager I, Network Services
Yu, Fei, Sr. Data Scientist I, Finance
Zhao, Li Sr. Health Data Analyst I, Finance

<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION</th><th>RECOMMENDATIONS / ACTION</th></tr>
<tr><td>I. Call to Order
Approval of Minutes
Announcements</td><td>CMO Robert Moore, MD, MPH, MBA called the meeting to order at 1:32 p.m. from the Fairfield-West office. He welcomed back committee scribe Leslie Erickdon and thanked all those who covered IQI work in her absence, particularly Robert Bides, RN, Cindy Rodriguez, and Chandler Ackerman. “It was well done with a smile, a smile of stress.,” he said, adding that this situation exemplifies why “we need to build capacity so (anyone) can take time off.”
The April 7 IQI Minutes were approved without comment.
“Policy review update” will be a standing item for some months to come.
Shreya Kulkarni of Regulatory Affairs & Compliance (RAC) is point of contact for any questions.
RAC wants those responsible for editing policy updates and bringing them to this or other reviewing committees to first refer to template CMP44-A under CMP44 Development, Structure and Formatting of Policies/Procedures (available in Power DMS) as they work.
Jan. 1, 2028 is our new target date to go-live with Medicare (i.e., “Partnership Advantage”). After some discussion, it was agreed that all published policies now noting Jan. 1, 2026 or Jan. 1 2027 go-live dates may be changed to Jan. 1, 2028 in Power DMS if and only if this is the only change to be made to the policy. (The policy need not first come back through committees if an annual review is not yet due.) Motion: Anna Campbell/Lisa Ward, MD
If a policy alpha/numeric designation changes from MC to MP (i.e., Medi-Cal to Multi Program) or vice versa, it is the policy owner’s responsibility to inform the owners of all “Related Policies” to accordingly update those policies. Power DMS power users may electronically update their published policies without first bringing the policies to committee if this is the only change to be made to the related policy and the policy is not otherwise due for annual review. Motion: Anna Campbell/Lisa Ward, MD
Anna Campbell noted that – insofar as multiple policies state readers should “refer to website” or says “If you need SUD treatment, go to this webpage” or “If you need P-MEDS, go to this webpage” – she has concerns with Communications’ plans to shift our external website from one SharePoint to another and eventually to a new platform. Links could be inoperable by October. She reported that Communications has said they will take this into account if provided a list of such policies. Dr. Moore said policies must always include the link’s name and not just point to a hidden URL so that readers can do an internet search if necessary.</td><td>Motion to approve IQI Minutes: Mark Netherda, MD
Second: Isaac Brown, MHA/ MBA
The date of the last RAC review for regulatory compliance with All Plan Letters (APLs) etc. and/or the Department of Health Care Services’ (DHCS) review for contract compliance, etc. should be captured in policies.
The formatting and placement of this new date will be decided offline this summer before policy point persons must comply (in policies submitted for Aug. 11 IQI consideration).</td></tr>
<tr><td colspan="3">II. Old Business – None</td></tr>
<tr><td colspan="3">III. New Business Consent Calendar (Committee Members as applicable)</td></tr>
<tr><td colspan="2">Health Services Policies
<u>Behavioral Health</u>
MPBP8005 – Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health
<u>Care Coordination</u>
MPCP2026 – Diabetes Prevention Program
MPCP2034 – Transitional Care Services – pulled for discussion
<u>Enhanced Health Services</u>
MPAP7004 – Community Health Worker (CHW) Services Benefit
MPAP7005 – Street Medicine</td><td>Motion to approve the slate without the three policies pulled for discussion: Mark Netherda, MD
Second: Lisa Ward, MD

<u>Next Steps HS Policies</u>:
May 20 Quality/Utilization Advisory Committee (Q/UAC)</td></tr>
</table>

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

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
IV. New Business – Discussion Policies		
Policy Owner: Behavioral Health – *Presenter: Jeffrey DeVido, MD, Behavioral Health Clinical Director*		
MPBP8003 – Mental Health Services	Added related policy: MPBP8007 - Screening and Treatment for Substance Use Disorders • **VI. B. 1. a. – Added** "should Partnership impose any authorization requirements, Partnership must ensure authorization determinations are based on the requested medically necessary health care services and are consistent with current evidence-based clinical guidelines." to align with wording from APL 26-002. • **VI. I. G. - Re-Added** "through the diagnosis or treatment of disease, illness or injury" per request from Policy Analyst • **VI. I. N. – Added** "should be performed by PCP." • **VI. I. O. – Added** "as outlined in APL 21-014." • **VI. S. – Added** "Data sharing" section to align with APL 26-004 "Medi-Cal Managed Care Plan Responsibilities For Behavioral Health Data-Sharing" • **VI. S.4 – Added** "ASCMI" initiative update noted in APL 26-004 • Updated all Partnership Advantage effective dates to Jan. 1, 2028 • Updated references to include APL 26-002 and APL 26-004 Dr. DeVido noted that IQI saw this policy last month with changes related to APL 26-002. Changes this month are largely "boiler plate" data sharing guidance lifted from APL 26-004. "This is all very fresh," he said, adding that some specifics have yet to be addressed. "We have been able to address some needs per DHCS request (e.g., bringing the call center in house to be later today in the Grand Analysis presentation). The benefit is that a caller can now be directly connected to a service provider, what we call 'first call resolution.' We are already working on closed loop tracking systems for each of our 24 counties." We are still working on this and with the (Behavioral Health Plans) BHPs (formerly known as Mental Health Plans or MHPs) in the counties on information exchange – such that we can have automatic bi-directional communication, possibly using SacValley MedShare data exchange. Anna Campbell asked if the policy should still reference Carelon. Dr. DeVido replied he tells everyone to call Partnership; however, Senior Director of Behavioral Health Mark Bontrager noted that Varelon is still an option available to primary care providers seeking consultation. Dr. Moore added that phone numbers, with few exceptions, should not be listed in policies. Web addresses are preferred.	Motion: **approve changes presented today knowing that some Carelon language will be clarified before the policy moves to Q/UAC:** Kristine Gual, PMP, CPHQ Second: Anna Campbell, MPH <u>Next Steps</u>: May 20 Q/UAC June 10 PAC
Policy Owner: Care Coordination – *Presenter: Aryana Cunningham, Care Coordination Policy Analyst*		
MPCP2023 – New Member Needs Assessment	**Policy edits due to APL 26-001 Initial Health Appointment.** Throughout the policy Partnership Advantage effective date has been updated to reflect Jan. 1, 2028. The body of the policy has been updated to reflect Partnership Advantage "Enrollee" instead of Partnership Advantage "Member." • **Related Policies added:** MCQP1021 – Initial Health Appointment • **Definition Added:** Initial Health Appointment (IHA) • **Added VI.C. Initial Health Appointment (IHA)** 1. For Members/Enrollees, Partnership must ensure Members engage in primary care consistent with IHA requirements. This requirement may be met by confirming the Member's/Enrollee's engagement with	Motion to **approve the policy itself as presented, with the form's header and footer changes as noted:** Anna Campbell, MPH Second: Mark Netherda, MD <u>Next Steps</u>: May 20 Q/UAC

<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION</th><th>RECOMMENDATIONS / ACTION</th></tr>
<tr><td></td><td>their PCP and documenting that the member was seen by a PCP within the past 12 months.
a. If the Member/Enrollee was not seen by a PCP within the past 12 months. The requirement may be met by assisting in identifying and connecting with a PCP who accepts Member's or Enrollees coverage or by conducting a warm handoff to a care coordination entity affiliated with the Medicare Enrollee's plan, if applicable.
b. For more information regarding IHA please review Partnership's policy MCQP1021 Initial Health Appointment.
• References added: DHCS All Plan Letter 26-001: Initial Health Appointment (01/07/2026)

Aryana presented, adding that this policy has been submitted to DHCS, which thus far has not returned any AIRs. There was some discussion whether the form headers and footers really need to reference "SPDs" (Seniors/Persons with Disabilities), which some IQI members said can be confusing or even offensive to some members. Dr. Moore and Chief Health Services Officer Katherine Barresi, RN, agreed to change the form header to "Adult Health Risk Assessment" (adhering to the HRA acronym familiar to us) and add the SPD acronym to the footnote to clue in staff as to the form's utility.</td><td>June 10 PAC

Senior Director of Member Services and Grievance Edna Villasenor noted the form still must be translated for inclusion in new member packets. Aryana said Communications is aware and will broker this once DHCS has approved our changes. Edna asked that her staff remain apprised.</td></tr>
<tr><td colspan="3">Policy Owner: Quality Improvement / Behavioral Health – Presenter: Jeffrey DeVido, MD, Behavioral Health Clinical Director</td></tr>
<tr><td>MPXG5003 – Major Depression in Adults Clinical Practice Guidelines</td><td>Attachment A flowchart:
• Added reference to 2023 American College of Physicians (ACP) guidelines, against which this Partnership Clinical Guideline was reviewed.
• Added bubble to remind of the importance of considering pregnancy status and substance use, as these can impact pharmacotherapy decision making.
• Added bubble to remind of the need to continue to consider suicidality throughout the duration of treatment, as suicidality can emerge throughout treatment.

Dr. DeVido added that the flowchart date reading "2025" will be changed to "2026" before Q/UAC sees this May 20. Reference to Partnership Advantage will be struck from one flowchart bubble. This may come back in a future update closer to the D-SNP go-live target Jan. 1, 2028.

Dr. DeVido said he was curious how our guideline might compare to an AI discussion, and so he looked at Claude. He was pleased that our policy did not need further work as a result. (Claude did return one additional reference, which Dr. DeVido added.)</td><td>Motion to approve as presented with the flowchart to be amended in two places: Kristine Gual, PMP, CPHQ
Second: Anna Campbell, MPH

<u>Next Steps</u>:
May 20 Q/UAC
June 10 PAC</td></tr>
<tr><td colspan="3">Policy Owner: Utilization Management – Presenter: Mark Netherda, MD, Medical Director for Quality</td></tr>
<tr><td>MPUP3047 – Tuberculosis Related Treatment</td><td>Section VI.B: Guidance for Directly Observed Therapy was updated, and a link was provided to a California Department of Public Health (CDPH) guidance document titled, "Information for Physicians Regarding Directly Observed Therapy (DOT) for Active Tuberculosis (TB)."

Section VII.G and I.: Minor updates were made in the References section to combine two Title 17 citations and to update former Medi-Cal Rx APL number 22-012 to the current number 25-013.
Attachment A: The TB Screening Guidelines were combined into one flow chart, instead of two, and a clarification was made at the end to say that "Consideration of Treatment of Latent TB" would be "by PCP."</td><td>Motion to approve as presented:
Lisa Ward, MD
Second: Kristine Gual

<u>Next Steps</u>:
May 20 Q/UAC
June 10 PAC</td></tr>
</table>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Dr. Netherda thanked former Yuba/Sutter County Public Health Officer Phuong Luu, MD, for the suggestion on the attachment. He also thanked Associate Medical Director Teresa Frankovich, MD, Regional Medical Director (Santa Roa) Lisa Ward, MD, and UM Policy Analyst Anna Campbell for their contributions.	
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations*		
MPUP3136 – Microbiota-Based Therapeutics (MBT) **NEW TITLE**(formerly Fecal Microbiota Transplant [FMT]	During the annual review of this policy, the title was updated from Fecal Microbiota Transplant (FMT) to Microbiota-Based Therapeutics (MBT) to reflect coverage of lab-grown microbial consortia. **Section I.C.:** MCRP4068 Medical Benefit Medication TAR Policy was added as a Related Policy because lab-grown microbial consortia is covered as a Physician Administered Drug. **Section III.A.:** Definition of FMT was updated to MBT (which includes FMT). **Sections V. and VI.:** Acronym FMT was updated to MBT throughout the policy. **Section VII.** Minor updates were made to existing References to reflect most-current article information. After Tony went through the synopsis, Anna noted that the title change was made at the behest of Deputy CMO Kermit Jones, MD. Dr. Netherda explained that patients can still receive a familial donor but that a lab-grown option I now available where indicated.	Motion to **approve as presented:** Anna Campbell, MPH Second: Jeffrey DeVido, MD Next Steps: May 20 Q/UAC June 10 PAC
Policy Owner: Utilization Management – *Presenter:*		
MCUP3104 – Transplant Authorization Process	This policy was updated to address an APL revision. **Section I.** Related Policy H, which was formerly numbered MCCP2016. was updated to MPTP2501 *Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)* to reflect its transfer of ownership from Care Coordination to the Transportation department. **Sections V. and VI.A.** The purpose statement and policy were updated to reflect the new DHCS term, "Organ and Bone Marrow Transplant (OBMT)" in lieu of previous terminology, "Major Organ Transplant (MOT). **Section VI.B.4.:** Per a revision to Attachment 2 of APL 21-015, this statement was added to the policy: "Initial denial determinations will have a second review by the CMO (or designees Deputy Chief Medical Officer or supervising Medical Director if CMO is unavailable)." Dr. Moore noted that we became aware of the new DHCS nomenclature during our recent audit, which is one reason why we now have "policy wranglers."	Motion to **approve as presented:** Mark Netherda, MD Second: Lisa Ward, MD Next Steps: May 20 Q/UAC June 10 PAC

V. Presentations

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

- May is a big month for primary care providers to learn about what they have earned this past year though participating in the PCP Quality Incentive Program (PCP QIP) and to also see specific data, including where care gaps exist, via the Partnership Quality Dashboard (PQD).
- We have finished our survey cycle for our regulated Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and should be sharing that in our August meetings. As you know, the member experience has been a big topic of conversation throughout the organization and so we are looking forward to updating our baseline of where we are at. A quick example: We recently went to a Joint Leadership Initiative (JLI) for Western Sierra. They mentioned our mobile mammography event. One of the things they have done is actually expand their event to include several cancer screenings. (This is an effort we are pushing more broadly to have

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

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

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

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

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

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

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

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

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

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

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

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

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

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

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

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

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

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

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

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

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

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

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

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

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

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

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

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

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

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

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

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

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

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

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

VI. Adjournment

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

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

Approval Signature: *Date:*

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

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

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

Locations: Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano Room
2525 Airpark Drive, Redding, CA 96002 | Trinity Alps Conference Room
495 Tesconi Circle, Santa Rosa, CA 95401 | Santa Rosa Huddle Room
1000 Fortress St., Chico, CA 95973 | Stony Creek Conference Room

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

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

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Quality and Utilization Advisory Committee (Q/UAC) Meeting Policy Approvals
Wednesday, May 20, 2025 / 7:32 a.m. – 9:04 a.m.
Fairfield: Napa/Solano Room, Redding: Airpark, Chico: Story Creek

Voting Members Present:
Choudhry, Sara, MD
Gwiazdowski, Steven, MD, FAAP
Lane, Brandy, Consumer Member
Montenegro, Brian, MD
Mulligan, Meagen, FNP-BC
Murphy, John, MD
Quon, Robert, MD, FACP
Strain, Michael, Consumer Member
Swales, Chris, MD
Thomas, Randy, MD
Wilson, Jennifer, MD, MPH

Voting Members Absent: Emma Hackett, MD, FACOG

Partnership *Ex-Officio* Members Present:
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI
Bontrager, Mark, Senior Director of Behavioral Health
Brown, Isaac, MBA/MHA, Interim Senior Director of Q & P Improvement
Cox, Bradley, DO, Regional Medical Director (Northeast)
DeVido, Jeff, MD, Behavioral Health Clinical Director
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)
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Katz, Dave, MD, Associate Medical Director
Leung, Stan, Pharm.D, Director of Pharmacy Services
Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair
Netherda, Mark, MD, Medical Director for Quality – Vice Chair
Newman, Rachel, RN, BSN, Mgr, Clinical Compliance – Quality Inspections
O'Connell, Lisa, Director, Enhanced Health Services
Randhawa, Manleen, Senior Health Educator, Population Health
Ribordy, Jeff, MD, Regional Medical Director (Northwest)
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Townsend, Colleen, MD, Regional Medical Director (Southeast)
Ward, Lisa, MD, Regional Medical Director (Southwest)
Watkins, Kory, MBA-HM, Director, Grievance & Appeals

Partnership *Ex-Officio* Members Absent:
Guillory, Ledra, Senior Manager of Provider Relations Representatives
Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination
Spiller, Bettina, MD, Associate Medical Director

Guests:
Beard, Alyssa, RN, Manager of CC Regulatory Performance
Campbell, Anna, Health Policy Analyst, Utilization Management
Cunningham, Aryana, Policy Analyst, Care Coordination
Devan, James, Director of Quality Management
Durst, Jennifer, Manage of Performance Improvement (Fairfield)
Elder, Alaina, M.A. Ed, Mger of Provider Network Teams, Provider Relations
Escobar, Nicole, Senior Manager of Behavioral Health
George, Michael, MD, Associate Medical Director
Gual, Kristine, Director of Quality Measurement
Jarrett-Lee, Kevin, RN, Associate Director, UM
Katz, Dave, MD, Associate Medical Director
Kubota, Marshall, MD, Reg. Medical Director
Matthews, Richard, MD, Regional Medical Director (Chico)
Morris, Matthew, MD, Regional Medical Director (Auburn)
O'Leary, Hannah, Manager of Population Health, Pop Health
Quichocho, Sue, Manager of Quality Measurement, QI
Shamoiel, Shantal, County Child Welfare Liaison, Behavioral Health
Smith, Christine, Community Health Needs Liaison, Pop Health
Stites, Jaylyn, Program Manager ll, Provider Relations
Thornton, Aaron, MD, Associate Medical Director
Vall-Spinosa, Leah, MD, Med. Dir., Dutton Campus, Santa Rosa CHC
Vo, Kathleen, Pharm. D, Clinical Pharmacist, Pharmacy

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *none made* Approval/ Acceptance of Minutes Remarks	Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 7:32 a.m. Committee scribe Leslie Erickson pulled the Initial Health Assessment (IHA report) from its mistaken presentation placement on today's agenda and instead included it on the consent calendar. • The April 15, 2026 Q/UAC Minutes were approved without any corrections. • *Acknowledgment and acceptance of draft meeting minutes of the* ○ April 7 Internal Quality Improvement (IQI) Committee Dr. Moore welcomed back Leslie and thanked Robert Bides, RN, and his Member Safety (Investigations) team for covering for Leslie during her absence. Special thanks also to Chandler Ackerman. Medical Director for Quality Mark Netherda, MD, announced Rachel Newman, RN, is temporarily assisting Network Services with organizational needs. Jackie Krznarich, RN, supervisor of Clinical Compliance, will lead the Member Safety (Inspections) team during Rachel's reassignment.	Motion to **approve the Q/UAC minutes:** Steven Gwiazdowski, MD, FAAP Second: Brian Montenegro, MD *Approved unanimously* Motion to **accept IQI minutes:** Robert Quon, MD Second: Steven Gwiazdowski, MD *Accepted unanimously*
New Business – Consent Calendar (Committee Members as Applicable)		
Proposed 2027 Perinatal Quality Incentive Program (QIP) Measure Summary – direct *questions to Troy Foster* Initial Health Assessment (IHA) Claims and Encounters Summary – *direct questions to Rchel Newman, RN* **Health Services Policies** <u>Behavioral Health</u> MPBP8005 – Dispute Resolution Between Partnership and BHPs in delivery of Mental Health <u>Care Coordination</u> MPCP2026 – Diabetes Prevention Program MPCP2034 – Transitional Care Services <u>Enhanced Health Services</u> MPAP7004 – Community Health Worker (CHW) Services Benefit <u>Quality Improvement</u> MPQP1038 – Physician Orders for Life-Sustaining Treatment (POLST) MPQP1047 – Advance Directives MPQP1055 – Provider Preventable Condition (PPC) Reporting <u>Utilization Management</u> MPUP3137 – Palliative Care: Intensive Program (Adult) MPUP3144 – Residential Substance Use Disorder Treatment Authorization **Non-Health Services Policy** <u>Network Services</u> MPNET101 – Wellness and Recovery Access Standards and Monitoring		Motion to **approve the slate:** Steven Gwiazdowski, MD Second: Randy Thomas, MD *Approved unanimously* <u>Next Steps</u>: All policies go to the June 10 Physician Advisory Committee (PAC)

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
V. New Business – Discussion Policies		
Policy Owner: Behavioral Health – *Presenter: Jeffrey DeVido, MD, Behavioral Health Clinical Director*		
MPBP8003 – Mental Health Services	**Seen recently in this committee, this policy is back today for updates in compliance with All Plan Letter (APL) 26-004** (3/16/26) "Medi-Cal Managed Care Plan Responsibilities For Behavioral Health Data-Sharing." **Added related policy:** MPBP8007 - Screening and Treatment for Substance Use Disorders **Section B. 1. a. – Added** "should Partnership impose any authorization requirements, Partnership must ensure authorization determinations are based on the requested medically necessary health care services and are consistent with current evidence-based clinical guidelines." to align with wording from APL 26-002. **Section I. G. - Re-Added** "through the diagnosis or treatment of disease, illness or injury" per request from Policy Analyst **Section I. N.** – Added "should be performed by PCP." **Section I. O.** – Added "as outlined in APL 21-014." **Section S.** – Added "Data sharing" section to align with APL 26-004. **Section S.4** – Added "ASCMI" initiative update noted in APL 26-004. **Updated all Partnership Advantage** effective dates to Jan. 1, 2028. **Updated references to include** APL 26-002 and APL 26-004.	Motion to **approve as presented:** Brian Montenegro, MD Second: Randy Thomas, MD *Approved unanimously* Next Steps: June 10 PAC
Policy Owner: Care Coordination – *Presenter: Aryana Cunningham, Policy Analyst – Care Coordination*		
MPCP2023 – New Member Needs Assessment	**Policy edits due to APL 26-001 Initial Health Appointment. Pursuant to May 12 IQI discussion regarding suggested revisions to the HRA form, the IQI-requested SPD (Seniors/Persons with Disabilities) updates therein are paused until the Department of Health Care Services (DHCS) may respond, at which time this policy may come back to committee.** (At this time, each of the three DCHS form attachments remains the same.) Throughout the policy Partnership Advantage effective date has been updated to reflect January 1, 2028. The body of the policy has been updated to reflect Partnership Advantage "Enrollee" instead of Partnership Advantage "Member." **Related Policies added:** MCQP1021 – Initial Health Appointment **Definition Added:** Initial Health Appointment (IHA) **Added VI.C. Initial Health Appointment (IHA)** 1. For Members/Enrollees, Partnership must ensure Members engage in primary care consistent with IHA requirements. This requirement may be met by confirming the Member's/Enrollee's engagement with their PCP and documenting that the member was seen by a PCP within the past 12 months. a. If the Member/Enrollee was not seen by a PCP within the past 12 months. The requirement may be met by assisting in identifying and connecting with a PCP who accepts Member's or Enrollees coverage or by conducting a warm handoff to a care coordination entity affiliated with the Medicare Enrollee's plan, if applicable.	Motion to **approve as presented:** Steven Gwizadowski, MD Second: Randy Thomas, MD *Approved unanimously* Next Steps: June 10 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	b. For more information regarding IHA please review Partnership's policy MCQP1021 Initial Health Appointment. **References added:** DHCS All Plan Letter 26-001: Initial Health Appointment (01/07/2026)	
Policy Owner: Quality Improvement / Behavioral Health – *Presenter: Jeffrey DeVido, MD, Behavioral Health Clinical Director*		
MPXG5003 – Major Depression in Adults Clinical Practice Guidelines	Changes to Fow Chart (Attachment A): **Added reference to 2023 ACP guidelines**, against which this Partnership Clinical Guideline was reviewed. **Added bubble** to remind of the importance of **considering pregnancy** status and substance use, as these can impact pharmacotherapy decision making. **Added bubble** to remind of the need to continue to **consider suicidality** throughout the duration of treatment, as suicidality can emerge throughout treatment.	*There were no questions.* Motion to **approve as presented:** Jennifer Wilson, MD Second: Chris Swales, MD *Approved unanimously* Next Steps: June 10 PAC
Policy Owner: Utilization Management – *Presenter: Kermit Jones, MD, JD, Deputy Chief Medical Officer*		
MPUP3136 – Microbiota-Based Therapeutics (MBT) **NEW TITLE** *formerly Fecal Microbiota Transplant (FMT)*	During the annual review of this policy, the title was updated from Fecal Microbiota Transplant (FMT) to Microbiota-Based Therapeutics (MBT) to reflect coverage of lab-grown microbial consortia. **Section I.C.:** MCRP4068 Medical Benefit Medication TAR Policy was added as a Related Policy because lab-grown microbial consortia is covered as a Physician Administered Drug. **Section III.A.:** Definition of FMT was updated to MBT (which includes FMT). **Sections V. and VI.:** Acronym FMT was updated to MBT throughout the policy. **Section VII.** Minor updates were made to existing References to reflect most-current article information. **Amendment after discussion: Strike VI.B.2.a.**	Motion to **approve with one amendment:** Brian Montenegro, MD Second: Jennifer Wilson, MD *Approved unanimously* Next Steps: June 10 PAC
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director of UM Regulations*		
MCUP3104 – Transplant Authorization Process	This policy was updated to address a revision to APL 21-015. **Section I.** Related Policy H. which was formerly numbered MCCP2016, was updated to MPTP2501 *Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)* to reflect its transfer of ownership from Care Coordination to the Transportation department. **Sections V. and VI.A.** The purpose statement and policy was updated to reflect the new DHCS term, "Organ and Bone Marrow Transplant (OBMT)" in lieu of previous terminology, "Major Organ Transplant (MOT). **Section VI.B.4.:** Per a revision to Attachment 2 of APL 21-015, this statement was added to the policy: "Initial denial determinations will have a second review by the CMO (or designees Deputy Chief Medical Officer or supervising Medical Director if CMO is unavailable)."	Motion to **approve as presented:** John Murphy, MD Second: Chris Swales, MD *Approved unanimously* Next Steps: June 10 PAC
Policy Owner: Utilization Management: – *Mark Netherda, MD, Medical Director for Quality*		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
MPUP3047 – Tuberculosis Related Treatment	**Section VI.B:** Guidance for Directly Observed Therapy was updated, and a link was provided to a CDPH guidance document titled, “Information for Physicians Regarding Directly Observed Therapy (DOT) for Active Tuberculosis (TB).” **Section VII.G and I.:** Minor updates were made in the References section to combine two Title 17 citations and to update former Medi-Cal Rx APL number 22-012 to the current number 25-013. **Attachment A:** The TB Screening Guidelines were combined into one flow chart, instead of two, and a clarification was made at the end to say that “Consideration of Treatment of Latent TB” would be “by PCP.”	Motion to **approve with one amendment top of flow chart (Attachment A):** Chris Swales, MD Second: Brian Montenegro, MD *Approved unanimously* Next Steps: June 10 PAC

Adjournment

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

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

Signature of Approval: ______________________________ Date:

Robert Moore, MD, MPH, MBA
Chief Medical Officer

AGENDA ITEM: II.B.1
DATE: 06/10/2026

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

TO: Physician Advisory Committee

FROM: Robert Moore, MD, MPH, MBA, Chief Medical Officer

DATE: 06/10/2026

SUBJECT: Partnership Committee Memberships

Resignation

Physician Advisory Committee

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

The Physician Advisory Committee thanks Dr. Luu for her support of PAC.

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

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

QUALITY DATA TOOLS

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

PERFORMANCE IMPROVEMENT (PI)

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

4. Glycemic Status Assessment for People with Diabetes (GSD)
5. Timely Prenatal Care (PPC-Pre)

Workgroup Updates

- **Pediatrics:** The process of spreading measure-specific best practices from high performing practices to lower performing practices is ongoing.
- **Women's Health & Perinatal:** Partnership's Enhancing Perinatal Support and Services Webinar is occurring monthly through June 2026.
- Fostering Connections provider meeting planning is underway with a focus on Timely Prenatal Care (PPC Pre). One session has been completed with Dr. Townsend and a large prenatal care provider in Shasta County. More are being scheduled with focus on the Redding region.
- One on One provider training on hrHPV self-collect is ongoing. Our lab vendors have informed us that a completely at-home sample collection option should be available in 2027.
- **Chronic Disease:** At the April 2026 meeting, the group welcomed Dr. Matthew Morris as the new clinical lead. The group is focusing on three measures that have high impact and a high need for improvement across the network: Blood Pressure control, Blood Sugar Control, and Colorectal Cancer Screening. We are conducting root cause analyses of each measure and will aim for change ideas and any project work to begin mid-year.
- **Behavioral Health:** There are new (as of April 1) state mandates for real-time data sharing as a key strategy to maintain ongoing data access.

IMPROVEMENT ACADEMY

Program Overview

The Partnership Improvement Academy launched in 2014 to offer various programs which provide training and technical assistance designed to help practices optimize population health, enhance the patient experience, promote provider and care team satisfaction, and foster a culture of continuous quality improvement.
These programs are designed for a variety of audiences, including clinicians, administrators, and staff to gain quality improvement expertise from industry leaders and peers.

Current Offerings

QI Project Management Training Program

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

Program Update

- Registration for the Fall 2026 cohort is open through 08/25/26.
- Following the successful conclusion of the Spring, a comprehensive evaluation is currently underway. The final analysis is slated for completion by 06/30/2026, and

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

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

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

QI Program & Project Management

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

	We extend our sincere thanks to all participants for their engagement, flexibility, and collaboration, which helped ensure a smooth and efficient process. RWC has repeatedly noted their strong impression of our health plan and the quality of work produced. This month, the project will move into the executive engagement phase, during which RWC will present their comprehensive report to Executive Leadership and facilitate discussions on key findings, priorities, and next steps. ***Fiscal Year 2025/2026 Organizational Goal 5: Member Experience (MX)*** • Fiscal Quarter 4: Goal activities continue, led by champions from four departments: Transportation, Member Services, Population Health, and Quality Improvement. • All goals are on-track to be completed by the end of the goal period. For more insights on goal progress and milestone accomplishments, please visit the OpEx|PMO internal goal dashboard (Partnership4Me, under Smart Links).

EQUITY & PRACTICE TRANSFORMATION PROJECT	**Program Overview**
	The DHCS Equity and Practice Transformation (EPT) Program is a statewide initiative aimed at advancing health equity while reducing COVID-19 driven care disparities. During the three (3) year program, practices receive payments for achieving population health milestones that enable the implementation of improvements across their infrastructure, data capabilities and care management processes to promote patient well-being, health equity and whole-person care.
	
	Currently, 22 providers are participating in the EPT Program, with total estimated funding of $13.3 million over the three-year project period. These providers are expected to receive payments tied to milestone achievements that support sustainable practice transformation. The last and final opportunity to submit eligible deliverables for milestone achievement is in November 2026 when the program concludes. Payments for the November 2026 successfully completed milestones will be paid out early 2027.
	
	Program Updates
	• PHLC established minimum requirements for providers to remain in the program. Deliverables, due 05/01/2026, include:
	  ○ 2026 PhmCAT
	  ○ Milestone 3: Empanelment Policy & Procedure
	  ○ Milestone 4: Data Governance & HEDIS Policy & Procedure
	  ○ Milestone 6: Data Implementation Plan
	  ○ Milestone 8: Disparity Reduction Plan
	  ○ One Model of Care Document (Milestones 9-12)
	• Provider Portal was open for deliverable submissions beginning 04/01/26 and closed on 05/01/26 at 5:00 PM PST.

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

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

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

	• Initial notices for the 2025-2026 QI Program Evaluation will be sent on 05/12/2026 with submissions due on 05/29/2026.
	
	• Sponsor Business Owner Tracker update request for the 2026-2027 QI Work Plan will be sent to Business Owners on 05/19/2026. Initial notices will be sent on 06/02/2026 with submissions due on 06/18/2026.
	
	• QI Trilogy live trainings have been scheduled with invites sent to Sponsors, Business Owners, and Contributors:
	  ▪ 2025-2026 QI Program Evaluation: 05/13/2026 at noon
	  ▪ 2026-2027 QI Work Plan (Goal Submissions): 06/04/2026 at noon
	
	• The updated QI Trilogy LMS training launched on 04/29/2026 and will be advertised during the live training sessions as another resource.

SAGE GRANT	**Program Overview** The *Systems Advancement for General EHR* (SAGE) Grant is designed to assist healthcare providers in implementing or upgrading their EHR systems, to help modernize and enhance their ability to deliver high-quality, efficient, and member-centered care. This grant will help providers overcome common barriers to EHR adoption by offering financial support and implementation guidance. The recipient of the SAGE grant, Kimaw Medical Center, signed the agreement on 12/5/2025. The first payment installment of $125,000 was initiated. The SAGE Grant team will continue to conduct regular check-ins and monitor implementation milestones. The SAGE Grant Timeline can be found here. **Program Updates** • Coordination activities are underway to prepare for the January-June Progress Check-In with Kimaw and Partnership to be scheduled in June.
D-SNP MEDICARE	**D-SNP** **Program Overview** The D-SNP Quality team is responsible for 1) Development and finalization of the Model of Care document, 2) Management of Partnership's CMS Medicare Star quality program, and 3) Developing D-SNP readiness for all Quality Improvement teams. The team has revised QI Department D-SNP Project plans to reflect the launch postponement with vendor-related projects TBD.
ACTIVITY	**UPDATE**
QUALITY ASSURANCE AND PATIENT SAFETY	

ACTIVITY	UPDATE

Potential Quality Issues (PQI) for the period: 4/02/2026 to 4/26/2026

Program Overview

To identify, report, and manage Potential Quality Issues (PQI), to determine opportunities for improvement in the provision of care and services to our members, and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity.

Program Update

- 33 referrals were received with 30 coming from Grievance and Appeals, 1 from Utilization Management, 1 from other (Regulator) and 1 from QI Member Safety
- 18 cases were processed and closed
- 115 cases are currently open
- One case was discussed at Peer Review Committee (PRC) on 04/15/2026 and there are three cases awaiting PRC review.

Facility Site Reviews (FSR) & Medical Record Reviews (MRR) For Jan-March 2026

Program Overview

Site Review and Medical Record Review performed for monitoring of providers.

Program Update

- As of 4/27/2026, we have a total of 538 reviews including PCP, OB, Multiple check-in's and delegated reviews
- **Primary and OB Reviews:**

Region	# of FSR conducted	# of MRR conducted	# of FSR CAP issued	# of MRR CAP issued
Auburn	1	0	0	0
Chico	7	6	0	1
Eureka	5	3	1	2
Fairfield	13	9	2	4
Redding	11	12	2	7
Santa Rosa	5	5	1	4

- New sites opened this period →
    - 4 new sites were reviewed

Healthcare Effectiveness Data Information Set (HEDIS)

ACTIVITY	UPDATE

Annual HEDIS® Projects

Program Overview

HEDIS is used to evaluate clinical quality in a standardized way. This program shares performance measurement rates with the intent of improving the quality of care delivered to members.

Program Update

- No Update

HEDIS® Program Overall	**Program Updates** • **No Update**
NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION	
ACTIVITY	**UPDATE**
NCQA Health Plan Accreditation (HPA)	**Program Overview** The State of California requires all Managed Care Plans (MCPS) to be both Health Plan (HP) and Health Outcome (HO) Accredited. The process involves completing a Renewal Survey every three (3) years, and reporting HEDIS and CAHPS results every year for a Health Plan Rating (HRP) score. Partnership's next HPA Renewal Survey is scheduled for 09/15/2026. **Program Update** • The NCQA Project Management Team hosted an HPA Renewal Survey evidence preparation and collection training on 03/25/2026. The team also distributed communications for evidence collection process, which began on 03/31/2026. All annotated and bookmarked evidence is due 05/22/2026 unless otherwise discussed with the NCQA Program Management Team. • HPA Mock File Reviews were held with our NCQA consultant, Managed Healthcare Resources (MHR), in February and March 2026 with the Utilization Management, Grievance and Appeals, and Pharmacy departments. Mock File Reviews will also take place in April 2026 with Care Coordination and Network Services. Most file review requirements are Must-Pass requirements, and an organization must receive a MET score on all Must-Pass requirements to achieve or maintain accreditation. These Mock File Reviews will help to ensure Partnership remains in compliance throughout the look-back period. Some risks and opportunities for improvement were identified by MHR and results were shared with the applicable Business Owners (BOs). BOs have submitted Action Plans to address each finding/recommendation. • The HPA Compliance Dashboard is updated monthly and available on the Y:Drive. The NCQA Program Management Team presents the dashboard monthly to the NCQA Steering Committee and quarterly to BOs, with an intent to create project transparency, track key activities and facilitate timely escalation. The NCQA Program Management Team is working closely with the BOs to ensure all applicable evidence is revised or finalized to sustain compliance in accordance with NCQA's look-back periods, timelines, and expectations.
NCQA Health Outcome Accreditation (HOA)	**Program Overview** The State of California requires all Managed Care Plans (MCPs) to be both Health Plan (HP) and Health Outcome (HO) Accredited. The process involves completing a Renewal Survey every three (3) years. Partnership's next HOA Renewal Survey is tentatively scheduled for 05/16/2028. **Program Update**

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

Partnership
Policy & Procedure Updates

June 2026

Policy Number	Policy/Procedures/Guidelines	Version Links	RD	CD
	The following documents were reviewed by the Quality / Utilization Advisory Committee (Q/UAC) in ***May 2026.*** ***All policy versions hyperlinked for review.* *Highlighted policies have significant changes, new attachments, or were amended during the Q/UAC meeting. Redline versions contain attachments.* *Please review all drafts and the detailed* ***Synopsis of Changes, p. 47***.		Page No.	
			RD	CD
Behavioral Health				
MPBP8003	Mental Health Services	C	50	68
MPBP8005	Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services	C	86	91
MPXG5003	Major Depression in Adults Clinical Practice Guidelines *Updates to Attachment A p. 98*	C	96	99
Care Coordination				
MPCP2023	New Member Needs Assessment	C	101	104
MPCP2026	Diabetes Prevention Program	C	107	113
MPCP2034	Transitional Care Services (TCS)	C	119	132
Enhanced Health Services				
MPAP7004	Community Health Worker (CHW) Services Benefit	C	145	156
MPAP7005	Street Medicine	C	167	175
Network Services				
MPNET101	Wellness and Recovery Access Standards and Monitoring	C	183	186
Quality Improvement				
MPQP1038	Physician Orders for Life-Sustaining Treatment (POLST) *Attachment A p. 192*	C	189	194
MPQP1047	Advance Directives	C	197	200
MPQP1055	Provider Preventable Condition (PPC) Reporting	C	203	208

Utilization Management				
MPUP3144	Residential Substance Use Disorder Treatment Authorization	C	213	219
MPUP3137	Palliative Care: Intensive Program (Adult) *Attachment A p. 233*	C	225	239
MPUP3136	Microbiota-Based Therapeutics (MBT)	C	247	250
MPUP3047	Tuberculosis Related Treatment *Updates to Attachment A p. 257*	C	253	258
MCUP3104	Transplant Authorization Process	C	262	268

Synopsis of Changes to Discussion Policies

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

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

Synopsis of Changes to Discussion Policies

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

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

I. RELATED POLICIES:

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

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

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

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

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

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

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

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

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

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

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

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

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

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

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

IV. ATTACHMENTS:

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

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

A. Partnership HealthPlan of California provides mental health services for Medi-Cal Members. Effective January 1, 20287, Partnership will also provide mental health services for Partnership Advantage enrollees who are eligible to receive both Medi-Cal and Medicare services.
   1. For services specific to Partnership Advantage enrollees, see section VI.T. of this policy below.

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

information about the following topics:

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

2) The Youth Screening Tool includes screening questions that are intended to elicit information about the following topics:
a) Safety: Information about whether the Member needs immediate attention and the reason(s) a Member is seeking services
b) System Involvement: Information about whether the Member is currently receiving treatment, and if they have been involved in foster care, child welfare services, or the juvenile justice system.
c) Life Circumstances: Information about challenges the Member may be experiencing such as issues related to school, work, relationships, housing, or other circumstances.
d) Risk: Information about suicidality, self-harm, emergency treatment, and hospitalizations.
e) SMHS access and referral of other services

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

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

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

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

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

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

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

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

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

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

SMHS.

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

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

and medications
4) Requested services and plan contact information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~Q.~~S. Dyadic Services Benefit

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

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

community settings.

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

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

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

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

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

Information Organization (QHIO).

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

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

~~T.~~U. Partnership Advantage Mental Health Services (Effective January 1, 2028~~7~~)
1. Availability: Partnership maintains a telephone line for behavioral health assistance 24 hours per day, 7 days a week, to provide information, referral to treatment for conditions pursuant to 42 CFR § 438.3(q). Behavioral-health services are available 24 hours a day, 7 days a week, when medically necessary, per 42 CFR § 438.206(c)(1)(iii)
2. Non-Discrimination: In accordance with 42 CFR § 422.110(a), Partnership ensures that Partnership Advantage enrollees may self-refer for an outpatient mental health assessment or service with a contracted in-network mental health provider without prior authorization requirements and does not deny or limit service if medical necessity requirements are met.
3. Coordination: For Partnership Advantage enrollees who meet criteria for Specialty Mental Health Services (SMHS) and/or substance use disorder treatment services provided by a county BHP,

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

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

VII. REFERENCES:

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

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

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

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

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

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

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

X. REVISION DATES:
MPB~~H~~P8003
06/11/25; 11/12/25; 02/11/26; 05/13/2026; 06/10/2026

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

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

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

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

UP100328: 04/25/1994 – 10/18/2006

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

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

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

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

<table>
<tr><td colspan="3">Policy/Procedure Number: MPBP8003 (previously MCUP3028, UP100328)</td><td colspan="3">Lead Department: Health Services
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Last Review Date: 06/10/2026</td></tr>
<tr><td>Applies to:</td><td>☐ Employees</td><td>☒ Medi-Cal</td><td colspan="3">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td>☒ IQI</td><td>☐ P & T</td><td colspan="3">☒ QUAC</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: 06/10/2026</td></tr>
</table>

I. **RELATED POLICIES**:

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

II. **IMPACTED DEPTS**:

A. Health Services
B. Claims
C. Member Services

III. **DEFINITIONS**:

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

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

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

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

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

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

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

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

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

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

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

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

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

IV. ATTACHMENTS:

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

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

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

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

information about the following topics:

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

2) The Youth Screening Tool includes screening questions that are intended to elicit information about the following topics:
   a) Safety: Information about whether the Member needs immediate attention and the reason(s) a Member is seeking services
   b) System Involvement: Information about whether the Member is currently receiving treatment, and if they have been involved in foster care, child welfare services, or the juvenile justice system.
   c) Life Circumstances: Information about challenges the Member may be experiencing such as issues related to school, work, relationships, housing, or other circumstances.
   d) Risk: Information about suicidality, self-harm, emergency treatment, and hospitalizations.
   e) SMHS access and referral of other services

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

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

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

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

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

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

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

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

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

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

SMHS.

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

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

and medications
4) Requested services and plan contact information
d. Following the completion of the Transition of Care Tool, Partnership shall:
1) Refer the Member to the BHP, or directly to a BHP provider delivering SMHS if appropriate processes have been established in coordination with BHPs.
2) Coordinate Member care services with BHPs to facilitate care transitions or additions of services, including ensuring that the referral process has been completed, the Member has been connected with a provider in the new system, the new provider accepts the care of the Member, and medically necessary services have been made available to the Member.
3) All appropriate consents must be obtained in accordance with accepted standards of clinical practice.
4) When Closed Loop Referrals (see section III.B.) are made for behavioral health services between NSMHS, SMHS or county level SUD treatment services, Partnership will ensure that that there is an appointment in the other system of care, along with tracking the outcome of that appointment. If Partnership is unable to confirm with the other system of care or provider that the appointment was fulfilled, Partnership will seek to confirm with the member or to further understand what barriers to care the member may experience. At all times, parties involved will adhere to relevant privacy regulations for the sharing of mental health and SUD information. Obtaining appropriate releases of information (with appropriate Member consent) is recommended to allow information exchange for facilitating exchange of pertinent clinical information.
5) Outcomes of referrals are monitored through monthly referral trackers between Partnership (and/or its delegate) and each BHP.
e. The determination to transition services to and/or add services from the BHP delivery system must be made by a clinician via a patient-centered, shared decision-making process in alignment with the plan's protocols?
1) Once a clinician has made the determination to transition care or refer for additional services, the Transition of Care Tool may be filled out by a clinician or a non-clinician.
2) Members must be engaged in the process and appropriate consents must be obtained in accordance with accepted standards of clinical practice
f. The Transition of Care Tool is not considered an assessment and does not replace:
1) MCP policies and procedures that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals
2) MCP protocols that address clinically appropriate, timely, and equitable access to care
3) MCP clinical assessments, level of care determinations, and service recommendations
4) MCP requirements to provide EPSDT services

C. Members may self-refer for mental health services to an appropriate mental health provider. Members do not need a referral from their Primary Care Provider (PCP) to receive mental health services.
D. In an effort to coordinate medical and mental health care, providers should ask Members to sign a release of information so that the Member's providers can best coordinate care. However, the release of information is not a condition for services to be provided.
E. California Health and Safety Code (HSC) section 124260(b)(1) allows minors 12 and older to consent to mental health treatment if they are mature enough to participate.
1. Effective July 1, 2024, without consent from a parent or legal guardian, minors 12 years of age or older may consent to non-specialty outpatient Medi-Cal mental health treatment or counseling if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the outpatient services.
2. The professional person must use their clinical judgment and expertise to make a determination regarding the minor's maturity to participate intelligently in these services.

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

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

G. The PCP's role in providing mental health services:
   1. A certain level of mental health services is appropriately dealt with in a primary care practice, including screening and referrals to services. For detailed screening, referral and consultation procedures, PCPs can refer to Partnership Policy MPBP8011 Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines.
      a. If a Member's screening is positive and indicates further assessment, the assessment may be performed either by the PCP or by referral to a network mental health provider.

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

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

I. Partnership provides or arranges for the provision of NSMHS including outpatient laboratory tests, drugs, supplies and supplements prescribed by NSMHS mental health providers in-network and PCPs

as follows:

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

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

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

L. Partnership covers family therapy under Medi-Cal's NSMHS benefit, including for Members ages 20 or below who are at risk for behavioral health concerns and for whom clinical literature would support that the risk is significant such that family therapy is indicated, but may not have a mental health diagnosis. Family therapy is composed of at least two family members receiving therapy together provided by a mental health provider to improve parent/child or caregiver/child relationships and encourage bonding, resolving conflicts, and creating a positive home environment.

1. All family members do not need to be present for each service.
2. Members ages 20 or below may receive up to five family therapy sessions before a mental health diagnosis is required.
3. Family therapy is delivered without regard to the five session limit for Members under age 21 with any of the following risk factors:
    a. mental health disorders or parents/caregivers with related risk factors, including separation from a parent/caregiver due to incarceration, immigration, or death
    b. foster care placement
    c. food insecurity
    d. housing instability
    e. exposure to domestic violence or trauma
    f. maltreatment

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

    g. severe/persistent bullying
    h. discrimination

M. Partnership is responsible for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations (CCR). This includes all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the Member. Emergency services include facility and professional services and facility charges claimed by emergency departments.
N. SABIRT services including alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT) for Members ages 11 and older, including pregnant Members, should be performed by PCP.
O. Preventive Screenings including tobacco, alcohol, and illicit drug screenings for adults and children, conducted in accordance with UPSTF grade A and B recommendations and AAP Bright Futures recommendations as outlined in APL 21-014.
P. Partnership is responsible for the provision of Medications for Addiction Treatment (MAT) in primary care, inpatient hospital, emergency departments, and other contracted medical settings as well as for emergency services necessary to stabilize the Member. *(see also policy MPBP8007 Screening and Treatment for Substance Use Disorders)*
Q. Clinically appropriate and covered Drug Medi-Cal (DMC) services delivered by DMC providers whether delivered through the Drug Medi-Cal Organized Delivery System (DMC-ODS) model or the DMC State Plan model are covered by the counties respectively, whether or not the Member has a co-occurring mental health condition. *(See also policy MPBP8007 Screening and Treatment for Substance Use Disorders.)*
R. The Parity in Mental Health and Substance Use Disorder Benefits requirements of Subpart K of Part 438 of Title 42 of the Code of Federal Regulations (CFR) stipulate that treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. Therefore, Partnership ensures direct access to an initial mental health assessment by a licensed mental health provider within the Partnership provider network, and no referral from a PCP or prior authorization is required for an initial mental health assessment to be performed by a network mental health provider.
    1. Partnership provides information regarding mental health services for Members in the Partnership Medi-Cal Member Handbook as well as through Partnership's website www.partnershiphp.org. Applicable Member informing materials state that referral and prior authorization are not required for a Member to seek an initial mental health assessment from a network mental health provider and Partnership will notify members of such applicable policies.
    2. Partnership covers the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service within the applicable timely access to care requirements.
    3. Pursuant to DHCS requirements and the Memorandums of Understanding (MOU) template, Partnership will execute MOUs with County Mental Health Plans for the purpose of sharing clinical data in order to better coordinate care of Members, improve quality and meet the requirements of the Behavioral Health Quality Incentive Program (BHQIP). To the extent permitted by law, Partnership will exchange with county partners, member demographic information, behavioral and physical health information, diagnoses, assessments, medications prescribed, laboratory results, referrals/discharges to/from inpatient or crisis services and known changes in condition that may adversely impact the Member's health.
S. Dyadic Services Benefit
Partnership reimburses for all medically necessary mental health services pursuant to the Non-Specialty Mental Health Services: Psychiatric and Psychological Services section of the Medi-Cal Provider Manual.

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

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

codes as outlined in the Medi-Cal Provider Manual.

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

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

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

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

   1) DBH Well-Child Visits

      a) DBH well-child visits are provided for the child and caregiver(s) or parent(s) at medical visits. The DBH portion of the well-child visit must be limited to those services not already covered in the medical well-child visit.

      b) When possible and operationally feasible, the DBH well-child visit should occur on the same day as the medical well-child visit. When this is not possible, MCPs must ensure the DBH well-child visit is scheduled as close as possible to the medical well-child visit, consistent with timely access requirements.

      c) MCPs may deliver DBH well-child visits as part of the HealthySteps program, a different DBH program, or in a clinical setting without a certified DBH program as long as all of the following components are included:

         i. Behavioral health history for child and parent(s) or caregiver(s), including parent(s) or caregiver(s) interview addressing child's temperament, relationship with others, interests, abilities, and parent or caregiver concerns.

         ii. Developmental history of the child.

         iii. Observation of behavior of child and parent(s) or caregiver(s) and interaction between child and parent(s) or caregiver(s).

         iv. Mental status assessment of parent(s) or caregiver(s).

         v. Screening for family needs, which may include tobacco use, substance use, utility needs, transportation needs, and interpersonal safety, including guns in the home.

         vi. Screening for SDOH such as poverty, food insecurity, housing instability, access to safe drinking water, and community level violence.

         vii. Age-appropriate anticipatory guidance focused on behavioral health promotion/risk factor reduction, which may include:

            a. Educating parent(s) or caregiver(s) on how their life experiences (e.g., Adverse Childhood Experiences (ACEs) impact their child's development and their parenting.

            b. Educating parent(s) or caregiver(s) on how their child's life experiences (e.g., (ACEs) impact their child's development.

            c. Information and resources to support the child through different stages of development as indicated.

         viii. Making essential referrals and connections to community resources through care coordination and helping caregiver(s) prioritize needs.

   2) Dyadic Comprehensive Community Supports Services, separate and distinct from California Advancing and Innovating Medi-Cal's (CalAIM) Community Supports, help the child (Member ages 20 or below) and their parent(s) or caregiver(s) gain access to needed medical, social, educational, and other health-related services, and may include any of the following:

      a) Assistance in maintaining, monitoring, and modifying covered services, as outlined in the dyad's service plan, to address an identified clinical need.

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

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

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

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

a. Support real-time, bidirectional behavioral health data exchange
b. MCP and BHP will bidirectionally share up to date member rosters on a monthly basis.
c. Share only minimum necessary information
d. Support care coordination and referrals by sharing key referral, eligibility, and clinical MH/SUD information for timely access to services
e. Support transitions of care by exchanging Admission, Discharge, and Transfer (ADT) notifications to ensure continuity of services
f. Maintain electronic data exchange capability by sustaining policies, procedures, and technical infrastructure to electronically send, receive, and use standardized behavioral health data
g. Ensure privacy, security, and confidentiality by protecting behavioral health data in compliance with HIPAA, 42 C.F.R. Part 2, state confidentiality laws, and information security requirements
h. Manage consent and disclosure by implementing policies to obtain, document, honor, and revoke member data-sharing consent
i. Formalize data sharing relationships through MOUs or equivalent agreements defining purpose, roles, responsibilities, permitted disclosures, and compliance obligations
j. Use shared data to support CalAIM initiatives, including ECM, care coordination, referrals, member engagement, and whole-person care integration
k. Partnership (MCP) and County BHP will share encounter data to meet state and federal quality, accountability, and monitoring reporting requirements, including DHCS accountability reporting, CMS Core Set measures, and Comprehensive Quality Strategy performance measures.

4. Authorization to Share Confidential Member Information (ASCMI): A DHCS CalAIM initiative that standardizes member consent to securely share sensitive health and social services data to support care coordination, interoperability, and person-centered care, including ECM and Community Supports. Managed care plans and county BHPs are required to adopt this authorization form and participate in the statewide patient consent platform once it goes live.

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

U. Partnership Advantage Mental Health Services (Effective January 1, 2028)
1. Availability: Partnership maintains a telephone line for behavioral health assistance 24 hours per day, 7 days a week, to provide information, referral to treatment for conditions pursuant to 42 CFR § 438.3(q). Behavioral-health services are available 24 hours a day, 7 days a week, when medically necessary, per 42 CFR § 438.206(c)(1)(iii)
2. Non-Discrimination: In accordance with 42 CFR § 422.110(a), Partnership ensures that Partnership Advantage enrollees may self-refer for an outpatient mental health assessment or service with a contracted in-network mental health provider without prior authorization requirements and does not deny or limit service if medical necessity requirements are met.
3. Coordination: For Partnership Advantage enrollees who meet criteria for Specialty Mental Health Services (SMHS) and/or substance use disorder treatment services provided by a county BHP, Partnership will coordinate with BHP providers to ensure enrollees have access to and are connected with medically necessary services delivered by the BHP.

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

VII. REFERENCES:

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

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

J. DHCS APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans (10/04/2021)
K. DHCS APL 22-005 No Wrong Door for Mental Health Services Policy (03/30/2022)
L. DHCS APL 22-029 *Revised* Dyadic Services & Family Therapy Benefit (03/20/2023)
M. California Welfare and Institutions Code section 14132.755, Dyadic Behavioral Health Visits
N. Behavioral Health Information Notice (BHIN) 26-002 (01/20/2026) *Supersedes (BHIN) 21-073*
O. California Health Care Foundation explanation of The Drug Medi-Cal Organized Delivery System
P. DHCS APL 24-012 Non-Specialty Mental Health Services: Member Outreach, Education, and Experience Requirements (09/17/2024)
Q. DHCS APL 24-019 Minor Consent to Outpatient Mental Health Treatment or Counseling (12/31/2024)
R. DHCS APL 25-010 Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services (6/3/2025) *Supersedes APL 22-028*
S. DHCS APL 26-002 MediCal Managed Care Plan Responsibilities for Non-Specialty Mental Health Services (02/02/2026) *Supersedes APL 22-006*
T. DHCS APL 26-002 Attachment A Approved Youth Trauma Screening Tools for Specialty Mental Health Services Access Criteria.
U. DHCS Screening and Transition of Care Tools for Medi-Cal Mental Health Services
    1. Adult Screening Tool for Medi-Cal Mental Health Services (DHCS 8765A 01/2023)
    2. Youth Screening Tool for Medi-Cal Mental Health Services (DHCS 8765C 01/2023)
    3. Transition of Care Tool for Medi-Cal Mental Health Services (Adult & Youth) (DHCS 8765B 01/2023)
V. DHCS All Plan Letter APL 25-013 "Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage" (09/18/2025)
W. DHCS All Plan Letter (APL) 26-004 "Medi-Cal Managed Care Plan Responsibilities for Behavioral Health Data-Sharing" (03/16/2026)
X. California Family Code section 6924
Y. State Medicare Advantage Contract, Exhibit A, Exclusively Aligned Enrollment D-SNP, currently in draft (2025).
Z. Code of Federal Regulations: 42 CFR § 422.100(c)(1); 42 CFR § 409.62; 42 CFR § 410.10; 42 CFR § 410.54; 42 CFR § 422.100(c)(1); 42 CFR § 409.62; 42 C.F.R. § 410.15; 42 CFR § 422.112(a)(1)(iii); 42 CFR § 438.3(q); 42 CFR § 438.206(c)(1)(iii)
AA. Medicare Managed Care Manual, Ch. 4 § 110.1.1

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

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

X. REVISION DATES:
MPBP8003
06/11/25; 11/12/25; 02/11/26; 05/13/2026; 06/10/2026

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

PREVIOUSLY APPLIED TO:

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

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

UP100328: 04/25/1994 – 10/18/2006

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

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

I. RELATED POLICIES:

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

II. IMPACTED DEPTS:

A. Health Services
B. Finance

III. DEFINITIONS:

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

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

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

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

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

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

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

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

must file a Request for Resolution with DHCS within one business day. The request must include an affirmation of the Member's stated jeopardy.

4. If either plan fails to submit a Request for Resolution and/or documentation to DHCS, DHCS will base its decision upon the documentation submitted.
5. DHCS will render a decision within one business day upon receipt of said request.

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

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

VII. REFERENCES:

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

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

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

X. REVISION DATES:

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

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

PREVIOUSLY APPLIED TO:

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

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

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Business Unit: Behavioral Health</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services</td><td colspan="2">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 02/21/2015</td><td colspan="3">Next Review Date: 06/10/2027
Last Review Date: 06/10/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: 06/10/2026</td></tr>
</table>

I. RELATED POLICIES:

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

II. IMPACTED DEPTS:

A. Health Services
B. Finance

III. DEFINITIONS:

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

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

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

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

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

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

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

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

must file a Request for Resolution with DHCS within one business day. The request must include an affirmation of the Member's stated jeopardy.

4. If either plan fails to submit a Request for Resolution and/or documentation to DHCS, DHCS will base its decision upon the documentation submitted.
5. DHCS will render a decision within one business day upon receipt of said request.

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

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

VII. REFERENCES:

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

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

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

X. REVISION DATES:

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

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

PREVIOUSLY APPLIED TO:

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPXG5003			**Lead Department: Health Services** Business Unit: Quality Improvement	
Policy/Procedure Title: Major Depression in Adults Clinical Practice Guidelines			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/19/2000		**Next Review Date**: ~~: 06/11/2026~~06/09/2027 **Last Review Date:** ~~06/11/2025~~06/10/2026		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~06/11/2025~~06/10/2026	

I. RELATED POLICIES:

A. MPCP2017 – Scope of Primary Care – Behavioral Health and Indication for Referral Guidelines

II. IMPACTED DEPTS:

A. Health Services
B. Provider Relations

III. DEFINITIONS:

A. N/A

IV. ATTACHMENTS:

A. Clinical Decision Flow Chart

V. PURPOSE:

To define the appropriate diagnostic criteria and therapy for patients with major depression.

This guideline is meant to be a basic guideline, not an enforceable standard, and is intended to assist the primary care professional in caring for Partnership HealthPlan of California (Partnership) adult members with major depression. Recommendations are not intended to replace sound clinical judgment in caring for individual patients.

VI. POLICY / PROCEDURE:

A. Overview
Nationally accepted clinical practice guidelines for depression are created and updated regularly. Pharmacologic choices for depression also continually change as new products enter the market. For these reasons, and upon the recommendation of Partnership's Physician Advisory Committee, this clinical practice guideline (CPG) will be annually updated with the appropriate internet references, which will provide timely guidelines for the management of major depression in adults.

VII. REFERENCES:

A. From the American Psychiatric Association: Practice Guideline for the Treatment of Patients with Major Depressive Disorder (2010) https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf
B. From the American Psychological Association: APA Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts (February 2019) https://www.apa.org/depression-guideline/guideline.pdf

Policy/Procedure Number: MPXG5003			Lead Department: Health Services Business Unit: Quality Improvement
Policy/Procedure Title: Major Depression in Adults Clinical Practice Guidelines			☒ External Policy ☐ Internal Policy
Original Date: 04/19/2000			**Next Review Date:** ~~06/11/2025~~06/09/2027 **Last Review Date:** ~~06/11/2026~~06/10/2026
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

C. From the US Preventive Services Task Force (USPSTF) Final Recommendation Statement (June 20, 2023) Depression and Suicide Risk in Adults: Screening: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-depression-suicide-risk-adults
D. National Institute of Mental Health: Sequenced Treatment Alternatives to Relieve Depression (STAR*D) Study (2006): https://www.nimh.nih.gov/funding/clinical-research/practical/stard
E. U.S. Department of Veterans Affairs. VA/DoD Clinical Practice Guideline: Assessment and Management of Patients at Risk for Suicide (2024): https://www.healthquality.va.gov/guidelines/mh/srb/index.asp
F. VA/DoD Clinical Practice Guidelines: Management of Major Depressive Disorder (2022) https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFinal508.pdf
G. Qaseem A, et al. Nonpharmacologic and Pharmacologic Treatments of Adults in the Acute Phase of Major Depressive Disorder: A Living Clinical Guideline From the American College of Physicians. Ann Intern Med. 2023 Feb. 176 (2):239-252. https://www.acpjournals.org/doi/10.7326/M22-2056~~https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFinal508.pdf~~

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

VIII. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

IX. REVISION DATES:

Medi-Cal
09/18/02; 10/20/04; 11/15/06; 05/18/11; 06/19/13; 7/27/15; 08/19/15; 08/19/16; 11/15/17; *10/10/18; 11/13/19; 11/11/20; 04/14/21; 06/08/22; 06/14/23; 06/12/24; -10/09/24; 06/11/25; 06/10/26

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

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

IX. PREVIOUSLY APPLIED TO:

Healthy Families
05/18/11
Partnership*Advantage*
11/15/06; 05/18/11
Healthy Kids
11/15/06; 05/18/11; 08/19/15, 08/19/16 (Healthy Kids Program ended 12/01/2016)

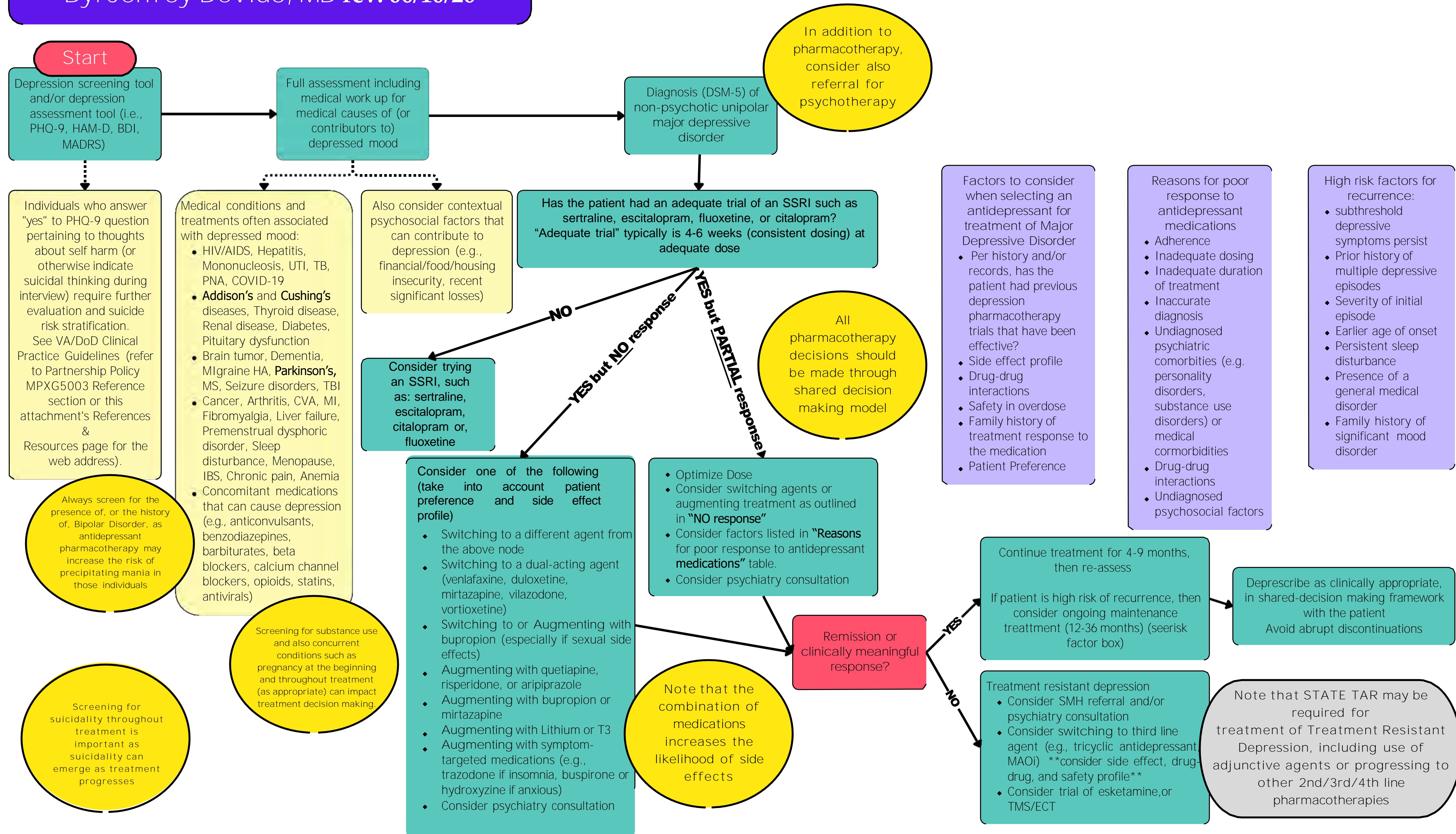
Adult Depression Treatment Flow Diagram

(MPXG5003 Policy Attachment A)

By: Jeffrey DeVido, MD **rev. 06/10/26**

PROVIDERS PLEASE NOTE:

Medi-Cal mental health treatment services are divided between county specialty mental health (SMH) and managed care plan non-specialty mental health (NSMH) programs. The differentiation is based on clinical severity, with higher severity patients being preferentially routed to SMH systems of care. For members with Partnership Advantage, Partnership is responsible for coordination of services for all levels of severity [See: MPBP8003].



This algorithm is drawn from several sources listed below. This algorithm is not intended to be comprehensive or definitive; rather, it aims to provide one possible approach to depression pharmacotherapy that could be considered in primary care practice settings.

- Osser, DN (ed). Psychopharmacology Algorithms: Clinical Guidance from the Psychopharmacology Algorithm Project at the Harvard South Shore Psychiatry Residency Program. Wolters Kluwer, New York, 2021.
- Schatzberg, AF and Nemeroff CB (eds). The American Psychiatric Association Publishing Textbook of Psychopharmacology, 5th Ed. APA Publishing, Arlington, VA, 2017.
- Qaseem A, et al. Nonpharmacologic and Pharmacologic Treatments of Adults in the Acute Phase of Major Depressive Disorder: A Living Clinical Guideline From the American College of Physicians. Ann Intern Med. 2023 Feb. 176 (2):239-252.

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<tr><td colspan="4">Policy/Procedure Title: Major Depression in Adults Clinical Practice Guidelines</td><td colspan="2">☒ External Policy
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<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: 06/10/2026</td></tr>
</table>

I. **RELATED POLICIES**:
A. MPCP2017 – Scope of Primary Care – Behavioral Health and Indication for Referral Guidelines

II. **IMPACTED DEPTS**:
A. Health Services
B. Provider Relations

III. **DEFINITIONS**:
A. N/A

IV. **ATTACHMENTS**:
A. Clinical Decision Flow Chart

V. **PURPOSE:**
To define the appropriate diagnostic criteria and therapy for patients with major depression.

This guideline is meant to be a basic guideline, not an enforceable standard, and is intended to assist the primary care professional in caring for Partnership HealthPlan of California (Partnership) adult members with major depression. Recommendations are not intended to replace sound clinical judgment in caring for individual patients.

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VII. **REFERENCES:**
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B. From the American Psychological Association: APA Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts (February 2019) https://www.apa.org/depression-guideline/guideline.pdf

C. From the US Preventive Services Task Force (USPSTF) Final Recommendation Statement (June 20, 2023) Depression and Suicide Risk in Adults: Screening: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-depression-suicide-risk-adults
D. National Institute of Mental Health: Sequenced Treatment Alternatives to Relieve Depression (STAR*D) Study (2006): https://www.nimh.nih.gov/funding/clinical-research/practical/stard
E. U.S. Department of Veterans Affairs. VA/DoD Clinical Practice Guideline: Assessment and Management of Patients at Risk for Suicide (2024): https://www.healthquality.va.gov/guidelines/mh/srb/index.asp
F. VA/DoD Clinical Practice Guidelines: Management of Major Depressive Disorder (2022) https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFinal508.pdf
G. Qaseem A, et al. Nonpharmacologic and Pharmacologic Treatments of Adults in the Acute Phase of Major Depressive Disorder: A Living Clinical Guideline From the American College of Physicians. Ann Intern Med. 2023 Feb. 176 (2):239-252. https://www.acpjournals.org/doi/10.7326/M22-2056

VIII. DISTRIBUTION:

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B. Partnership Department Directors

VIII. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

IX. REVISION DATES:

Medi-Cal
09/18/02; 10/20/04; 11/15/06; 05/18/11; 06/19/13; 7/27/15; 08/19/15; 08/19/16; 11/15/17; *10/10/18; 11/13/19; 11/11/20; 04/14/21; 06/08/22; 06/14/23; 06/12/24; 10/09/24; 06/11/25; 06/10/26

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

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

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11/15/06; 05/18/11
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11/15/06; 05/18/11; 08/19/15, 08/19/16 (Healthy Kids Program ended 12/01/2016)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MPCP2023 (previously MCCP2023)</td><td colspan="2">Lead Department: Health Services
Business Unit: Care Coordination</td></tr>
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☐ Internal Policy</td></tr>
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Last Review Date: ~~01/14/2026~~06/10/2026</td></tr>
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<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: ~~01/14/2026~~06/10/2026</td></tr>
</table>

I. RELATED POLICIES:

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

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
B. Care Coordination (CC) Staff: Partnership's CC staff members have either experience in health care fields (e.g., Medical Assistant, Emergency Medical Technician, etc.) or are licensed and possess the appropriate skills and training to assist Members. All staff are trained in care coordination and motivational interviewing.
C. Health Information Form (HIF)/Member Evaluation Tool (MET): Screening tool sent to newly enrolled Members to identify Members needing expedited care.
D. Health Risk Assessment (HRA): An assessment form mailed to newly enrolled adult Members (ages 21 and over) with corresponding Seniors and Persons with Disabilities (SPD) aid codes who may be at risk for adverse health outcomes without support from an Individualized Care Plan (ICP).
~~D.~~E. Initial Health Appointment (IHA): is defined as a Member's visit to their Primary Care Provider (PCP) or other provider of primary care services, within stipulated timelines for an evaluation that consists of a history and physical examination sufficient to assess and manage the acute, chronic and preventive health needs of the member. The IHA must be documented in the member's medical record.
~~E.~~F. Partnership Advantage: Effective January 1, 202~~7~~8, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Enrollees~~Members~~ will be qualified to receive both Medi-Cal and Medicare services as

described in the Partnership Advantage Member Handbook.

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

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

IV. ATTACHMENTS:

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

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

A. New Member Outreach Process

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

B. Initial Screening

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

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

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

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

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

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

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

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

Partnership Advantage (Program effective January 1, 2028~~7~~)
01/14/26; 06/10/26

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

PREVIOUSLY APPLIED TO: N/A

<table>
<tr><td colspan="3">Policy/Procedure Number: MPCP2023 (previously MCCP2023)</td><td colspan="2">Lead Department: Health Services
Business Unit: Care Coordination</td></tr>
<tr><td colspan="3">Policy/Procedure Title: New Member Needs Assessment</td><td colspan="2">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 08/16/2017</td><td colspan="3">Next Review Date: 06/10/2027
Last Review Date: 06/10/2026</td></tr>
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B. Health Risk Assessment (HRA)
C. Pediatric HRA

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Partnership Advantage (Program effective January 1, 2028)
01/14/26; 06/10/26

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

PREVIOUSLY APPLIED TO: N/A

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

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

I. RELATED POLICIES:

A. MCUP3052 – Medical Nutrition Services
B. MPCR701 – Ancillary Care Services Provider Credentialing and Re-credentialing Requirements

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Diabetes Prevention Program (DPP): An evidence-based lifestyle change program, taught by lifestyle coaches designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with pre-diabetes.
B. Lifestyle Coach (also known as Peer Coaches): A person formally trained in Centers for Disease Control and Prevention (CDC) approved curriculum for a minimum of 12 hours or approximately two days. A lifestyle coach may have credentials [e.g. Physician, Registered Dietician (RD), and Registered Nurse (RN)], but they are not required. The CDC approved training may be provided by one of the following:
   1. A training entity listed on the CDC website
   2. A private organization with a national network of CDC recognized program sites
   3. A CDC recognized virtual organization with national reach or
   4. A Master Trainer, as designated by the CDC recognized program, who has delivered that lifestyle change program for at least one year and has completed a Master Trainer program offered by a training entity listed on the CDC website.
C. Medicare Diabetes Prevention Program (MDPP): An evidence-based lifestyle change program for individuals eligible for Medicare, available to Partnership Advantage ~~members~~Enrollees, taught by lifestyle coaches designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with pre-diabetes.
D. Partnership Advantage: Effective January 1, 2028~~7~~, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS) - approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Enrollees~~Members~~ will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

IV. ATTACHMENTS:

A. NA

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

A. Program Description

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

B. Eligibility Criteria

1. DPP Eligibility Criteria:

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

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

2. MDPP Specific Eligibility Criteria:

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

      1) Must be enrolled as a Partnership Advantage Enrollee~~Member~~.
      2) Participants cannot have end-stage renal disease (ESRD) at any point during the MDPP services period. A Member who previously had ESRD may be eligible to participate in MDPP if:
         a) It has been 12 months after the month the Enrollee~~Member~~ stops dialysis treatments, or
         b) It has been 36 months after the month the Enrollee~~Member~~ had a kidney transplant.
      3) Participants cannot have received MDPP services previously.
      4) All other requirements for MDPP are listed above in VI.B.1.b-e for reference.

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

   a. A blood test within the past year meeting one of the following specifications:
      1) Fasting glucose of 1~~0~~10 to 125 mg/dl
      2) Plasma glucose reading of 140 to 199 mg/dl measured 2 hours after a 75 g glucose load
      3) HbA1c of 5.7 to 6.4%
   b. Clinically diagnosed gestational diabetes mellitus (GDM) during a previous pregnancy
   c. Received a high-risk result (score of 5 or higher) on the Prediabetes Risk Test.
   d. A health care professional may refer potential participants to the program, but a referral or

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

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

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

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

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

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

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

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

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

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

VII. REFERENCES:

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

E.G. Medicare and Medicaid Programs CY 2026 https://www.federalregister.gov/documents/2025/11/05/2025-19787/medicare-and-medicaid-programs-cy-2026-payment-policies-under-the-physician-fee-schedule-and-other (11/05/2025)
F.H. Prediabetes Risk Test Sheet https://www.cdc.gov/diabetes/prevention/pdf/Prediabetes-Risk-Test-Final.pdf
G.I. Centers for Disease Control and Prevention, Diabetes Prevention Recognition Program Standards and Operating Procedures (03/01/202106/01/2024) 2024 DPRP Standards and Operating Procedureshttps://www.cdc.gov/diabetes-prevention/media/pdfs/legacy/dprp-standards.pdfhttps://nccpa.org/sites/default/files/2021-05/2021-DPRP-Standards-and-Operating-Procedures.pdf
H.J. National Diabetes Prevention Program, Preventing Type 2 Diabetes with Medicare (05/15/2024) https://www.cdc.gov/diabetes-prevention/lifestyle-change-program/ndpp-medicare-program.html
I.K. Medicare Diabetes Prevention Program (MDPP) Expanded Model Fact Sheet https://www.cms.gov/priorities/innovation/Files/x/MDPP_Overview_Fact_Sheet.pdf
J.L. Medicare Diabetes Prevention Program (MDPP) Medicare Advantage Fact Sheet https://www.cms.gov/priorities/innovation/files/fact-sheet/mdpp-ma-fs.pdf
K.M. Medicare Diabetes Prevention Program (MDPP) Basics (04/30/2024) https://coveragetoolkit.org/medicare/mdpp-basics/

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

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

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

PREVIOUSLY APPLIED TO:

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

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

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

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

<table>
<tr><td colspan="4">Policy/Procedure Number: MPCP2026 (previously MCCP2026)</td><td colspan="2">Lead Department: Health Services
Business Unit: Care Coordination</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Diabetes Prevention Program</td><td colspan="2">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 03/13/2019
Effective Date: 01/01/2019 per DHCS</td><td colspan="3">Next Review Date: 06/10/2027
Last Review Date: 06/10/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td colspan="2">☒ Medi-Cal</td><td>☒ 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>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD MPH MBA</td><td colspan="2">Approval Date: 06/10/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3052 – Medical Nutrition Services
B. MPCR701 – Ancillary Care Services Provider Credentialing and Re-credentialing Requirements

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Diabetes Prevention Program (DPP): An evidence-based lifestyle change program, taught by lifestyle coaches designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with pre-diabetes.
B. Lifestyle Coach (also known as Peer Coaches): A person formally trained in Centers for Disease Control and Prevention (CDC) approved curriculum for a minimum of 12 hours or approximately two days. A lifestyle coach may have credentials [e.g. Physician, Registered Dietician (RD), and Registered Nurse (RN)], but they are not required. The CDC approved training may be provided by one of the following:
   1. A training entity listed on the CDC website
   2. A private organization with a national network of CDC recognized program sites
   3. A CDC recognized virtual organization with national reach or
   4. A Master Trainer, as designated by the CDC recognized program, who has delivered that lifestyle change program for at least one year and has completed a Master Trainer program offered by a training entity listed on the CDC website.
C. Medicare Diabetes Prevention Program (MDPP): An evidence-based lifestyle change program for individuals eligible for Medicare, available to Partnership Advantage Enrollees, taught by lifestyle coaches designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with pre-diabetes.
D. Partnership Advantage: Effective January 1, 2028, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS) - approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

IV. ATTACHMENTS:

A. NA

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

A. Program Description

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

B. Eligibility Criteria

1. DPP Eligibility Criteria:

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

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

2. MDPP Specific Eligibility Criteria:

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

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

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

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

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

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

      1) Fasting glucose of 110 to 125 mg/dl
      2) Plasma glucose reading of 140 to 199 mg/dl measured 2 hours after a 75 g glucose load
      3) HbA1c of 5.7 to 6.4%

   b. Clinically diagnosed gestational diabetes mellitus (GDM) during a previous pregnancy
   c. Received a high-risk result (score of 5 or higher) on the Prediabetes Risk Test.
   d. A health care professional may refer potential participants to the program, but a referral or treatment authorization are not required for participation. Members/Enrollees meeting the

eligibility criteria may self-refer.

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

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

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

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

F. DPP Frequency

The DPP benefit for Medi-Cal Members only may be offered as often as necessary, but the Member's medical record must indicate that the Member's medical condition or circumstance warrants repeat or additional participation in the DPP benefit. Examples of circumstance that may warrant repeat or additional participation include:

1. Member switched enrollment from one Managed Care Plan (MCP) to a different MCP
2. Member transitioned from Fee for Service Medi-Cal into an MCP
3. Member moved to a different county
4. Member experienced a lapse in Medi-Cal enrollment
5. Member has or had medical conditions that hinder DPP session attendance

G. Curriculum and Translations

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

H. Documentation of Performance-Based Codes

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

I. Ancillary Care Services Provider

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

J. Partnership Medical Equipment Distribution Services (PMEDS) Program

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

VII. REFERENCES:

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

G. Medicare and Medicaid Programs CY 2026 https://www.federalregister.gov/documents/2025/11/05/2025-19787/medicare-and-medicaid-programs-cy-2026-payment-policies-under-the-physician-fee-schedule-and-other (11/05/2025)
H. Prediabetes Risk Test Sheet https://www.cdc.gov/diabetes/prevention/pdf/Prediabetes-Risk-Test-Final.pdf
I. Centers for Disease Control and Prevention, Diabetes Prevention Recognition Program Standards and Operating Procedures (06/01/2024) https://www.cdc.gov/diabetes-prevention/media/pdfs/legacy/dprp-standards.pdf
J. National Diabetes Prevention Program, Preventing Type 2 Diabetes with Medicare (05/15/2024) https://www.cdc.gov/diabetes-prevention/lifestyle-change-program/ndpp-medicare-program.html
K. Medicare Diabetes Prevention Program (MDPP) Expanded Model Fact Sheet https://www.cms.gov/priorities/innovation/Files/x/MDPP_Overview_Fact_Sheet.pdf
L. Medicare Diabetes Prevention Program (MDPP) Medicare Advantage Fact Sheet https://www.cms.gov/priorities/innovation/files/fact-sheet/mdpp-ma-fs.pdf
M. Medicare Diabetes Prevention Program (MDPP) Basics (04/30/2024) https://coveragetoolkit.org/medicare/mdpp-basics/

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

X. REVISION DATES:

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

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

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use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY / PROCEDURE

Policy/Procedure Number: MPCP2034 (previously MCCP2034)				**Lead Department: Health Services** Business Unit: Care Coordination	
Policy/Procedure Title: Transitional Care Services (TCS)				☒**External Policy** ☐ **Internal Policy**	
Original Date: 06/12/2024 **Effective Date: 01/01/2023**			**Next Review Date: 06/11/202606/10/2027** **Last Review Date: 06/11/202506/10/2026**		
Applies to:	☐ **Employees**		☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date: 06/11/202506/10/2026**	

I. RELATED POLICIES:

A. MPCD2013 – Care Coordination Program Description
B. MPCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services
C. MPCCP2007 – Complex Case Management
D. MCAP7002 MCCP2032 – CalAIM: Enhanced Care Management (ECM)
E. MPCAP7003 – CalAIM Community Supports (CS)
F. MCAP7001 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
G. MPCND9001 – Population Health Management Strategy & Program Description
H. MCUP3041 – Treatment Authorization Request (TAR) Review Process
I. MPUD3001 – Utilization Management Program Description
J. MCUP3106 – Waiver Programs
K. MPUG3011 – Criteria for Home Health Services
L. MPBP8003 – Mental Health Services
M. MPBP8007MCUP3101 – Screening and Treatment for Substance Use Disorders
N. MCUP3013 – Durable Medical Equipment (DME) Authorization
O.N. MCUP3064 – Communications Services
P.O. MPCCP2018 – Advice Nurse Program
P. MPAP7004 – Community Health Worker (CHW) Services Benefit
Q. MCUP3012 – Discharge Planning (Non-capitated Members)
Q.R. MCUP3141 – Delegation of Inpatient Utilization Management

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

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

patients.

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

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

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

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

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

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

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

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

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

interdisciplinary, high-touch, and person-centered.

K. HCBS: Home and Community Based Services

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

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

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

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

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

P.Q. Partnership Advantage: Effective January 1, 20287, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage EnrolleesMembers will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

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

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

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

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

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

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

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

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

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

A. Transitional Care Services (TCS):

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

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

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

B. TCS Member Eligibility & Identification:

1. As part of Partnership's Risk Stratification/Segmentation (RSS) and Risk Tier process, Partnership Members shall be proactively identified for TCS services.
   a. For more information on Partnership's Population Health Management Program and/or Risk Stratification/Segmentation process, see Partnership policy MP~~C~~ND9001 Population Health Management Strategy & Program Description.
   b. All Partnership Advantage E~~e~~nrollees~~d members~~.
      1) For the purpose of identifying TCS for Partnership Advantage, Enrollees~~members~~ receive all services in Section VI.B. and VI.C. required for High Risk members.
   c. All Non-Partnership Advantage members receiving TCS are differentiated by High- and Low-risk designations.
   d. High-risk transitioning Members means all Members that meets criteria under MP~~C~~CP2019 Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services Section VI.D.1 and other Members assessed as high-risk by RSS and Risk Tier Process. Noting for TCS purposes, pregnant individuals include individuals hospitalized during pregnancy, admitted during the 12-month period post-partum, and discharges related to the delivery.
   e. In addition to these groups, and in recognition of high-risk of poor outcomes in transition for Partnership Members enrolled in multiple payors, those transitioning from SNFs, and those at high-risk who are potentially not captured in criteria mentioned~~ in section VI.C.1.c~~, Partnership must also consider the following Members high-risk for the purpose of TCS:
      1) Any Member who has been served by county Special Mental Health Services (SMHS) and/or DMC or DMC-ODS (if known) within the last 12 months, or any Member who has been identified as having a specialty mental health need or substance use disorder by Partnership or discharging facility
      2) Any Member transitioning to or from a SNF
      3) Any Member that is identified as high-risk by the discharging facility and thus is referred or recommended by the facility for high-risk TCS
   f. Lower-risk transition Members are defined as those not included in the high-risk transitioning

Members noted above.

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

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

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

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

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

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

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

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

2. For high-risk Members identified for TCS, the Member shall be referred to Partnership's CCM program, ECM benefit, or for PA Members; CICM benefit, as appropriate.
3. Partnership Advantage Enrollees~~members~~ are assigned a Primary Case Manager for all of the ~~member's~~ Enrollees care coordination, including TCS. The PA primary case manager is the primary responsible person for longitudinal support and to collaborate with the staff involved with member transitions and will invite participation to the ICT based on a prioritized and active need in the ICP addressing transitions. Transitions of care involved staff (not all inclusive of inpatient review nurse coordinators, LTSS nurse coordinators, for example) provide clinical support and expertise related to transitions between care settings including LTSS.
4. For lower-risk Members identified for TCS, Partnership is required:
   a. To ensure Member has access to a dedicated contact to provide assistance for any TCS need (at Partnership or a delegate) for a period of at least 30 days from discharge.
   b. To ensure Member can reach a dedicated telephonic support service. See Partnership Policy ~~MCUP3064 Communication Services,~~ MP~~C~~CP2018 Advice Nurse Program ~~,~~ and latest Member Handbook for more details.
   c. To facilitate Members' ambulatory follow-up within 30 days of discharge for necessary post-discharge service, as needed.
5. For all other Members identified for TCS, Partnership shall evaluate and identify an appropriate TCS Care Manager. Examples include, but are not limited to, Partnership Health Services staff, hospital staff, PCPs, and/or other contracted agencies.
   a. Facility staff who help with discharge planning should work with, but not take the place of the responsible TCS Care Manager, unless Partnership has formally assigned the facility to act as the TCS Care Manager.
6. The TCS Care Manager is notified of the Member's admission, discharge and/or transfer status including the location of admission and facility contact information.
7. Partnership will notify the discharging facility of the name and contact information, including phone number, of the identified TCS Care Manager for the facility to include in the discharge planning document.
8. Partnership will provide the TCS Care Manager's contact information to the Member, legal guardian/caregiver(s)/legal representative/authorized representative, as part of the TCS engagement.
9. The TCS Care Manager must obtain permission from the Member, legal guardian/caregiver(s)/legal representative/authorized representative, as appropriate, to share information with providers to facilitate transitions, in accordance with federal and state privacy laws and regulations (ex: Release of Information (ROI), etc.)
10. The TCS Care Manager must also ensure non-duplication of services provided through other programs such as ECM, CCM, CICM Targeted Case Management, etc.
11. The assigned TCS Care Manager shall ensure that all TCS are provided in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up and post-discharge.
12. High-Risk Member Outreach: The identified TCS Care Manager is responsible for contacting the Member within 7 calendar days of discharge and supporting the Member in all needed TCS care identified at discharge, as well as addressing any new needs identified through engagement with the Member or their care providers.
13. Low-Risk Member Outreach: Partnership must make best efforts to ensure Members receive direct communication about the dedicated TCS team and phone line, and how to access it, no later than 24 hours after the plans are notified of the discharge. Acceptable methods of communication include automated phone calls, incorporating information into discharge documents, and letters (either as supplemental to other efforts or if no other effort was effective). More than one method of

notification can be utilized.

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

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

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

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

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

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

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

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

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment III – 4.3, Population Health Management and Coordination of Care
B. DHCS APL 22-024 Population Health Management Policy Guide (11/28/2022)
C. DHCS APL 23-006 Delegation and Subcontractor Network Certification (03/28/2023)
D. DHCS APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates (*Revised* 08/31/2022)
E. DHCS APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (*Revised* 08/11/2025~~01/08/2025~~)
   1. Specialty Mental Health Services MOU template (DHCS contract Attachment E)
F. Title 42 Code of Federal Regulations (CFR) Section 438.208
G. CalAIM Dual Eligible Special Needs Plans Policy Guide - Contract 2026 (February 2026~~5~~)
H. CalAIM Population Health Management Policy Guide (January 2026~~4~~)
I. DHCS Birthing Care Pathway
J. Medicare Advantage Options for Dual Eligible Beneficiaries
K. DHCS BHIN 26-001 Inpatient Criteria SMHS
https://www.dhcs.ca.gov/Documents/BHIN-26-001-Inpatient-Criteria.pdf
L. DHCS BHIN 26-002 Criteria for Medi-Cal Member Access to SMHS
https://www.dhcs.ca.gov/Documents/BHIN-26-002-Access-Criteria.pdf

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

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

Partnership Advantage (Program effective January 1, 20287)
06/10/26N/A

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.

<table>
<tr><td colspan="3">Policy/Procedure Number: MPCP2034 (previously MCCP2034)</td><td colspan="2">Lead Department: Health Services
Business Unit: Care Coordination</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Transitional Care Services (TCS)</td><td colspan="2">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 06/12/2024
Effective Date: 01/01/2023</td><td colspan="3">Next Review Date: 06/10/2027
Last Review Date: 06/10/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td>☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td>☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE ☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE ☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td>☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: 06/10/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MPCD2013 – Care Coordination Program Description
B. MPCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services
C. MPCP2007 – Complex Case Management
D. MCAP7002 – CalAIM Enhanced Care Management (ECM)
E. MPAP7003 – CalAIM Community Supports (CS)
F. MCAP7001 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
G. MPND9001 – Population Health Management Strategy & Program Description
H. MCUP3041 – Treatment Authorization Request (TAR) Review Process
I. MPUD3001 – Utilization Management Program Description
J. MCUP3106 – Waiver Programs
K. MPUG3011 – Criteria for Home Health Services
L. MPBP8003 – Mental Health Services
M. MPBP8007 – Screening and Treatment for Substance Use Disorders
N. MCUP3013 – Durable Medical Equipment (DME) Authorization
O. MPCP2018 – Advice Nurse Program
P. MPAP7004 – Community Health Worker (CHW) Services Benefit
Q. MCUP3012 – Discharge Planning (Non-capitated Members)
R. MCUP3141 – Delegation of Inpatient Utilization Management

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

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

B. Admission, Discharge, and Transfer (ADT) data: Feeds providing notifications of Member admission, discharge, and transfer data in standardized formats.
C. California Integrated Care Management (CICM): California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNPs as determined by the state
D. Closed Loop Referral: A closed loop referral means bidirectional information sharing between two or more parties to communicate requests for services and the associated outcomes of the requests. The frequency and format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and/or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required.
E. Community Health Worker (CHW): Individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, who connect and engage with their community to provide equitable health care through culturally competent services. CHWs are trusted Members of their community who help address chronic conditions, preventive health care needs, and health related social needs within their communities.
F. Community Health Worker (CHW) Services: CHW services are preventive health services as defined in 42 CFR health 440.130(c) delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health and well-being. CHW services can help Members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services.
G. Community Supports (CS): Pursuant to 42 CFR 438.3(e)(2), In-Lieu of Services (ILOS) are optional services or settings that are offered in place of services or settings covered under the California Medicaid State Plan (Medi-Cal) and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. These services or settings require Department of Health Care Services (DHCS) approval. Under CalAIM, these services are known as Community Supports (CS).
H. Complex Case Management (CCM): The process of applying evidence-based practices to individual Members to assist them with the coordination of their care and promote their well-being.
I. Drug Medi-Cal Organized Delivery System (DMC-ODS): An opt-in 1115 waiver program available in California since 2015 that provides the opportunity for counties to expand substance use disorder treatment options outside of traditional Medicaid substance use disorder treatment offerings. In the DMC-ODS, opted-in counties provide a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services which enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance use treatment, and coordinates with other systems of care. Of Partnership's 24 counties, 7 participate in Partnership's Regional Model or DMC-ODS program (aka as Partnership's "Wellness & Recovery program" see III.Q.): Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties. Seven other counties have organized their own county-managed DMC-ODS programs (over which Partnership has no regulatory oversight responsibilities): Lake, Marin, Napa, Nevada, Placer, Sonoma, and Yolo counties. The remaining counties have not opted into the DMC-ODS program and therefore abide by the county-managed "State Plan" DMC program.
J. Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.
K. HCBS: Home and Community Based Services

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

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

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

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

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

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

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

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

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

U. Specialty Mental Health Services (SMHS): *aka Serious and Persistent Mental Health Services*
County Behavioral Health Plans (BHPs) are contractually required to provide or arrange for the provision of SMHS for Medi-Cal Members who have significant impairment or reasonable probability of functional deterioration due to a diagnosed or suspected mental health disorder as described in

Behavioral Health Information Notice. (BHIN) 26-002

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

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

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

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

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe and define Partnership HealthPlan of California (Partnership) Transitional Care Services (TCS) in accordance with the Department of Health Care Services (DHCS) Population Health Management (PHM) Policy Guide. This policy outlines the roles and collaboration among Partnership's Health Services staff, provider network, and Members to support continuity of care and coordinated care planning before, during, and after transitions across health care settings and levels of care. This policy is established pursuant to DHCS PHM program requirements and applicable CalAIM Dual Eligible Special Needs Plan (D-SNP) guidance.

VI. POLICY / PROCEDURE:

A. Transitional Care Services (TCS):

1. Partnership shall ensure Transitional Care Services are provided to Members/Enrollees transferring from one setting, or level of care, to another in accordance with 42 CFR section 438.208, other applicable federal and state laws and regulations, and DHCS guidance. Settings include, but are not limited to, discharges from hospitals, institutions, acute care facilities, and Skilled Nursing Facilities (SNFs) to home or community-based settings, Community Supports (CS) placements (including Sobering Centers, Recuperative Care, and Short-Term Post Hospitalization), post-acute care facilities, or Long-Term Care (LTC) settings. Across these settings, TCS shall prioritize member-centered care by:
    a. Ensuring Members are supported with discharge planning until they have been successfully connected to all needed services and supports.
    b. Ensuring that a single point of contact, herein referred to as a TCS Care Manager, can assist throughout all high-risk Members' transitions, providing longitudinal support, and ensuring all required services are completed.
    c. Ensuring that a dedicated TCS Team and a phone number is available to support lower-risk transitioning Members telephonically when needed.
    d. Ensuring Members receive timely follow-up care after emergency department (ED) visits for mental health or substance use disorder (SUD) needs.
    e. Ensuring Members receive timely follow-up after ED visits for pregnant and postpartum individuals (through 12 months postpartum), given the association of ED visits and maternal morbidity and mortality.
    f. Updating a Partnership Advantage Enrollee's Individualized Care Plan (ICP) as appropriate and

distributing the updated ICP to the ICT.

B. TCS Member Eligibility & Identification:
   1. As part of Partnership's Risk Stratification/Segmentation (RSS) and Risk Tier process, Partnership Members shall be proactively identified for TCS services.
      a. For more information on Partnership's Population Health Management Program and/or Risk Stratification/Segmentation process, see Partnership policy MPND9001 Population Health Management Strategy & Program Description.
      b. All Partnership Advantage Enrollees.
         1) For the purpose of identifying TCS for Partnership Advantage, Enrollees receive all services in Section VI.B. and VI.C. required for High Risk members.
      c. All Non-Partnership Advantage members receiving TCS are differentiated by High- and Low-risk designations.
      d. High-risk transitioning Members means all Members that meets criteria under MPCP2019 Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services Section VI.D.1 and other Members assessed as high-risk by RSS and Risk Tier Process. Noting for TCS purposes, pregnant individuals include individuals hospitalized during pregnancy, admitted during the 12-month period post-partum, and discharges related to the delivery.
      e. In addition to these groups, and in recognition of high-risk of poor outcomes in transition for Partnership Members enrolled in multiple payors, those transitioning from SNFs, and those at high-risk who are potentially not captured in criteria mentioned, Partnership must also consider the following Members high-risk for the purpose of TCS:
         1) Any Member who has been served by county Special Mental Health Services (SMHS) and/or DMC or DMC-ODS (if known) within the last 12 months, or any Member who has been identified as having a specialty mental health need or substance use disorder by Partnership or discharging facility
         2) Any Member transitioning to or from a SNF
         3) Any Member that is identified as high-risk by the discharging facility and thus is referred or recommended by the facility for high-risk TCS
      f. Lower-risk transition Members are defined as those not included in the high-risk transitioning Members noted above.
   2. Partnership utilizes Admission, Discharge and Transfer (ADT) data feeds to assist in Member identification for TCS services and for assistance with timely authorizations for services that require prior authorization (e.g. acute in-patient care setting requests, etc.).
   3. Partnership utilizes the ADT feed, PointClickCare (PCC) formerly Collective Medical Technologies (CMT), to receive timely notifications within 24 hours of a Member's admission, transfer or discharge.
      a. When ADT feeds are not available, Partnership shall utilize other mechanisms to identify Members who may be eligible for TCS. This includes but is not limited to: fax notifications from facilities/institutions, Treatment Authorization Requests (TAR) for services, existing data-sharing agreements with providers/vendors, direct referrals to the Health Services department, and/or internal reports. Notification is necessary within 24 hours of Partnership being aware of any planned admission, or of any admissions, discharges, or transfers. However, this notification time frame will not apply if the care manager responsible for TCS is notified of the admission, discharge, or transfer through an ADT feed directly.

C. Transitional Care Services shall include the following:
   1. Ensuring collaboration and partnership with discharging facilities, including ensuring hospitals provide patient-centered discharge planning as required by federal and state requirements. Partnership must ensure discharging facilities complete a discharge planning process that:

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

2. As defined above in Section III.C, closed loop referrals to CS and/or coordination with county social service agencies and waiver agencies for In-Home Support Services (IHSS), Long Term Services and Supports (LTSS) and/or Home and Community Based Waiver (HCBS) services and programs.
3. Ensuring that medication reconciliation is conducted both pre- and post-transition, including education and counseling about the Member's medications.
4. Ensuring all necessary prior authorizations required for a Member's discharge are completed in timeframes consistent with the Member's condition and regulatory requirements. Examples include, but are not limited to, authorizations for:
    a. Therapy
    b. Home care / Home Health
    c. Medical supplies
    d. Prescription medications
    e. Durable Medical Equipment (DME)
5. Coordination to ensure appropriate follow-ups are completed for post-discharge appointments includes:
    a. Ensuring the post-discharge providers are notified and receive necessary clinical information, including a discharge summary in the medical record that outlines the care, treatment, and services provided, the patient's condition and disposition at discharge, information provided to the patient and family, and provisions for follow-up care.
    b. Confirming hospital has secured necessary follow-up appointments prior to discharge.
    c. Assisting with scheduling/arranging transportation when necessary for follow-up appointments.
    d. Ensuring needed post-discharge services are provided and follow-up visits are scheduled, including, but not limited to, follow-up provider appointments, SUD and/or mental health

treatment initiation.

6. Follow-up with Member and/or their legal guardian/caregiver(s)/legal representative/authorized representative to ensure that services are coordinated and post-discharge needs have been met.
7. Members may choose to have limited or no contact with the identified TCS Care Manager. In such cases, the TCS Care Manager must, at a minimum, act as a liaison to coordinate care among the discharging facility, the Primary Care Provider (PCP), and Partnership.
8. Coordination and verification that the Member is receiving all appropriate services regardless of setting.
9. Ensuring collaboration, communication and coordination with the Member, their legal guardian/caregiver(s)/legal representative/authorized representative and the care team including, but not limited to, hospitals, physicians (including the Member's PCP), LTSS providers, discharge planners, social workers, and/or other case managers to ensure and facilitate a safe and successful transition.
10. A core responsibility of the TCS Care Manager is to coordinate with discharging facilities to fully understand the Member's potential needs and follow-up plans. Additionally, the TCS Care Manager must ensure the Member participates in the care plan and receives and comprehends the information about their required care. To achieve this, the TCS Care Manager must complete the following:
    a. Risk Assessment: The TCS Care Manager must assess Members' risk for adverse outcomes to inform needed TCS. This must include reviewing information from the discharging facility's assessment(s) and discharge planning process (e.g., the discharge summary). The TCS Care Manager may supplement this risk assessment through Member engagement as needed. During this process, the TCS Care Manager must also identify Members who may be newly eligible for ongoing care management (ECM/CCM), or for PA Members (CICM), and/or Community Supports and make appropriate referrals.
    b. Discharge Instructions: The TCS Care Manager must receive and review a copy of the discharging facility's discharge instructions given to the Member, including the medication reconciliation completed upon discharge by the discharging facility. After discharge, upon Member engagement, the TCS Care Manager must review the discharge instructions with the Member and ensure that Member can have any questions answered. A best practice (not required) is for the TCS Care Manager to work with the facility to ensure that the TCS Care Manager's name and contact information are integrated into the discharge documents.
    c. Discharge Summary and Clinical Information Sharing: The TCS Care Manager must receive and review a copy of the discharging facility's discharge summary once it is complete. The TCS Care Managers must ensure all follow-up providers have access to the clinical information needed from the discharging facility, including the discharge summary.
    d. Preadmission Status: Includes living arrangements, physical and mental function, SUD needs, social support, DME usage, and other services received prior to admission.
    e. Pre-discharge Support Needs: Includes the Member's medical condition, physical and mental function, financial resources, and social supports at the time of discharge.
    f. Discharge Location: The hospital, institution, or facility to which the Member was admitted.
    g. Specific Agency or Home: Recommended by the hospital, institution, or facility after the Member's discharge based on the Member's needs and preferences.
    h. Specific Services Needed After the Member's Discharge: A specific description of the type of placement preferred by the Member, the type of placement agreed to by the Member, the agency or Member's return to home agreed to by the Member, and recommended pre-discharge counseling.
    i. Summary of Participation in the Discharge Planning Process: A summary of the nature and outcome of the participation of the Member/legal guardian/caregiver(s)/legal representative/authorized representative in the discharge planning process.

j. Anticipated Problems and Further Actions: Anticipated problems in implementing post-discharge plans and further actions contemplated by the hospital, institution, or facility to be included in the Member's Medical Record.
k. Information on Post-Discharge Care and Services: Information regarding available care, services, and supports that are in the Member's community once the Member is discharged from a hospital, institution or facility, including the scheduled outpatient appointment or follow-up with the Member.
l. TCS Care Manager Information: The TCS Care Manager's name and contact information, along with a description of TCS, should also be included.

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

D. TCS Care Manager, Care Manager Assignment, & TCS Team

1. Once a high-risk Member has been admitted, Partnership shall identify a TCS Care Manager who shall serve as the single point of contact for the Member to provide longitudinal support and who ensures completion of all TCS services outlined in section VI.A.
   a. For Members enrolled in Partnership's Complex Case Management (CCM) program, the Partnership Case Manager shall serve as the TCS Care Manager and perform all TCS services for the Member.
   b. For Members enrolled in the ECM benefit, the ECM Lead Care Manager shall serve as the TCS Care Manager and perform all ECM services for the Member. For more information regarding the ECM benefit, see Partnership Policy MCAP7002 CalAIM Enhanced Care Management (ECM).
2. For high-risk Members identified for TCS, the Member shall be referred to Partnership's CCM program, ECM benefit, or for PA Members; CICM benefit, as appropriate.
3. Partnership Advantage Enrollees are assigned a Primary Case Manager for all of the Enrollees care coordination, including TCS. The PA primary case manager is the primary responsible person for longitudinal support and to collaborate with the staff involved with member transitions and will invite participation to the ICT based on a prioritized and active need in the ICP addressing transitions. Transitions of care involved staff (not all inclusive of inpatient review nurse coordinators, LTSS nurse coordinators, for example) provide clinical support and expertise related to transitions between care settings including LTSS.
4. For lower-risk Members identified for TCS, Partnership is required:
   a. To ensure Member has access to a dedicated contact to provide assistance for any TCS need (at Partnership or a delegate) for a period of at least 30 days from discharge.
   b. To ensure Member can reach a dedicated telephonic support service. See Partnership Policy MPCP2018 Advice Nurse Program and latest Member Handbook for more details.
   c. To facilitate Members' ambulatory follow-up within 30 days of discharge for necessary post-discharge service, as needed.
5. For all other Members identified for TCS, Partnership shall evaluate and identify an appropriate TCS Care Manager. Examples include, but are not limited to, Partnership Health Services staff, hospital staff, PCPs, and/or other contracted agencies.
   a. Facility staff who help with discharge planning should work with, but not take the place of the responsible TCS Care Manager, unless Partnership has formally assigned the facility to act as the TCS Care Manager.
6. The TCS Care Manager is notified of the Member's admission, discharge and/or transfer status including the location of admission and facility contact information.
7. Partnership will notify the discharging facility of the name and contact information, including phone

number, of the identified TCS Care Manager for the facility to include in the discharge planning document.

8. Partnership will provide the TCS Care Manager's contact information to the Member, legal guardian/caregiver(s)/legal representative/authorized representative, as part of the TCS engagement.
9. The TCS Care Manager must obtain permission from the Member, legal guardian/caregiver(s)/legal representative/authorized representative, as appropriate, to share information with providers to facilitate transitions, in accordance with federal and state privacy laws and regulations (ex: Release of Information (ROI), etc.)
10. The TCS Care Manager must also ensure non-duplication of services provided through other programs such as ECM, CCM, CICM Targeted Case Management, etc.
11. The assigned TCS Care Manager shall ensure that all TCS are provided in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up and post-discharge.
12. High-Risk Member Outreach: The identified TCS Care Manager is responsible for contacting the Member within 7 calendar days of discharge and supporting the Member in all needed TCS care identified at discharge, as well as addressing any new needs identified through engagement with the Member or their care providers.
13. Low-Risk Member Outreach: Partnership must make best efforts to ensure Members receive direct communication about the dedicated TCS team and phone line, and how to access it, no later than 24 hours after the plans are notified of the discharge. Acceptable methods of communication include automated phone calls, incorporating information into discharge documents, and letters (either as supplemental to other efforts or if no other effort was effective). More than one method of notification can be utilized.

E. End of TCS
   1. High-Risk Members
      a. TCS will end once the Member has been connected to needed services as identified in the discharge risk assessment or in the discharge planning document. TCS should extend at least 30 days post-discharge.
      b. If Partnership has delegated TCS to another contracted entity (e.g. hospital, PCP), Partnership will ensure that the delegate follows and coordinates services for the Member until all aforementioned activities are completed. A monitoring plan would be in place to ensure all required TCS are completed.
         1) This arrangement for managed care plan (MCP) contracted entities to provide TCS is not considered formal delegation. Therefore, Partnership is not subject to the requirements outlined in APL 23-006 "Delegation and Subcontractor Network Certification."
      c. For those Members who have ongoing unmet needs post-TCS, eligibility for ECM or CCM should be reconsidered.
      d. If the Member is enrolled in ECM, CCM, or CICM and if the TCS Care Manager responsible for TCS will not continue as their ECM, CCM, or CICM Lead Care Manager, the Member should be connected to their new TCS Care Manager through a referral.
      e. For Members who are unresponsive to Partnership's outreach attempts or did not attend scheduled follow-up ambulatory visits, Partnership must make reasonable effort to ensure Members:
         1) Are aware that TCS support is available for at least 30 days.
         2) Are engaged and that follow-up ambulatory visits are completed.
      f. For Members with multiple care transitions within a 30-day period, Partnership must ensure the same TCS Care Manager is assigned to support the Member through all transitions. If the second transition occurs within 7 days of the first transition, the TCS Care Manager must facilitate, as needed, a follow-up visit to be completed within 7 days post-discharge after the last

transition. The TCS Care Manager must also provide TCS support for at least 30 days after the last transition. These Members should be considered for ECM/CCM/CICM and/or CS eligibility.

2. Lower-Risk Members
   a. Partnership must continue to offer TCS support through a dedicated telephonic team for at least 30 days post-discharge.
   b. In addition to accepting referrals to longer term care management at any point during the transition, Partnership will use data including any information from admission, to identify newly qualified Members for outreach and enrollment into ECM/CCM/CICM and/or CS as appropriate.
3. Partnership may utilize Community Health Workers (CHWs) when available through the CHW benefit to facilitate Member outreach and engagement. Refer to Partnership policy MPAP7004 Community Health Worker (CHW) Services Benefit for details.

F. Prior Authorization and Timely Discharge
   1. Partnership adheres to regulatory prior authorization processing timeframes. The timely processing of authorizations supports Partnership's contracted providers in discharge planning and ensuring necessary services and supports are in place prior to discharge. Partnership policy MCUP3041 Treatment Authorization Request (TAR) Review Process describes how Partnership monitors performance and complies with regulatory prior authorization processing timeframes and standards as well as APL 21-011 "Grievance and Appeal Requirements, Notice and "Your Rights" Templates".
   2. As described in Partnership policy MPUD3001 Utilization Management Program Description, Members are evaluated for appropriateness of care setting pursuant to medical necessity and the documented discharge plan. The discharge plan shall take into account the continuing care needs and initiation of arrangements for services or placement needed after discharge.
      a. Partnership shall collaborate with hospital discharge planners, case managers, admitting/attending physicians and ancillary service providers to assist in making necessary arrangements for post-discharge needs.
   3. To support effective discharge planning practices, Partnership shall ensure all network providers (e.g. hospitals, acute care facilities, institutions, etc.) educate their discharge staff on the services, supplies, medications, and DME that require a Treatment Authorization Request (TAR). A list of items that require prior authorization is attached to Partnership policy MCUP3041 Treatment Authorization Request (TAR) Review Process as Attachment A. The policy is made available on Partnership's website for further education and to support the provider network and discharge planning staff.
   4. Partnership maintains mutually agreed upon policies and procedures for Discharge Planning and Transitional Care Services that apply to each of our Network Providers and Out-of-Network Provider hospitals within our Service Area.

G. TCS For Partnership Members with Other Health Insurance/ Multiple Payers
   1. Partnership is responsible for providing TCS to Partnership assigned Members even for services or benefits carved-out from Partnership's Medi-Cal contract. (e.g., hospitalization for a Medicare FFS dual-eligible Member, in-patient acute psychiatric admissions, etc.)
   2. For Members who have multiple payers (other health insurance) and are undergoing any transition, Partnership will make a good faith attempt to obtain necessary ADT information from the corresponding facility. For these Members, Partnership shall notify existing CCM and/or ECM care managers of the admission, discharge and/or transfer in the manner outlined above in section VI. C.
   3. For Members who are admitted for an acute psychiatric hospital, psychiatric health facility, adult residential or crisis residential stay where the county Mental Health Plan is the primary payer, the county Mental Health Plan has the primary responsibility to coordinate the Member's care upon

discharge. Partnership and the county Mental Health Plan must share necessary data and information to coordinate care for TCS per [APL 23-029](#) Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (08/11/2025).

   a. Partnership will be responsible for all TCS during the transfer/discharge to the behavioral health facility.
   b. Partnership shall identify a TCS Care Manager for these Members to coordinate with county behavioral health and/or county case managers to ensure physical health follow-up needs are met, assessed for, and additional care management needs such as CCM, ECM, CICM, or CS are addressed.
   c. TCS for this transfer/discharge end once the Member is admitted to the behavioral health facility and connected to all needed services, including care coordination.

4. After the Member's treatment at the behavioral health facility is complete and the Member is ready to be discharged or transferred, Partnership must follow the same transitional care requirements as either psychiatric admission or residential SUD treatment facility admission listed above. For Partnership members who have Medicare as primary coverage for inpatient, acute, and/or skilled nursing services:
   a. The Member's Medicare Medi-Cal Plan (MMP) or the Member's Dual-Eligible Special Needs Plan (D-SNP) is responsible for coordinating the delivery of all benefits covered by both Medicare and Partnership. Partnership is not responsible for providing TCS or assigning a transitional care manager for Members enrolled in a Medicare Medi-Cal Plan or Dual-Eligible Special Needs Program (D-SNP).
      1) Effective January 1, 2028, members enrolled in Partnership's Partnership Advantage program for D-SNP will have transitions of care coordinated under the Partnership Advantage plan.
5. Drug Medi-Cal Organized Delivery System (DMC-ODS) or Partnership's Wellness and Recovery services:
   a. For Members needing SUD services in counties participating in Partnership's Wellness & Recovery program (Regional Model), Partnership will be responsible for all TCS during the transfer/discharge to the behavioral health facility.
   b. For Members needing SUD services in the counties not participating in Partnership's Wellness & Recovery program, Partnership shall identify a TCS Care Manager for these Members to coordinate with county behavioral health and/or county case managers to ensure physical health follow-up needs are met, assessed for, and additional care management needs such as CCM, ECM, CICM or Community Supports (CS) are addressed.
   c. TCS for this transfer/discharge end once the Member is admitted to the behavioral health facility and connected to all needed services, including care coordination.
   d. After the Member's treatment at the behavioral health facility is complete and the Member is ready to be discharged or transferred, Partnership must follow the same transitional care requirements as either psychiatric admission or residential SUD treatment facility admission listed above.

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

VII. REFERENCES:

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

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

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

Partnership Advantage (Program effective January 1, 2028)
06/10/26

PREVIOUSLY APPLIED TO:

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

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

I. RELATED POLICIES:

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

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.

~~A.~~B. California Integrated Care Management (CICM): California-specific requirements for integrated care coordination for specific vulnerable populations covered by Dual-Eligible Special Needs Plans (D-SNPs) as determined by the State.

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

~~C.~~D. Community-Based Organization (CBO): A public or private non-profit organization dedicated to the overall health, well-being, and functions of their community.

~~D.~~E. Community Health Worker (CHW): Individuals known by a variety of job titles, such as ~~promotores~~promotors, community health representatives, navigators, and other non-licensed public

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

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

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

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

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

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

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

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

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

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

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

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

B. CHW Qualifications

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

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

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

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

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

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

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

CHW Certificate.

b. Work Experience Pathway: Individuals having at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and who demonstrate skills and practical training in the areas described above (as determined and validated by the Supervising Provider) may provide CHW services without a certificate for a maximum period of 18 months.
   1) A CHW who does not have CHW certification must earn certification, as described above, within 18 months of the first CHW visit provided to a Member.

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

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

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

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

referrals from outside agencies.

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

E.F. Informing providers about the CHW benefit

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

F.G. Informing members about the CHW benefit

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

G.H. Member Eligibility for CHW services

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

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

j. Member expressed need for support in health system navigation or resource coordination services.
k. Need for recommended preventive services, including updated immunizations, annual dental visit, and well-child care visits for children.
~~k.~~l. Services are medically necessary to correct or ameliorate CCS eligible conditions.

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

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

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

~~I.~~J. Documentation Requirements

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

~~J.~~K. Authorization for CHW Services and Care Plans

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

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

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

~~K.~~L. Partnership's CHW Program Standards

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

services to members facing these challenges.

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

~~L.~~M. CHW Services Provided

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

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

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

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

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

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

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

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

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

encounter data for CHW generated under subcontracting arrangements.

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

VII. REFERENCES:

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

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

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

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

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

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Business Unit: EHS</td></tr>
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Effective Date: 07/01/2022 vs. DHCS</td><td colspan="3">Next Review Date: 06/09/2027
Last Review Date: 06/10/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: 06/11/2025</td></tr>
</table>

I. RELATED POLICIES:

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

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

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

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

F. Community Health Worker (CHW) Services: CHW services are preventive health services as defined in 42 CFR health 440.130(c) delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health and well-being. CHW services can help members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services.
G. Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.51532).
H. Enhanced Care Management (ECM) Provider: A Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.
I. Licensed Practitioner of the Healing Arts (LPHA): For the purposes of this policy, an individual who, within the scope of State law, has the ability and appropriate state licensure to independently make a clinical assessment, certify a diagnosis and recommend treatment.
J. Managed Care Plan (MCP): Partnership HealthPlan of California (Partnership) is contracted as a Department of Health Care Services (DHCS) Managed Care Plan (MCP).
K. Partnership Advantage: Effective January 1, 2027, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.
L. Street Medicine: Refers to a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment.
M. Supervising Providers: The organizations with which Partnership HealthPlan of California (Partnership) contracts that employ or otherwise oversee the CHWs. The Supervising Provider must be a licensed provider, a hospital including the Emergency Department (ED), outpatient clinic, local health jurisdiction (LHJ), or community-based organization (CBO). The Supervising Provider ensures that CHWs meet Department of Health Care Services (DHCS) qualifications as listed in APL 24-006, oversees CHWs and the services delivered to Partnership Members, and submits claims for services provided by CHWs.
N. Whole Child Model (WCM): A comprehensive program for the whole child encompassing providing comprehensive diagnostic and treatment services and care coordination in the areas of primary, specialty, and behavioral health for any pediatric Member with CCS eligible conditions insured by Partnership

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

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

B. CHW Qualifications

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

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

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

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

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

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

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

CHW Certificate.

b. Work Experience Pathway: Individuals having at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and who demonstrate skills and practical training in the areas described above (as determined and validated by the Supervising Provider) may provide CHW services without a certificate for a maximum period of 18 months.
    1) A CHW who does not have CHW certification must earn certification, as described above, within 18 months of the first CHW visit provided to a Member.

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

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

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

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

referrals from outside agencies.

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

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

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

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

j. Member expressed need for support in health system navigation or resource coordination services.
k. Need for recommended preventive services, including updated immunizations, annual dental visit, and well-child care visits for children.
l. Services are medically necessary to correct or ameliorate CCS eligible conditions.

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

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

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

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

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

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

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

services to members facing these challenges.

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

M. CHW Services Provided

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

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

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

N. Non-Covered CHW Services

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

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

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

P. Billing, Claims, and Payments

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

encounter data for CHW generated under subcontracting arrangements.

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

VII. REFERENCES:

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

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

Medi-Cal
MPAP7004: 6/11/26; 06/10/26
Partnership Advantage (effective Jan. 1, 2028)
N/A

PREVIOUSLY APPLIED TO:

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

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

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

I. RELATED POLICIES:

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

II. IMPACTED DEPTSM

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

III. DEFINITIONS:

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

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

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

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

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

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

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

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

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

K. Partnership Advantage: Effective January 1, ~~2027~~2028, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual-Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

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

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

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

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

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

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

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

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

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

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

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

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

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

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

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

(CS) and MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)

3) Have the capacity to provide culturally appropriate and timely in-person care management activities; and
4) Have formal agreements, data systems, and processes in place with entities across sectors to support care coordination and care management

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

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

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

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

VII. REFERENCES:

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

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

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

VIII. **DISTRIBUTION**:
B. Partnership Department Directors
C. Partnership Provider Manual

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

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

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

PREVIOUSLY APPLIED TO:
MCUP3146
(04/12/23; 05/08/24; ARCHIVED 6/11/25)

****

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

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

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

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

use disorder benefits in 42 CFR 438.910.

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

I. RELATED POLICIES:

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

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

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

2. Street Medicine Provider in a Direct Contracting Arrangement with Partnership
   a. To facilitate direct access, DHCS encourages Partnership to contract directly with street medicine providers. This is an option even if the provision of health care services is delegated to a Subcontractor.
      1) Direct contracts with street medicine providers can allow ready access to health care services for individuals experiencing unsheltered homelessness and reduce contracting complexity for street medicine providers.
      2) The street medicine provider would be subject to the same Partnership administrative processes (e.g. billing protocols, credentialing requirements, authorization guidelines, etc.) rather than having multiple processes and requirements under each subcontracting entity.
      3) The payment arrangement would be between the MCP and the street medicine provider.
      4) Under a direct contracting arrangement, the street medicine provider must have the ability to refer Members to medically necessary covered services within Partnership's network, and must coordinate care with Partnership, the Subcontractor, and/or Independent Physician/Provider Association (IPA) as appropriate.
3. Street Medicine Providers Serving Solely as Referring or Treating Contracted Provider
   a. The contracted street medicine provider has the right to decline the additional responsibilities of an assigned PCP, and instead, care for Members in a non-PCP capacity as a referring or treating contracted provider working with individuals experiencing unsheltered homelessness. To provide care in this capacity, street medicine providers must have processes in place to work with Partnership, the Member's PCP, and/or the ECM Care Manager to ensure the Member has referrals to primary care, Community Supports, behavioral health services, and other social services as needed.
   b. Licensed providers must follow Partnership credentialing requirements as per Partnership policies MPCR300 Physician Credentialing and Re-Credentialing Requirements, MPCR301 Non-Physician Clinician Credentialing and Re-Credentialing Requirements, and MPCR302 Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements.
   c. Licensed providers must be enrolled as a Medi-Cal provider in accordance with APL 22-013 Provider Credentialing/Re-Credentialing and Screening/Enrollment.
4. Street Medicine Provider as an ECM and/or Community Supports Provider
   a. A street medicine provider can be contracted to provide both PCP and ECM or Community Supports services to a Member but must avoid duplication of services. Street medicine providers that are also ECM or Community Support providers are required to do the following:
      1) Enroll in Medi-Cal if there is a state-level enrollment pathway
      2) Fulfill all ECM or Community Supports requirements per policies MCAP7002 CalAIM Enhanced Care Management (ECM), MCAP7003 CalAIM Community Supports (CS) and MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management

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

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

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

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

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

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-001 Street Medicine Provider: Definitions and Participation in Managed Care (01/12/2024)

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

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

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

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

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

PREVIOUSLY APPLIED TO:
MCUP3146
(04/12/23; 05/08/24; ARCHIVED 6/11/25)

****

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY / PROCEDURE

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

I. RELATED POLICIES:
A. MPNET100 – Access Standards and Monitoring

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

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

IV. ATTACHMENTS:
N/A

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

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

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

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

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

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

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

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

VII. REFERENCES:

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

VIII. DISTRIBUTION:

A. Partnership Department Directors

B. Partnership Provider Manual

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

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

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

PREVIOUSLY APPLIED TO:
N/A

<table>
<tr><td colspan="4">Policy/Procedure Number: MPNET101</td><td colspan="2">Lead Department: Network Services
Business Unit: Compliance</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Wellness and Recovery Access Standards and Monitoring</td><td colspan="2">☒External Policy
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<tr><td colspan="3">Original Date: 08/12/20</td><td colspan="3">Next Review Date: 06/10/2027
Last Review Date: 06/10/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: 06/10/2026</td></tr>
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I. RELATED POLICIES:

A. MPNET100 – Access Standards and Monitoring

II. IMPACTED DEPTS:

A. Member Services
B. Provider Relations
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D. Finance
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IV. ATTACHMENTS:

N/A

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VIII. DISTRIBUTION:

A. Partnership Department Directors

B. Partnership Provider Manual

IX. **POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE**:

Director, Network Services

X. **REVISION DATES:**

Medi-Cal
08/11/2021, 08/10/2022, 08/09/2023, 08/14/2024, 09/10/25, 06/10/26

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

PREVIOUSLY APPLIED TO:
N/A

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY/ PROCEDURE

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

I. RELATED POLICIES:
N/A

II. IMPACTED DEPTS:
A. Health Services

III. DEFINITIONS:
N/A

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

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

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

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

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

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

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

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

VII. REFERENCES:

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

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

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

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

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

PREVIOUSLY APPLIED TO:

PartnershipAdvantage:
MPQP1038 - 08/20/2008 to 01/01/2015

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

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

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

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

Physician Orders for Life-Sustaining Treatment (POLST)

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

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

A — Check One

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

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

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

B — Check One

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

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

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

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

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

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

Additional Orders: ____

____

C — Check One

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

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

Additional Orders: ____

D

INFORMATION AND SIGNATURES:

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

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

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

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

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

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

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

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

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

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

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

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

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

Directions for Health Care Provider

Completing POLST

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

Using POLST

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

Section A:

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

Section B:

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

Reviewing POLST

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

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

Modifying and Voiding POLST

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

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

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

<table>
<tr><td colspan="4">Policy/Procedure Number: MPQP1038</td><td colspan="2">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Physician Orders for Life-Sustaining Treatment (POLST)</td><td colspan="2">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 08/28/2008</td><td colspan="3">Next Review Date: 06/09/2027
Last Review Date: 06/10/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: 06/10/2026</td></tr>
</table>

I. RELATED POLICIES:
N/A

II. IMPACTED DEPTS:
A. Health Services

III. DEFINITIONS:
N/A

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

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

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

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

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

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

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

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

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

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

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

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

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

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

I. RELATED POLICIES:

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

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

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

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

A. Regarding Members

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

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

~~B.~~C. Regarding Practitioners

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

~~C.~~D. Regarding Partnership Staff

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

~~D.~~E. Regarding the Community

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

VII. REFERENCES:

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

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

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

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

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

PREVIOUSLY APPLIED TO:

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

<table>
<tr><td colspan="3">Policy/Procedure Number: MPQP1047 (previously MCQP1047)</td><td colspan="2">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Advance Directives</td><td colspan="2">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 06/17/2009</td><td colspan="3">Next Review Date: 06/09/2027
Last Review Date: 06/10/2026</td></tr>
<tr><td>Applies to:</td><td>☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</td></tr>
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<tr><td>☐ CEO ☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: 06/10/2026</td></tr>
</table>

I. **RELATED POLICIES**:
A. MPQP1038 – Physician Orders for Life-Sustaining Treatment
B. MPQP1022 – Site Review Requirements and Guidelines

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

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

IV. **ATTACHMENTS**:
A. N/A

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

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

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

C. Regarding Practitioners

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

D. Regarding Partnership Staff

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

E. Regarding the Community

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

VII. REFERENCES:

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

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

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

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

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

PREVIOUSLY APPLIED TO:

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

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

I. RELATED POLICIES:

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

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

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

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

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

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

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

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

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

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

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

VI. POLICY / PROCEDURE:

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

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

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

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

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

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

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

according to MPQP1016.

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

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

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

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

VII. REFERENCES:

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

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. PERSON RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Policy/Procedure Number: MPQP1055			Lead Department: Health Services Business Unit: Quality Improvement
Policy/Procedure Title: Provider Preventable Condition (PPC) Reporting			☒ **External Policy** ☐ **Internal Policy**
Original Date: 09/03/2012 (CMP36)			**Next Review Date:** ~~06/11/2026~~06/09/2027 **Last Review Date:** ~~06/11/2025~~06/10/2026
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

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

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

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

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

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Policy/Procedure Title: Provider Preventable Condition (PPC) Reporting				☒ **External Policy** ☐ **Internal Policy**	
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Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date: 06/10/2026**	

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

II. **IMPACTED DEPTS**:
   A. Health Services
   B. Claims
   C. Finance
   D. Provider Relations
   E. Regulatory Affairs & Compliance

III. **DEFINITIONS**:
   A. Partnership Advantage: Effective Jan. 1, 2028, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.
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C. DHCS PPC Frequently Asked Questions (last modified 03/23/2021)
D. DHCS PPC Online Reporting System
E. Department of Health and Human Services, Centers for Medicare & Medicaid Services, 42 CFR Parts 434, 438, and 447 - Medicaid Program; Payment Adjustment for Provider Preventable Conditions including Health Care-Acquired Conditions, effective July 1, 2011 https://www.govinfo.gov/content/pkg/FR-2011-06-06/pdf/2011-13819.pdf,
Centers for Medicare & Medicaid Services, Hospital-Acquired Conditions https://www.cms.gov/medicare/payment/fee-for-service-providers/hospital-aquired-conditions-hac

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. PERSON RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPUP3144 (previously MCUP3144, MCCP2028)</td><td colspan="2">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Residential Substance Use Disorder Treatment Authorization</td><td colspan="2">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 11/13/2019 (MCCP2028)
Effective Date: 07/01/2020 (MCCP2028)</td><td colspan="3">Next Review Date: ~~06/11/2026~~06/10/2027
Last Review Date: ~~06/11/2025~~06/10/2026</td></tr>
<tr><td>Applies to:</td><td>☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td>☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td>☐ CEO ☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: ~~06/11/2025~~06/10/2026</td></tr>
</table>

I. RELATED POLICIES:

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

II. IMPACTED DEPTS:

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

III. DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

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

treatment services.

VI. POLICY / PROCEDURE:

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

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

Department for review.

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

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

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

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

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

VII. REFERENCES:

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

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

MPUP3144 (06/11/2025)
06/11/25; 06/10~~1~~/26

PREVIOUSLY APPLIED TO:

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

MCCP2028 (11/13/2019 – 05/10/2022)

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

****

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

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

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

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

<table>
<tr><td colspan="4">Policy/Procedure Number: MPUP3144 (previously MCUP3144, MCCP2028)</td><td colspan="2">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Residential Substance Use Disorder Treatment Authorization</td><td colspan="2">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 11/13/2019 (MCCP2028)
Effective Date: 07/01/2020 (MCCP2028)</td><td colspan="3">Next Review Date: 06/10/2027
Last Review Date: 06/10/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: 06/10/2026</td></tr>
</table>

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

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

III. **DEFINITIONS**
   A. American Society of Addiction Medicine (ASAM) Criteria - As defined in the Department of Health Care Services (DHCS) Drug Medi-Cal Organized Delivery System Intergovernmental Agreement, pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. Currently using ASAM Criteria 3rd Edition.
   B. Discharge – The process to prepare the program beneficiary for referral into another level of care, post treatment return or re-entry into the community, and/or the linkage of the individual to essential community treatment, housing, and human services.
   C. Behavioral Health Clinical Director – The Partnership HealthPlan of California (Partnership) Behavioral Health Clinical Director is a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), clinical Doctor of Philosophy (PhD), or Doctor of Psychology (PsyD) who is actively involved in the behavioral health aspects of Partnership activities. This Director provides clinical oversight of Partnership's behavioral health activities including substance use services and the activities of Partnership's delegated organization for the administration of certain mental health services. The Behavioral Health Clinical Director has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for substance use disorder treatment related services.

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

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

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

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

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

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

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

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

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

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

treatment services.

VI. POLICY / PROCEDURE:

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

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

Department for review.

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

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

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

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

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

A. Department of Health Care Services (DHCS) Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services
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C. Title 42 Code of Federal Regulations (CFR) Section 438.210 (a)(4)
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F. InterQual® Behavioral Health Criteria
G. National Committee for Quality Assurance (NCQA) Guidelines UM 1 Program Structure Element A, UM 2 Clinical Criteria for UM Decisions Element A and UM 4 Appropriate Professionals Element A
H. DHCS All Plan Letter (APL) 21-011 Grievance and Appeals Requirements, Notice and "Your Rights" Templates (08/31/2021)
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VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

MPUP3144 (06/11/2025)
06/11/25; 06/10/26

PREVIOUSLY APPLIED TO:

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

MCCP2028 (11/13/2019 – 05/10/2022)
04/08/20; 04/14/21; 09/08/21

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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:

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- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY/ PROCEDURE

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

I. RELATED POLICIES:

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

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

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

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

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

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

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

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

IV. ATTACHMENTS:

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

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

A. ADULT GENERAL ELIGIBILITY CRITERIA

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

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

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

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

2) Willing to participate in Advance Care Planning discussions.

B. ADULT MEMBER ENGAGEMENT AND ENROLLMENT PROCESS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VII. REFERENCES:

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

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

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

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

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

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

****

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

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

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

Partnership HealthPlan of California
Palliative Care Eligibility Assessment Form
ADULTS

Name: ______________________________________

DOB: _______________

CIN: _______________

Type of Insurance: _____________________________

Name of Palliative Care Program: ______________________________

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

- ☐ Patient who is likely to or has started to use the hospital as a means to manage unanticipated decompensation in their late stage of illness. This refers to unplanned 'decompensation,' not elective procedures.
- ☐ Patient evaluated in their best compensated state
- ☐ The patient's death within a year would not be unexpected based on clinical status.
- ☐ Patients and Families are both:
  - a. Willing to attempt in-home disease management by the palliative care team instead of first going to the emergency department AND
  - b. Willing to participate in Advance Care Planning
- ☐ At least one of the following is true for their palliative qualifying condition:
  - a. Patient is intolerant to further therapy
  - ~~a.~~b. Patient's disease is progressing despite current therapy
  - ~~b.~~c. Patient declines further disease directed therapy
  - ~~c.~~d. Patient repeatedly decompensates due to severe non-compliance
- ☐ Palliative Performance Scale (PPS) or Karnofsky Performance Score (KPS) less than or equal to 70% or an Eastern Cooperative Oncology Group (ECOG) score of 3 or 4 (refer to pages 4~~5~~ -6~~7~~ of this document for these scales)

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

1. **Congestive Heart Failure (CHF)**
   - ☐ The member has been hospitalized with a primary diagnosis of CHF with no further invasive interventions planned OR
   - ☐ New York Heart Association (NYHA) heart failure classification III or higher NYHA (Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea or angina pain.)

   AND one of the following:
   - ☐ The member has an ejection fraction of < 30 for systolic failure
   - ☐ Significant comorbidities such as stage IV renal disease, coronary artery disease with persistent angina, severe lung disease, diabetes with significant vascular or neurologic complications, severe dementia
   - ☐ Heart failure due to advanced diastolic dysfunction with preserved ejection fraction
   - ☐ Other severe cardiomyopathy or non-operable severe valvular heart disease

2. **Pulmonary Disease:**

   Chronic Obstructive Pulmonary Disorder (COPD): Member must meet 1 or 2
   - ☐ The member has a Forced Expiratory Volume (FEV)1 less than 35% predicted and 24-hour oxygen requirement of less than 3 Liters (L) per minute, OR
   - ☐ The member has a 24-hour oxygen requirement of greater than or equal to 3L per minute.

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

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

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

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

   OR
   - ☐ The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.

6. **Progressive Degenerative Neurologic Disorder**
   - ☐ Neurodegenerative condition such as multiple sclerosis, muscular dystrophy, end-stage myasthenia gravis, Parkinson's disease or other progressive neurologic condition with significant deterioration as evidenced by any of the following:
     - ☐ dysphagia
     - ☐ aspiration pneumonia
     - ☐ unintentional weight loss of 10% or more
     - ☐ recurrent infections
     - ☐ significant cognitive decline
     - ☐ dependency on ventilator support
   - ☐ Amyotrophic Lateral Sclerosis (ALS) with a PPS score of 70 or less and a vital capacity of less than 55% predicted
   - ☐ Late stage dementia with progressive decline with both:
     - ☐ FAST scale score of 7a or more AND
     - ☐ Complications such as unintentional weight loss of 10% or more, dysphagia, aspiration pneumonia or a PPS score of 40% or less.

7. **Hematologic Disease**
   - ☐ Myelodysplastic syndrome dependent on transfusion and unresponsive to treatment **OR**
   - ☐ Sickle cell disease with organ failure, severe pulmonary hypertension, stage IV or worse renal disease, or other significant severe vascular disease.

8. **Cerebrovascular Accident**
   - ☐ PPS score of 50% or less

   AND
   - ☐ Progressive unintentional weight loss of 10% or more, **OR**
   - ☐ Recurrent infections such as aspiration pneumonia or sepsis.

9. **Renal Disease:**
   - ☐ Creatinine clearance of 15 ml/min or less **AND**
   - ☐ Discontinuing or declining dialysis and not seeking kidney transplant

10. **Acquired Immunodeficiency Syndrome (AIDS):** A CD4 count less than 200 or a positive HIV test and an AIDS defining condition
    - ☐ Chooses to forego antiviral treatment

    Or has one of these AIDS related conditions:
    - ☐ Advanced AIDS dementia complex
    - ☐ CNS lymphoma or systemic lymphoma unresponsive to treatment
    - ☐ Kaposi's sarcoma unresponsive to treatment
    - ☐ Mycobacterium avium complex infection unresponsive to treatment
    - ☐ Progressive wasting syndrome

11. **Other Covered Conditions may be considered on a case to case basis:**
    - ☐ Serious pre-terminal medical condition with a life expectancy of one year or less
    - ☐ PPS score of 70% or less
    - ☐ Member has received maximal member-desired treatment or treatment is no longer effective
    - ☐ Member is using inpatient or emergency department utilization for symptom management

Palliative Performance Scale (PPSv2)

PPS Level %	Ambulation ~~1~~	Activity & Evidence of Disease ~~2~~	Self-Care ~~3~~	Intake ~~4~~	Conscious Level ~~5~~
100%	Full	Normal Activity & Work, No Evidence of Disease	Full	Normal	Full
90%	Full	Normal Activity & Work, Some Evidence of Disease	Full	Normal	Full
80%	Full	Normal Activity & Work with e~~E~~ffort, Some e~~E~~vidence of d~~D~~isease	Full	Normal or Reduced	Full
70%	Reduced	Unable to do ~~to do~~ normal activity & work, Significant disease	Full	Normal or Reduced	Full
60%	Reduced	Unable to do hobby/ house work, ~~for most activities ,~~ Significant Disease	Occasional Assistance	Normal or Reduced	Full or Confusion
50%	Mainly sit/ lie~~Chair~~	Unable to do any work, ~~Minimal Activity,~~ Extensive Disease	Considerable Assistance	Normal or Reduced	Full or Drowsy or ~~±~~ Confusion
40%	Mainly in b~~B~~ed	~~As Above~~Unable to do most activity, Extensive disease	Mainly Assisted	Normal or Reduced	Full or Drowsy ± Confusion
30%	Totally b~~B~~ed b~~B~~ound	~~As Above~~Unable to do any activity, Extensive disease	Total Care	Normal or Reduced	Full or Drowsy ± Confusion
20%	Totally bed bound~~Moribund~~	~~As Above~~Unable to do any activity, Extensive disease	Total Care	Minimal s~~S~~ips	Full or Drowsy ± Confusion
10%	Totally bed bound~~Moribund~~	Unable to do any activity, Extensive disease~~As Above~~	Total Care	Mouth c~~C~~are o~~O~~nly	Drowsy or Coma
0%	Death	—	—	—~~0~~	—~~0~~

Instructions: PPS level is determined by reading left to right to find a 'best horizontal fit.' Begin at left column reading downwards until current ambulation is determined, then, read across to next and downwards until each column is determined. Thus, 'leftward' columns take precedence over 'rightward' columns.

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Victoria Hospice Society, Michael Downing, MD
https://victoriahospice.org/wp-content/uploads/2020/08/PPSv2-QA-Instructions-and-Definitions-updated-July-2020.pdf

Karnofsky Performance Status Scale

Able to carry on normal activity and to work; no special care needed	100	Normal, no complaints, no evidence of disease
	90	Able to carry on normal activity; minor signs or symptoms of disease
	80	Normal activity with effort; some signs or symptoms of disease
Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed	70	Cares for self; unable to carry on normal activity or to do active work
	60	Requires occasional assistance but is able to care for most of his/her personal needs
	50	Requires considerable assistance and frequent medical care
Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly	40	Disabled; requires special care and assistance
	30	Severely disabled; hospitalization is indicated;~~hospital admission necessary; active supportive treatment~~ although death not imminent
	20	Very sick, hospital admission necessary; active supportive treatment necessary
	10	Moribund; fatal processes progressing rapidly
	0	Deceased

Karnofsky, D.A., Abelmann, W.H., Craver, L.F. and Burchenal, J.H. (1948), The use of the nitrogen mustards in the palliative treatment of carcinoma. With particular reference to bronchogenic carcinoma. Cancer, 1: 634-656. https://doi.org/10.1002/1097-0142(194811)1:4<634::AID-CNCR2820010410>3.0.CO;2-L

Eastern Cooperative Oncology Group (ECOG) Performance Status Scale

Grade	ECOG Performance Status
0	Fully Active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g. light house work, office work
2	Ambulatory and capable of all self-care but unable to carry out any work activities.; up and about more than 50% or waking hours
3	Capable of only limited self-care; confined to bed or chair more than 50% of waking hours
4	Completely disabled; cannot carry on any self-care. Totally confined to bed or chair
5	Dead

Oken MM, Creech RH, Tormey DC, Horton J, Davis TE, McFadden ET, Carbone PP. Toxicity and response criteria of the Eastern Cooperative Oncology Group. *Am J Clin Oncol.* 1982 Dec;5(6):649-655. PMID: 7165009.

Credit: The ECOG Performance Status Scale was developed by the Eastern Cooperative Oncology Group (ECOG), now the ECOG-ACRIN Cancer Research Group, and published in 1982. To learn more, visit ecog-acrin.org/scale.

<table>
<tr><td colspan="3">Policy/Procedure Number: MPUP3137 (previously MCUP3137)</td><td colspan="2">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Palliative Care: Intensive Program (Adult)</td><td colspan="2">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 06/21/2017</td><td colspan="3">Next Review Date: 06/10/2027
Last Review Date: 06/10/2026</td></tr>
<tr><td>Applies to:</td><td>☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td>☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td>☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td>☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO ☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: 06/10/2026</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. MPCR13A – Credentialing of Hospice and Palliative Care Medicine Specialist
   E. MPCR300 – Physician Credentialing and Re-credentialing Requirements
   F. MPCR301 – Non-Physician Clinician Credentialing and Re-credentialing Requirements
   G. CGA024 – Medi-Cal Member Grievance System
   H. MPQP1022 – Site Review Requirements and Guidelines
   I. MPQP1038 – Physician Orders for Life-Sustaining Treatment (POLST)

II. **IMPACTED DEPTS**:
   A. Health Services
   B. Provider Relations
   C. Member Services
   D. Claims

III. **DEFINITIONS**:
   A. ED: Emergency Department
   B. Hospice Care: Services provided to a terminally ill patient with a prognosis of life of 6 months or less, if the disease follows its normal course.
   C. Interdisciplinary Care Team (ICT): ICT will only be applicable for Partnership Advantage Members. A group of key stakeholders including, at minimum, the Member, their Primary Care Provider (PCP), and case manager. This core group is responsible for developing, implementing, and evaluating the Member's individualized care plan. This includes the oversight and coordination of care for Partnership Advantage Members and may include additional specialists and family members if relevant to the Member's care needs. The extended ICT may also include other stakeholders who provide support as required across transitions and care settings. For Partnership Advantage Members with a serious illness participating in the palliative care program, Partnership will use a palliative care ICT.
   D. Medical Necessity: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
   E. Partnership Advantage: Effective January 1, 2028, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of

age or older who reside in the applicable counties. Partnership Advantage enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

F. Palliative Care: Patient and family-centered care that optimizes qualify of life by anticipating, preventing, and treating suffering.
G. Palliative Care Team: A group of healthcare individuals such as a Doctor of Medicine (MD) or Osteopathy (DO), Physician Assistant (PA), Nurse Practitioner (NP), Registered Nurse (RN), Medical Social Worker (MSW) and/or Chaplain who work together to meet the physical, medical, psychological, emotional and spiritual needs of a Member and the Member's family and assist in identifying sources of pain and discomfort.
H. RAF: Referral Authorization Form – The primary care provider (PCP) submits a RAF to Partnership HealthPlan of California (Partnership) to refer a Partnership Member to a specialist for evaluation and/or treatment.
I. TAR: Treatment Authorization Request – A request for a treatment, procedure, or service to be performed by a requested specialist or professional services in a health care setting, normally outside the requesting practitioner's office.

IV. ATTACHMENTS:

A. Adult Palliative Care Eligibility Assessment
B. Palliative Care Patient Summary
C. Engagement and Enrollment Process for Outpatient Palliative Care
D. Application to be a Contracted Outpatient Palliative Care Provider

V. PURPOSE:

To define Partnership HealthPlan of California's Palliative Care services for eligible beneficiaries ages 21 or older.

VI. POLICY / PROCEDURE:

A. ADULT GENERAL ELIGIBILITY CRITERIA
   1. In order to receive payment for services described in this policy, provider organizations must submit an application for approval (Attachment D) and have a palliative care contract in place with Partnership.
   2. The Intensive Palliative Care Management benefit is limited to Members who have Partnership HealthPlan of California as their primary insurance, either for Medi-Cal, or as a Partnership Advantage Member.
   3. A Member must meet all criteria below and at least one of the covered disease-specific criteria outlined in Section VI.B.6 to be eligible for Intensive Palliative Care services. Exceptions for other diagnoses will be made on a case-by-case basis as described below:
      a. The Member is likely to, or has started to, use the hospital or emergency department as a means to manage unanticipated decompensation in their late stage of illness.
      b. Member is in a late stage of illness (section VI.B.1.a.) and is not eligible for, or declines, hospice enrollment.
      c. The Member's death within a year would not be unexpected based on clinical status, as documented on the patient summary (Attachment B)
      d. Member has received maximum Member-desired medical therapy, or for whom treatment is no longer effective. Member should be evaluated in their best compensated state after receiving or being offered appropriate treatments to manage their underlying illnesses. Member is not in reversible acute decompensation.

e. Patient has a Palliative Performance Scale or Karnofsky Performance Scale score of 70 or less or an Eastern Cooperative Oncology Group (ECOG) score of 3 or 4.
f. Member, and if applicable, family/patient-designated support person, agree to both of the following:
    1) Willing to attempt in-home, residential or outpatient disease management as recommended by the Palliative Care team (and Palliative Care ICT for Partnership Advantage Members) instead of first going to the emergency department.
    2) Willing to participate in Advance Care Planning discussions.

B. ADULT MEMBER ENGAGEMENT AND ENROLLMENT PROCESS

1. Patient Palliative Care Assessment and Consultation (Engagement):
    a. No prior authorization is required for the engagement process before speaking with a Member who meets one or more of the following diagnostic categories.
        1) Congestive Heart Failure (CHF)
        2) Pulmonary Disease
        3) Advanced Cancer
        4) Advanced Liver Disease
        5) Progressive Degenerative Neurologic Disorder
        6) Hematologic Disease
        7) Cerebrovascular Accident
        8) Renal Disease
        9) Acquired Immunodeficiency Syndrome
        10) Other Conditions
    b. If the Member has one of the covered diagnoses listed above and does not meet the general or specific criteria or life expectancy for enrollment, submit a retroactive TAR for the engagement only. Engagement requires a comprehensive evaluation to include:
        1) Goals of care discussion and assessment of the Member's emotional and social support
        2) Advance care planning discussion including POLST discussion if appropriate
    c. If the Member meets the criteria for engagement AND enrollment criteria, submit a TAR for engagement along with the TAR for enrollment. Submit the TAR for engagement with progress or consultation notes documenting the following:
        1) One of the covered diagnoses or other pre-terminal conditions as defined in section VI.B.6
        2) Date of face-to-face or telemedicine visit with Doctor of Medicine (MD) or Osteopathy (DO), Nurse Practitioner (NP), Physician Assistant (PA), or Registered Nurse (RN)
        3) Advance care planning discussion with goals of care document
        4) Care Plan addressing medical, social, emotional and spiritual needs
        5) Include consultation or hospital discharge notes that confirm the Member's diagnosis, extent of disease, prognosis, functional status and goals of care
    d. A multidisciplinary comprehensive assessment is required.
    e. Engagement will occur after discharge from the hospital.
    f. When requested, Partnership will generate regional lists of Members who may qualify for palliative care services, providing these to community primary care and specialty providers to evaluate for potential referral to locally available palliative care clinicians and/or intensive palliative care providers. If Partnership determines that an intensive palliative care provider has the demonstrated capacity and capability to do active direct outreach to potential recipients of palliative care, Partnership will provide the list of local Members potentially qualifying for intensive palliative care services to the intensive palliative care provider, for the provider to perform this direct engagement coordinated with the Member's primary providers.
    g. Partnership intensive care management teams may identify and refer care managed Members who are potentially eligible for this benefit, to a contracted Partnership palliative care provider

2. Adult Enrollment Criteria (see Attachment C for detailed requirements)
   a. For Members who meet the disease specific criteria (VI.B.6)
      1) Submit a TAR for the Member's enrollment into the Intensive Home-Based Palliative Care program to Partnership in accordance with Partnership policy MCUP3041 TAR Review Process. With an enrollment TAR, the Provider must submit the information required for the engagement TAR [VI.B.1.c. 1) thru 4)] as well as:
         a) Eligibility Assessment Form (Attachment A)
         b) Patient Summary document (Attachment B)
   b. For Members in the hospital, enrollment will take place after discharge. The Palliative Care Management TAR will be approved for three months.
   c. Enrolled Members must have at minimum:
      1) One in-person or video visit by an RN every month
         a) The registered nurse must see the patient face to face a minimum of once in every 12-week period
         b) If face-to-face visits with the RN are not possible due to distance or other operation issues, palliative care providers may submit charges under the "virtual only care" billing code T2025 GT.
      2) One in-person or video visit by a social worker every month
      3) Standardized assessments of symptoms must be done approximately every 14 days. Assessments may be completed face to face, via telemedicine or telephonically.
3. Adult Re-Enrollment Criteria
   A new TAR is required every 3 months for all patients receiving Intensive Outpatient Palliative Care services. The TAR must include documentation and submission of the following items:
   a. Palliative Care Patient Summary (Attachment B) completed by the palliative care physician, nurse practitioner or physician's assistant
   b. Detailed progress notes completed by the palliative care physician, nurse practitioner or specialist documenting relevant specific clinical information showing continued decline in functional status and clinical condition as evidenced by decreasing palliative performance scale scores, weight loss or other specific documentation of decline in function and health (e.g. labs and imaging, include results if completed in the previous 3 months)
   c. Medical records must include a recent face to face visit by the registered nurse, medical provider (MD or DO, nurse practitioner, or physician assistant) that documents the patient's current clinical condition.
   d. For remote Members seen only through telemedicine visits, the medical records must include a recent detailed visit by the RN, NP or physician that clearly documents the patient's current clinical condition and functional status.
4. Remote Hospice Level Care
   A Member who lives in an area remote from Medi-Cal Hospice providers may be cared for under the intensive palliative care benefit at a higher reimbursement rate. The Member must be pre-approved via Partnership's TAR review process for palliative care to allow for billing under code T2025-TN.
   a. The Member must live more than 30 miles from the nearest Medi-Cal Hospice, or the palliative care provider must submit documentation that, although the Member meets hospice criteria, the local hospice is not able to enroll the Member for non-medical reasons.
   b. The Member must be seen in-person at least once a month by the palliative care RN.
5. Adult Disenrollment Criteria
   a. Member is not eligible for Partnership for more than 30 days
   b. Member moves out of the service area
   c. Member declines participation after enrollment

d. Member refuses to be contacted
e. Member cannot be reached or is lost to follow-up for 30 days
f. Member exhibits inappropriate or threatening behavior towards staff
g. Member is under the influence or illegal drugs or alcohol during visits
h. Member poses a safety or security risk to staff, other patients or clinic property
i. Member is deceased
j. Member is incarcerated for more than 30 days
k. Member enters a different equally intensive care management program
l. Member enters hospice
m. Member's condition stabilizes and/or is unlikely to meet 1 year life expectancy criteria
n. Member enrolls in Medicare with another health plan: A Member who becomes eligible for Medicare after enrollment into Partnership Medi-Cal may continue to receive palliative care services until the current TAR expires.
    1) Members who enroll into the Partnership Advantage (Medicare) plan are eligible for Intensive Palliative Care through Partnership.

6. Adult Disease Specific Criteria
    a. **Congestive Heart Failure (CHF)**:
        1) The Member has been hospitalized with a primary diagnosis of CHF with no further invasive interventions planned OR meets criteria for New York Heart Association (NYHA) heart failure classification III or higher, AND
            a) The Member has an ejection fraction of < 30% for systolic failure OR
            b) Significant comorbidities such as stage IV renal disease, coronary artery disease with persistent angina, severe lung disease, diabetes with significant vascular or neurologic complications, severe dementia OR
            c) Heart failure due to advanced diastolic dysfunction with preserved ejection fraction OR
            d) Other severe cardiomyopathy or non-operable severe valvular heart disease.
    b. **Pulmonary Disease:**
        1) **Chronic Obstructive Pulmonary Disorder (COPD)**: Member must meet 1) or 2)
            a) The Member has a Forced Expiratory Volume (FEV)1 less than 35% predicted and 24-hour oxygen requirement of less than 3 Liters (L) per minute, OR
            b) The Member has a 24-hour oxygen requirement of greater than or equal to 3L per minute.
        2) Other Progressive Pulmonary Disease:
            a) Idiopathic Pulmonary fibrosis, Primary Pulmonary Hypertension, or Cystic Fibrosis WITH
                i. Disabling dyspnea at rest AND
                ii. Hypoxemia (oxygen saturation < 88%) on 2 LPM AND
                iii. Poorly response or unresponsive to standard treatment.
    c. **Advanced Cancer**: Member must meet 1) and 2)
        1) The Member has a diagnosis of stage III or IV cancer, AND
        2) The Member has a Palliative Performance Scale (PPS) or Karnofsky Performance Scale (KPS) score less than or equal to 70, Eastern Cooperative Oncology Group (ECOG) score of 3 or 4 OR has failure of two lines of standard of care therapy (chemotherapy or radiation therapy) OR
        3) Member refuses further treatment for the cancer
    d. **Advanced Liver Disease**: Member must meet 1) and 2) combined, or 3) alone
        1) The Member has evidence of irreversible liver damage, serum albumin less than 3.0, and Internal Normalized Ratio (INR) greater than 1.3, AND
        2) The Member has a history of ascites, bacterial peritonitis, hepatic encephalopathy,

hepatorenal syndrome, or recurrent esophageal varices, OR

3) The Member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.

e. **Progressive Degenerative Neurologic Disorder**

1) Neurodegenerative condition such as multiple sclerosis, muscular dystrophy, end-stage myasthenia gravis, Parkinson's disease or other progressive neurologic condition with significant deterioration as evidenced by dysphagia, aspiration pneumonia, unintentional weight loss of 10% or more, recurrent infections, significant cognitive decline or dependency on ventilator support.
2) Amyotrophic Lateral Sclerosis (ALS) with a PPS score of 70 or less and a vital capacity of less than 55% predicted.
3) Late-stage dementia with progressive decline with both:
   a) FAST scale score of 7a or more AND
   b) Complications such as unintentional weight loss, dysphagia, aspiration pneumonia or a PPS score of 40% or less.

f. **Hematologic Disease**

1) Myelodysplastic syndrome dependent on transfusion and unresponsive to treatment **OR**
2) Sickle cell disease with organ failure, severe pulmonary hypertension, stage IV or worse renal disease, or other significant severe vascular disease.

g. **Cerebrovascular Accident**

1) PPS score of 50% or less **AND**
2) Progressive unintentional weight loss of 10% or more, **OR**
3) Recurrent infections such as aspiration pneumonia or sepsis.

h. **Renal Disease:**

1) Creatinine clearance of 15 ml/min or less **AND**
2) Discontinuing or declining dialysis and not seeking kidney transplant

i. **Acquired Immunodeficiency Syndrome (AIDS):** A patient with a CD4 count less than 200 or a positive HIV test and an AIDS defining condition who chooses to forego antiviral treatment or has one of these AIDS related conditions:

1) Advanced AIDS dementia complex
2) CNS lymphoma or systemic lymphoma unresponsive to treatment
3) Kaposi's sarcoma unresponsive to treatment
4) Mycobacterium avium complex infection unresponsive to treatment
5) Progressive wasting syndrome

j. **Other patients may be considered for the palliative care benefit on a case-by-case basis.** Consideration will depend upon the patient's functional status, pre-terminal condition and disease trajectory, hospital and emergency department utilization or the patient declining hospice services.

7. Providers of Services

a. Partnership will contract with qualified palliative care providers such as hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and Community Based Adult Service (CBAS) facilities that utilize providers with current palliative care training and/or certification to deliver authorized palliative care services to Members in accordance with this policy, existing Medi-Cal contracts and/or All Plan Letters. Certification of qualified palliative care providers shall occur in accordance with Partnership policies MPCR300 Physician Credentialing and Re-credentialing Requirements and MPCR301 Non-Physician Clinician Credentialing and Re-credentialing Requirements. Partnership will authorize palliative care services to be provided in a variety of settings including, but not limited to, inpatient, outpatient

or community-based settings. Palliative care provided in a Member's home must comply with existing Partnership policies and Medi-Cal requirements for in-home providers, services, and authorization such as physician assessments and care plans.

b. All approved Palliative Care service providers shall be listed in Partnership's Provider Directory.

c. Partnership-contracted intensive palliative care providers will contact Members referred to their program for evaluation within 7 calendar days to arrange an evaluation and assessment.

d. Provider organization must submit an application to become a contracted Intensive Home-Based Palliative Care Provider (See Attachment D for application). Criteria for consideration includes the following:
   1) Completed application (Attachment D)
   2) Organization or all providers are contracted Medi-Cal providers
   3) Organization must have the capacity to bill Partnership for services provided
   4) Organizations that are already contracted with Partnership for other services must be providers in good standing
   5) Clinical staff are trained in palliative care. Minimum training is the California State University San Marcos/ Shiley Haynes Institute for Palliative Care training curriculum, or equivalent, which must be completed by a staff Member no later than 3 months after beginning to work for the Intensive Outpatient Palliative Care Organization. Medical Director may be board certified, board eligible or have one year (at least 200 hours) in hospice or palliative care experience.
   6) Core staffing identified (hired or contracted to be hired by contract start date):
      a) Medical Director
      b) Registered Nurse
      c) Social Worker
      d) Administrator
   7) Organization or Medical Director already providing services in the region for at least 6 months prior to contracting.

e. Submission of an application does not guarantee that Partnership will contract with an organization. Submitted applications will be evaluated based on a variety of criteria including, but not limited to, the quality and completeness of the application, geographic network adequacy, and history of the organization submitting the application.

f. Contracted sites must pass a Partnership facility and medical record site audit within 3 months of contract start date, and every 3 years afterwards. Sites which do not pass the audit may have their contract terminated for cause, or may be required to submit and complete a corrective action plan. Timelines and appeals process for this audit will follow the general standards defined in Partnership policy MPQP1022 Site Review Requirements and Guidelines.

VII. REFERENCES:

A. Section 2302 of the Patient Protection and Affordable Care Act (ACA)
B. Centers for Medicare & Medicaid Services (CMS) *Medicare Benefit Policy Manual*
C. Title 22, California Code of Regulations (CCR) / Hospice Care 51349
D. Social Security Act 1812(d)(1)
E. Welfare and Institutions Code Section 14132.75
F. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020 Palliative Care (12/07/2018)
G. Medi-Cal Provider Manual/ Guidelines: Palliative Care *(palli care)*
H. DHCS "CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide - Contract Year 2026" (February 2026)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2028)
06/11/25; 06/10/26

Medi-Cal
11/15/17; *02/14/18; 02/13/19; 02/12/20; 02/10/21; 05/11/22: 06/14/23; 01/10/24; 01/08/25; (MPUP3137) 06/11/25; 06/10/26

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

MCUP3122 - Palliative Care policy was archived 06/21/2017

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPUP3136 (previously MCUP3136)			**Lead Department: Health Services** **Business Unit:** Utilization Management	
Policy/Procedure Title: ~~Fecal Microbiota Transplant (FMT)~~ Microbiota-Based Therapeutics (MBT)			☒**External Policy** ☐ **Internal Policy**	
Original Date: 05/17/2017		**Next Review Date:** ~~06/11/2026~~06/10/2027 **Last Review Date:** ~~06/11/2025~~06/10/2026		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~06/11/2025~~06/10/2026	

I. RELATED POLICIES:

A. MCUP3041 —Treatment Authorization Review (TAR) Review Process
B. MPUP3042 —Technology Assessment
~~B.~~C. MCRP4068 Medical Benefit Medication TAR Policy

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

~~Fecal microbiota transplantation (FMT) – the transfer of a processed stool specimen from a healthy donor to a diseased recipient for the purpose of restoring a normal population of bacteria to the colon of the recipient. Also known as fecal biotherapy, fecal bacteriotherapy, stool or fecal transplant, fecal transfusion, fecal enema and human probiotic infusion.~~ Microbiota-Based Therapeutics (MBT) (including Fecal Microbiota Transplantation or [FMT]) – The transfer of a prepared microbial community, either derived from the processed stool of a healthy donor or synthesized from defined, lab-grown microbial consortia, to a recipient. The purpose of this therapy is to restore a healthy and diverse microbial ecosystem to the recipient's gastrointestinal tract. This procedure is also known as fecal biotherapy, fecal bacteriotherapy, stool or fecal transplant, fecal transfusion, fecal enema and human probiotic infusion.

A.
B. *Clostridioides* (formerly *Clostridium*) *difficile* infection (CDI) - confirmed stool test positive for toxigenic *C. difficile* and patient currently has symptoms of watery diarrhea.
C. Non-severe CDI – CDI with documented White Blood Cell Count ≤15,000 cells/ml and serum creatinine <1.5 mg/dL. [E]
D. Severe CDI - CDI with WBC >15,000 cells/mL and/or serum creatinine ≥1.5 mg/dL. [E]
E. Complicated/fulminant CDI – CDI associated with hypotension or shock, ileus or megacolon. [E]
F. Recurrent or relapsing CDI (RCDI) – a second or greater episode of documented CDI.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The purpose of the ~~F~~MBT policy is to assist Utilization Management (UM) staff with decision making when reviewing Treatment Authorization Requests (TARs) for ~~FMT~~ MBT to treat confirmed recurrent CDI that has failed standard CDI treatment.

VI. POLICY / PROCEDURE:

A. A Treatment Authorization Request (TAR) is required for all ~~FMT~~ MBT procedures.

B. Partnership HealthPlan of California (Partnership) considers ~~FMT~~ MBT medically indicated in cases of recurrent CDI as follows:

1. Eligibility Criteria:
   a. Member must be 18 years of age or older.
   b. Documentation of current symptomatic recurrent CDI.
   c. Documentation of at least a moderate **second or more** episode of RCDI (as defined above) which is a third episode or more of CDI, unresponsive to standard AND alternate treatments.
      1) ~~FMT~~ MBT is no longer recommended as first line treatment for fulminant CDI.[E]
   d. Patient is not immunocompromised (including neutropenia).
   e. Severe or fulminant CDI in the hospital and the patient is not improving after completing standard antimicrobial therapy for CDI.
   f. All other uses of MBT~~FMT~~ are considered experimental or investigational, including first line treatment of CDI and the treatment of inflammatory bowel disease.
2. Methodology
   ~~a. FMT is limited to centers of expertise.~~
   ~~b.~~a. ~~FMT~~ MBT may be administered by colonoscopy, nasogastric or jejunal tube, enema, or oral route, as available from the provider performing the procedure.
   ~~c.~~b. The provider performing the ~~FMT~~ MBT and facility providing the transplant materials must comply with the U.S. Food and Drug Administration's regulations regarding MBT~~FMT~~[A].

VII. REFERENCES:

A. U.S. FDA Vaccines, Blood and Biologics Bulletin- Guidance for Industry: Enforcement Policy Regarding Investigational New Drug Requirements for Use of Fecal Microbiota for Transplantation to Treat *Clostridium difficile* Infection Not Responsive to Standard Therapies November 2022

B. ~~TJ Borody, MD~~Ramrakha S, Agrawal G ~~et al~~. Fecal microbiota transplantation for treatment of *Clostridioides difficile* infection; UpToDate. ~~Accessed~~ Last updated ~~03/21/2025~~04/09/2026.~~04/12/2024~~

C. Moore T, Rodriguez A, Bakken J ~~et al~~. Fecal Microbiota Transplantation: A Practical Update for the Infectious Disease Specialist; Clin Infect Dis ~~(~~2014 Feb 15;~~)~~ 58 (4) 541-545; doi.org/10.1093/CID/cit950. ~~Accessed March 24, 2017~~

D. Cho, Janice M. *et al*. Update on Treatment of *Clostridioides difficile* Infection; Mayo Clin Proc. April 2020; 95(4): 758-769. https://www.mayoclinicproceedings.org/ ~~Accessed March 23, 2021.~~

E. Johnson, Stuart et al. Clinical Practice Guideline by the Infectious Diseases Society of America (IDSA) and Society for Healthcare Epidemiology of America (SHEA): 2021 Focused Update Guidelines on Management of *Clostridioides difficile* Infection in Adults *Clinical Infectious Diseases*, Volume 73, Issue 5, 1 September 2021, Pages e1029–e1044, https://doi.org/10.1093/cid/ciab549 ~~Accessed March 30, 2022.~~

F. Consideration for Use of Fecal Microbiota-Based Therapies in Adults With GI Disorders. Gastroenterology, Volume 166, Issue 3, p.435. March 2024. DOI: 10.1053/S0016-5085(24)00075-1

G. Shapiro, M. (2024, February 21). AGA now recommends fecal microbiota transplant for the majority of recurrent C. diff patients. American Gastroenterological Association. https://gastro.org/press-releases/aga-recommends-fecal-transplant-for-recurrent-cdiff-patients/

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2028)
06/11/25; 6/10/26

Medi-Cal
*06/13/18; 06/12/19; 06/10/20; 06/09/21; 06/08/22; 06/14/23; 06/12/24; (MPUP3136) 06/11/25; 6/10/26

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:
N/A

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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.

Policy/Procedure Number: MPUP3136 (previously MCUP3136)			**Lead Department: Health Services** **Business Unit:** Utilization Management	
Policy/Procedure Title: Microbiota-Based Therapeutics (MBT)			☒**External Policy** ☐ **Internal Policy**	
Original Date: 05/17/2017		**Next Review Date: 06/10/2027** **Last Review Date: 06/10/2026**		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date: 06/10/2026**	

I. RELATED POLICIES:

A. MCUP3041 Treatment Authorization Review (TAR) Review Process
B. MPUP3042 Technology Assessment
C. MCRP4068 Medical Benefit Medication TAR Policy

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Microbiota-Based Therapeutics (MBT) (including Fecal Microbiota Transplantation or [FMT]) – The transfer of a prepared microbial community, either derived from the processed stool of a healthy donor or synthesized from defined, lab-grown microbial consortia, to a recipient. The purpose of this therapy is to restore a healthy and diverse microbial ecosystem to the recipient's gastrointestinal tract. This procedure is also known as fecal biotherapy, fecal bacteriotherapy, stool or fecal transplant, fecal transfusion, fecal enema and human probiotic infusion.
B. *Clostridioides* (formerly *Clostridium*) *difficile* infection (CDI) - confirmed stool test positive for toxigenic *C. difficile* and patient currently has symptoms of watery diarrhea.
C. Non-severe CDI – CDI with documented White Blood Cell Count ≤15,000 cells/ml and serum creatinine <1.5 mg/dL. [E]
D. Severe CDI - CDI with WBC >15,000 cells/mL and/or serum creatinine ≥1.5 mg/dL. [E]
E. Complicated/fulminant CDI – CDI associated with hypotension or shock, ileus or megacolon. [E]
F. Recurrent or relapsing CDI (RCDI) – a second or greater episode of documented CDI.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The purpose of the MBT policy is to assist Utilization Management (UM) staff with decision making when reviewing Treatment Authorization Requests (TARs) for MBT to treat confirmed recurrent CDI that has failed standard CDI treatment.

VI. POLICY / PROCEDURE:

A. A Treatment Authorization Request (TAR) is required for all MBT procedures.
B. Partnership HealthPlan of California (Partnership) considers MBT medically indicated in cases of recurrent CDI as follows:
   1. Eligibility Criteria:

a. Member must be 18 years of age or older.
b. Documentation of current symptomatic recurrent CDI.
c. Documentation of at least a moderate **second or more** episode of RCDI (as defined above) which is a third episode or more of CDI, unresponsive to standard AND alternate treatments.
   1) MBT is no longer recommended as first line treatment for fulminant CDI.[E]
d. Patient is not immunocompromised (including neutropenia).
e. Severe or fulminant CDI in the hospital and the patient is not improving after completing standard antimicrobial therapy for CDI.
f. All other uses of MBT are considered experimental or investigational, including first line treatment of CDI and the treatment of inflammatory bowel disease.

2. Methodology
   a. MBT may be administered by colonoscopy, nasogastric or jejunal tube, enema, or oral route, as available from the provider performing the procedure.
   b. The provider performing the MBT and facility providing the transplant materials must comply with the U.S. Food and Drug Administration's regulations regarding MBT[A].

VII. REFERENCES:

A. U.S. FDA Vaccines, Blood and Biologics Bulletin- Guidance for Industry: Enforcement Policy Regarding Investigational New Drug Requirements for Use of Fecal Microbiota for Transplantation to Treat *Clostridium difficile* Infection Not Responsive to Standard Therapies November 2022
B. Ramrakha S, Agrawal G. Fecal microbiota transplantation for treatment of *Clostridioides difficile* infection; UpToDate. Last updated 04/09/2026.
C. Moore T, Rodriguez A, Bakken J. Fecal Microbiota Transplantation: A Practical Update for the Infectious Disease Specialist; Clin Infect Dis 2014 Feb 15; 58 (4) 541-545; doi.org/10.1093/CID/cit950
D. Cho, Janice M. *et al*. Update on Treatment of *Clostridioides difficile* Infection; Mayo Clin Proc. April 2020; 95(4): 758-769. https://www.mayoclinicproceedings.org/
E. Johnson, Stuart et al. Clinical Practice Guideline by the Infectious Diseases Society of America (IDSA) and Society for Healthcare Epidemiology of America (SHEA): 2021 Focused Update Guidelines on Management of *Clostridioides difficile* Infection in Adults *Clinical Infectious Diseases*, Volume 73, Issue 5, 1 September 2021, Pages e1029–e1044, https://doi.org/10.1093/cid/ciab549
F. Consideration for Use of Fecal Microbiota-Based Therapies in Adults With GI Disorders. Gastroenterology, Volume 166, Issue 3, p.435. March 2024. DOI: 10.1053/S0016-5085(24)00075-1
G. Shapiro, M. (2024, February 21). AGA now recommends fecal microbiota transplant for the majority of recurrent C. diff patients. American Gastroenterological Association. https://gastro.org/press-releases/aga-recommends-fecal-transplant-for-recurrent-cdiff-patients/

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2028)
06/11/25; 6/10/26

Medi-Cal
*06/13/18; 06/12/19; 06/10/20; 06/09/21; 06/08/22; 06/14/23; 06/12/24; (MPUP3136) 06/11/25; 6/10/26

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:
N/A

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPUP3047 (previously MCUP3047, UP100347)			**Lead Department:** Health Services **Business Unit:** Utilization Management	
Policy/Procedure Title: Tuberculosis Related Treatment			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 07/31/2000		**Next Review Date:** **Last Review Date:**	~~06/11/2026~~06/10/2027 ~~06/11/2025~~06/10/2026	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~06/11/2025~~06/10/2026	

I. RELATED POLICIES:

A. MPQG1005 – Adult Preventive Health Guidelines
B. MCQG1015 – Pediatric Preventive Health Guidelines
C. MPQP1048 – Reporting Communicable Diseases
D. MCCP2035 – Local Health Department (LHD) Coordination

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. DOT: Directly Observed Therapy or the Direct Observation of the ingestion of prescribed anti-Tuberculosis medications by tuberculosis (TB) infected persons. DOT includes:
   1. Delivering of prescribed medications
   2. Assisting with the means to ingest prescribed medications
   3. Observing the ingestion of prescribed medications
   4. Monitoring for signs of non-adherence or adverse side effects
   5. Documenting that prescribed medications have been ingested and
   6. Reporting compliance and/or other problems

B. Partnership Advantage: Effective January 1, 2028~~7~~, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage ~~Members~~ enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

C. Tuberculosis (TB) related treatment means all outpatient services necessary for the medical management and follow-up of TB infection and/or active disease. This may include medical therapy, Targeted Case Management (as defined in Title 22, CCR, Section 51276) and DOT when provided by a provider meeting the qualifications (as defined in section 51276.)

IV. ATTACHMENTS:

A. TB Screening Guidelines (Flowcharts)

V. PURPOSE:

To define the roles of Partnership HealthPlan of California (Partnership) in providing TB Control and DOT for Medi-Cal and Partnership Advantage beneficiaries.

VI. POLICY / PROCEDURE:

A. Program Guidelines:

1. Partnership covers the screening, diagnosis, and follow-up care related to tuberculosis.
   a. Partnership Medi-Cal: Effective January 1, 2022 with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal Fee-For-Service as described in All Plan Letter (APL) ~~22-012~~23-015 ~~*Revised*~~ and all medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/ DHCS-contracted pharmacy administrator instead of Partnership. This includes medications used for the treatment of tuberculosis.
   b. Partnership Advantage: Effective January 1, 2028~~7~~, the pharmacy benefit for Partnership Advantage ~~Members~~ enrollees is delegated to a pharmacy benefit manager that will provide medications used for the treatment of tuberculosis.
2. Partnership will reference the current guidelines from the Center for Disease Control and Prevention (CDC), and the American Thoracic Society (ATS). For TB screening, Partnership network providers will use guidelines from the American Academy of Pediatrics (AAP) for persons age 0-20 years and from the United States Preventative Services Taskforce (USPSTF) for adults age 21 or over. The California Department of Public Health (CDPH) TB Risk Assessment Tools should be used to identify adult and pediatric patients at risk for TB.
3. Partnership network providers use laboratories that conform to Title 17, CCR, Section 2505 and CDC and ATS requirements.
4. Partnership Providers shall report all cases of confirmed or suspected active tuberculosis (TB) to the local county health department (LHD) within one day of identification in accordance with Title 17, CCR, Section 2500.

B. Directly Observed Therapy (DOT)

1. Per the California Department of Public Health (CDPH), Directly Observed Therapy (DOT) is a technique of delivering TB treatment to ensure timely completion of treatment, prevent further TB transmission, and prevent development of drug resistance.
2. National guidelines recommend DOT as standard treatment for TB disease.
3. In the event of limited available DOT resources, CDPH provides guidance on groups to be considered for DOT prioritization in their document titled, "Information for Physicians Regarding Directly Observed Therapy (DOT) for Active Tuberculosis (TB)."

~~1. Partnership Providers shall refer members with active tuberculosis (TB) to the local health department for DOT if the Member has any of the following risk categories:~~
   ~~a. Member with demonstrated multidrug-resistant tuberculosis (MDR-TB)~~
   ~~b. Member whose treatment has failed or who has relapsed after completing a prior regimen~~
   ~~c. Member is a child or adolescent~~
   ~~d. Member has demonstrated failed adherence/failure to keep appointments~~

~~2. Members in the following categories shall be referred if, in the opinion of the providers, the Member is at risk for non-adherence:~~
   ~~a. Substance users~~
   ~~b. Members with mental illness~~
   ~~c. Elderly members~~
   ~~d. Child and adolescent members~~
   ~~e. Members with unmet housing needs~~

~~f. Members with complex medical needs (e.g. end-stage renal disease, diabetes mellitus)~~
~~g. Members with language and/or cultural barriers~~
~~h. Members who have demonstrated any other reason to suspect non-adherence~~

~~3.~~4. In addition, Partnership Providers are expected to follow any local county health department regulations and instructions regarding the treatment of identified or suspected cases of active tuberculosis not covered by the above language.

~~4.~~5. Since DOT services are provided outside of Partnership's contract with the California Department of Health Care Services (DHCS), a Partnership Referral Authorization Form (RAF) is NOT required, and services will be reimbursed directly by the State of California.

~~5.~~6. The Local Health Department TB Control Program for DOT shall inform the HealthPlan of any changes to policy or of providers failing to refer members needing services.

~~6.~~7. Partnership maintains Memoranda of Understanding (MOUs) with each county it serves to ensure joint case management and care coordination with LHD TB Control Programs. Partnership provides all medically necessary covered services to members with TB on DOT.

VII. REFERENCES:

A. Center for Disease Control (CDC) guidelines https://www.cdc.gov/tb
B. Center for Disease Control (CDC) "TB 101for Health Care Workers https://www.cdc.gov/tb/webcourses/TB101/page16489.html
C. American Thoracic Society (ATS) guidelines https://www.thoracic.org/statements/tuberculosis-pneumonia.php
D. American Academy of Pediatrics (AAP) guidelines https://www.aap.org/
E. United States Preventative Services Taskforce (USPSTF) guidelines https://www.uspreventiveservicestaskforce.org/uspstf/
F. Medi-Cal Provider Manual/ Guidelines: Tuberculosis Program *(tuber)*
~~G.~~ Title 17, California Code of Regulations (CCR) Section 2500 and
~~H.~~G. ~~Title 17, California Code of Regulations (CCR)~~ Section 2505
~~I.~~H. Title 22, California Code of Regulations (CCR) Section 51276
~~J.~~I. DHCS All Plan Letter (APL) ~~22-012~~25-013 ~~*Revised* Governor's Executive Order N-01-19 Regarding Transitioning~~ Medi-Cal Rx Pharmacy Benefits and Cell and Gene Therapy Coverage ~~From Managed Care to Medi-Cal Rx~~ (~~12/30/2022~~09/18/2025)
~~K.~~J. DHCS All Plan Letter (APL) 23-029 *Revised* Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (~~10/11/2023~~08/11/2)
   1. Local Health Department Memorandum of Understanding template (DHCS Contract Attachment F)
~~L.~~K. California Department of Public Health (CDPH) TB Risk Assessment Tools
~~M.~~L. California Department of Public Health (CDPH) Information for Physicians Regarding Directly Observed Therapy (DOT) for Active Tuberculosis (TB)
~~N.~~M. California Tuberculosis Controllers Association (CTCA), Latent Tuberculosis Infection Guidance for Preventing Tuberculosis in California, available at: https://ctca.org/guidelines/guidelines-latent-tuberculosis-infection-guideline/

VIII. DISTRIBUTION:

A. Partnership Department Directors
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IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 202~~8~~7)
06/11/25; 6/10/26

Medi-Cal:
09/19/01; 10/16/02; 10/20/04; 10/19/05, 10/18/06; 10/17/07; 10/15/08, 01/20/10; 01/18/12; 05/20/15; 04/20/16; 04/19/17; *06/13/18; 05/08/19; 05/13/20; 05/12/21; 05/11/22; 04/12/23; 05/08/24; 06/11/25; 06/10/26

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PREVIOUSLY APPLIED TO: N/A

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TB Screening Guidelines
Partnership HealthPlan of California
Last updated: 2026

MPUP3047 - Attachment A
MPQG1005 - Attachment B
MCQG1015 - Attachment B
06/10/2026

Legend:

CXR: Chest X-Ray

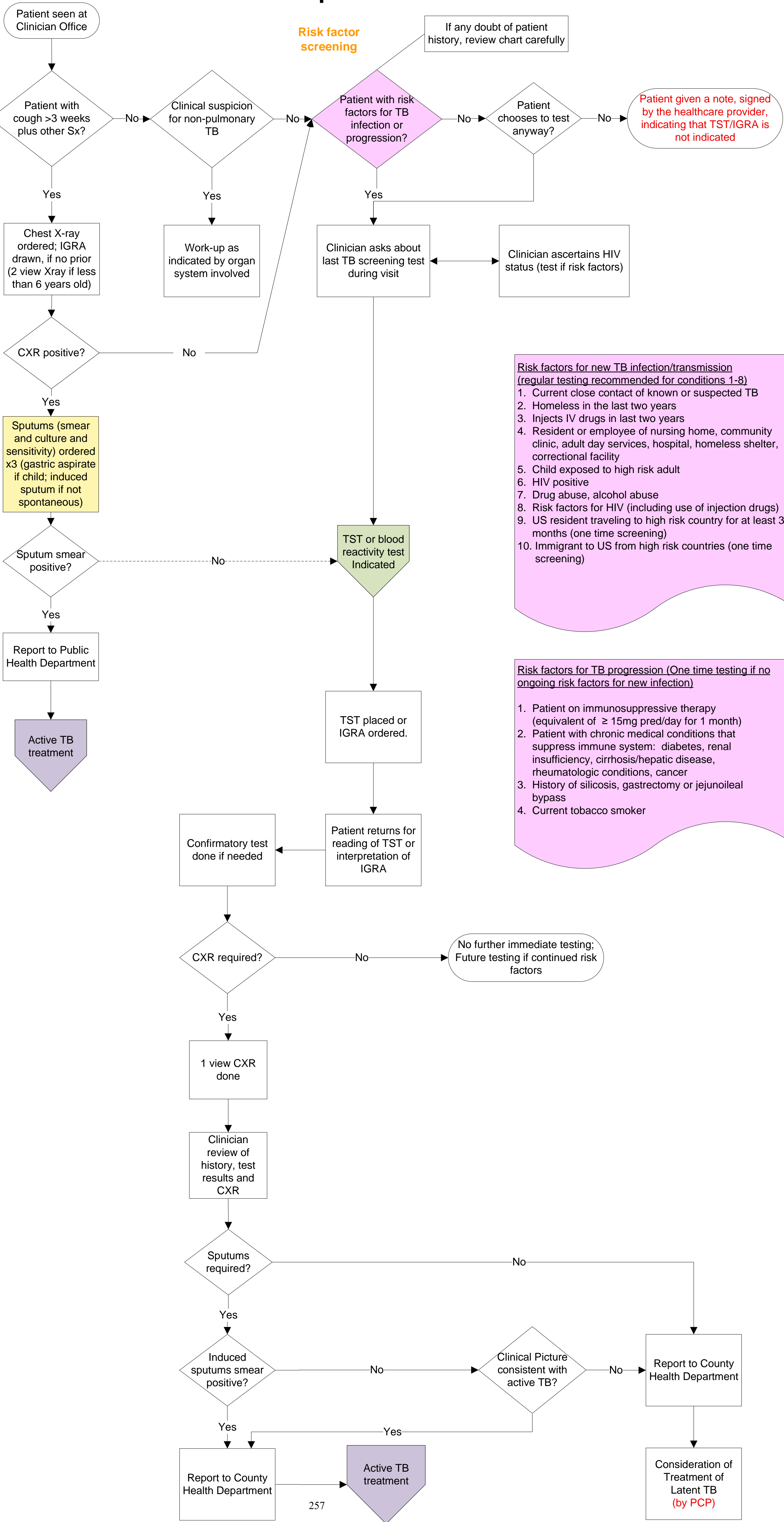
IGRA: Interferon-gamma Release Assays

TB: Tuberculosis

TST: Tuberculin Skin Test

Cough for greater than 3 weeks and one of:
1. weight loss
2. fatigue
3. night sweats
4. cough up blood

See separate protocols



Policy/Procedure Number: MPUP3047 (previously MCUP3047, UP100347)			**Lead Department:** Health Services **Business Unit:** Utilization Management	
Policy/Procedure Title: Tuberculosis Related Treatment			☒**External Policy** ☐ **Internal Policy**	
Original Date: 07/31/2000		**Next Review Date:** 06/10/2027 **Last Review Date:** 06/10/2026		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**	
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	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date: 06/10/2026**	

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IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2028)
06/11/25; 6/10/26

Medi-Cal:
09/19/01; 10/16/02; 10/20/04; 10/19/05, 10/18/06; 10/17/07; 10/15/08, 01/20/10; 01/18/12; 05/20/15; 04/20/16; 04/19/17; *06/13/18; 05/08/19; 05/13/20; 05/12/21; 05/11/22; 04/12/23; 05/08/24; 06/11/25; 06/10/26

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MCUP3104			**Lead Department: Health Services** Business Unit: Utilization Management	
Policy/Procedure Title: Transplant Authorization Process			☒**External Policy** ☐ **Internal Policy**	
Original Date: 04/21/2010		**Next Review Date: ~~02/11/2027~~06/10/2027** **Last Review Date: ~~02/11/2026~~06/10/2026**		
Applies to:	☐ **Employees**		☒ **Medi-Cal**	
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: ~~02/11/2026~~06/10/2026**	

I. RELATED POLICIES:

A. MCUP3124 – Referral to Specialists (RAF) Policy
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
C. MPUP3137 – Palliative Care: Intensive Program (Adult)
D. MCUP3140 – Palliative Care: Pediatric Program for Members Under the Age of 21
E. MPUP3039 – Direct Members
F. MP~~C~~UP3138 – External Independent Medical Review
G. MCCP2024 – Whole Child Model for California Children's Services (CCS)
H. ~~MCCP2016~~ MPTP2501 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)
I. MPTP2503 –Transportation-Related Travel Expenses: Lodging, Meals, Attendants, Parking and Tolls
J. MPCR700 – Assessment of Organizational Providers
K. MPPR200 – Provider Contracts

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Provider Relations
E. Transportation

III. DEFINITIONS:

A. Center of Excellence (COE): A Medi-Cal-approved transplant program which operates within a hospital setting, is certified and licensed through the Centers for Medicare and Medicaid Services (CMS), and meets Medi-Cal state and federal regulations consistent with 42 CFR, parts 405, 482, 488, 498 and Section 1138 of the Social Security Act (SSA) [42 USC section 1230b-8].
B. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status is based on the Member's aid code, prime insurance, demographics or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see Partnership network providers and/or certified Medi-Cal providers willing to bill Partnership for covered services. However, many specialists will still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP.
C. Organ Procurement and Transplantation Network (OPTN): The OPTN is operated under contract with the Health Resources & Services Administration (HRSA) of the U.S. Department of Health and Human

Services by the United Network for Organ Sharing (UNOS). OPTN maintains the National Waitlist but only a Transplant Program can register patients on the National Wait list or remove them from the list.

D. Transplant Program: A unit within a hospital that has received approval from CMS to perform transplants for a specific type of organ and is a current beneficiary of the Organ Procurement and Transplantation Network (OPTN), which is administered by the United Network for Organ Sharing (UNOS).

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

A. The purpose of this policy is to describe the Partnership HealthPlan of California treatment authorization process for medically necessary Organ and Bone Marrow Ttransplant (OBMT)s procedures including the following:
1. Bone Marrow (stem cell)*
2. Heart*
3. Lung*
4. Heart/lung*
5. Liver*
6. Combined liver/kidney*
7. Simultaneous Pancreas/Kidney (SPK)*
8. Pancreas After Kidney (PAK)*
9. Small Bowel (Intestinal) Transplant*
10. Combined liver/small bowel(intestinal)*
11. Kidney+
12. Corneal transplant+
13. Autologous islet cell+
14. Chimeric Antigen Receptor T-Cell (CAR T-cell) therapy

* These transplants can only be approved when performed by a Medi-Cal approved Center of Excellence (COE) as defined in III.A.

+ Programs that perform corneal, autologous islet cell or kidney transplants are not required to be a Medi-Cal approved COE.

VI. POLICY / PROCEDURE:

A. Partnership authorizes, refers, and coordinates the delivery of the Medi-Cal Major Organ and Bone Marrow Transplant (MOBMT) benefit and all medically necessary services associated with MOBMTs, including, but not limited to, pre-transplantation assessments and appointments, organ procurement costs, hospitalization, surgery, discharge planning, readmissions from complications, post-operative services, medications[1], and care coordination for transplants. All medically necessary adult and pediatric major organ transplants are covered as outlined in the Medi-Cal Provider Manual, including all updates and amendments to the Provider Manual. The Transplant section of the Medi-Cal Provider Manual is available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/8B313A4A-3B84-49DB-B98B-6A51BECCF01C/transplant.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.
   1. Transplants will only be authorized to be performed in an approved transplant program located within a hospital that meets the Department of Health Care Services' (DHCS) criteria.

[1] As per APL 25-013, the pharmacy (prescription) benefit was carved-out to State Medi-Cal as of January 1, 2022. Please refer to the State Medi-Cal Rx webpage: https://medi-calrx.dhcs.ca.gov/home/cdl/.

2. As noted in V.A. above, certain transplants are only covered when performed by Medi-Cal approved Centers of Excellence (COE).
3. Bone marrow transplant programs must have current accreditation by the Foundation for the Accreditation of Cellular Therapy.
4. Major organ transplants for pediatric beneficiaries are required to be performed only in a Special Care Center (SCC) as approved by California Children's Services (CCS). A directory of SCCs can be found here: https://www.dhcs.ca.gov/services/ccs/scc/Pages/SCCType.aspx
5. Total pancreatectomy with autologous islet cell transplantation (TPIAT) is reimbursable by Medi-Cal when the patient has chronic pancreatitis or relapsing acute pancreatitis and meets medical necessity criteria as stated in the Transplants section of the Medi-Cal Provider Manual.
6. Kidney transplants must be performed by transplant programs approved by the Centers for Medicare & Medicaid (CMS) and the program must have current membership in the Organ Procurement and Transplantation Network (OPTN). Patients must meet medical necessity criteria as stated in the Transplants section of the Medi-Cal Provider Manual.
7. CAR T-cell therapy must meet drug-specific requirements. For more information, refer to Medi-Cal Provider Manual Guidelines for chemotherapy drugs as Referenced in VII.F.- P. below.
   a. While all CAR T-cell therapies previously had mandated Risk Evaluation and Mitigation Strategy (REMS) requirements, the U.S. Food and Drug Administration (FDA) announced on June 26, 2025 that the approved REMS for the following products should be eliminated because a REMS is no longer necessary to ensure that the benefits of the autologous CAR T-cell immunotherapies outweigh their risks.
      1) Abecma (idecabtagene vicleucel)
      2) Breyanzi (lisocabtagene maraleucel)
      3) Carvykti (ciltacabtagene autoleucel)
      4) Kymriah (tisagenlecleucel)
      5) Tecartus (brexucabtagene autoleucel)
      6) Yescarta (axicabtagene ciloleucel)

B. Members Age 21 and Over
   1. When a Member is identified as a potential candidate for a transplant, the Member should be referred to a Partnership-contracted Medi-Cal approved Transplant Center for evaluation as described in VI.A. Consistent with Partnership policy MCUP3124 Referral to Specialists (RAF) Policy, referrals to contracted specialists are auto-adjudicated and written approval is generated to the requesting primary care provider (PCP) and the specialist within one working day of the receipt of the request (not to exceed 72 hours).
   2. Members remain assigned to their primary care provider (PCP) during the evaluation process.
   3. Upon completion of the evaluation, if the Transplant Center Team confirms the Member is appropriate for transplant, the transplant program is responsible for placing the beneficiary on the National Waitlist maintained by The Organ Procurement and Transplantation Network OPTN. A Treatment Authorization Request (TAR) must then be submitted to Partnership. The request may be submitted electronically through Partnership's O~~o~~nline Services~~Provider~~ (OLS) p~~P~~ortal, or by fax to 707-863-4118. The complete medical record, including the M~~m~~ember's medical and treatment history (including, starting in January 2020, either a palliative care consultation or equivalent documentation of discussion of options, prognosis, goals of care, and completion of advance care planning documents), pertinent lab studies, current condition and treatment, and requested procedure, must accompany the TAR.
   4. Partnership will review the transplant request for medical necessity using the most up-to-date InterQual® criteria and DHCS medical and procedural guidelines. Transplant requests are reviewed by Partnership's Chief Medical Officer (CMO) or Physician designee and may be sent for external independent medical review as appropriate. Initial denial determinations will have a second review

by the CMO (or designees Deputy Chief Medical Officer or supervising Medical Director if CMO is unavailable) in accordance with Section IV.1. of Attachment 2 of APL 21-015.

5. Once the TAR is approved, the Member, physician and facility are notified in writing.
6. When the TAR for a transplant is approved, Partnership assigns the Member to a Direct Member status, Health Plan 5 (H5), to ensure continuity of care. Re-evaluation of the continued need for Direct Member status will be reviewed at the end of 12 months or as follows:
   a. Heart transplant recipients are granted H5 Direct Member status for plan lifetime.
   b. Bone Marrow transplant Members (including CAR T-cell therapy and gene therapy) become eligible for assignment to a PCP two years after receiving the transplant, but may qualify for continued Direct Member H5 status based on continuity of care criteria as detailed in policy MPUP3039 Direct Members.

C. Members Under Age 21
1. For members under age 21, the procedures noted in sections VI.B.1 through VI.B.4 remain the same. However, these members will also be evaluated for eligibility under the California Children's Services (CCS) program (see VI.C.3 for additional authorization criteria).
2. If the Member has not already been determined eligible under the CCS program, Partnership will work with the member's physician, parents/legal guardians and refer the case to the designated County CCS office for a financial and residential eligibility determination.
3. If the Member is determined eligible for CCS, Partnership will review the transplant request for medical necessity using a combination of the most up-to-date InterQual® criteria as well as the medical and procedural guidelines as directed in the DHCS "Numbered Letters" for CCS (some of which have not been updated for current standards of medical care). Medical Directors may obtain outside expert advice for complex cases or those where the Numbered Letters seem to conflict with current standards of care.
4. Members under age 21 with coverage under CCS are assigned to a Partnership Direct Member status called "Whole Child Model" (WCM) and will remain in that status until they reach their 21st birthday, as long as they retain residential, financial and medical eligibility with CCS. This status allows for direct referral to a specialist, without being subject to Partnership's Referral Authorization Form (RAF) process. (See policy MCCP2024 Whole Child Model for California Children's Services and MPUP3039 Direct Members).
5. Partnership will provide ongoing case management services and continue to coordinate care and transition of services for these members regardless of age, for as long as they remain eligible for coverage under Partnership. In the event that a WCM Member moves outside of Partnership's services area, Partnership will collaborate with the receiving county CCS staff to facilitate continuity of care.

D. Donors
1. Per DHCS policy, Partnership will cover designated donor related hospital services associated with the transplant, including organ procurement for cadaver organ transplants or living donor care and related transportation expenses, if not covered by other insurance. (see also policy MPTP2501Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) as well as policy MPTP2503 Transportation-Related Travel Expenses: Lodging, Meals, Attendants, Parking and Tolls).

VII. REFERENCES:

A. In compliance with the California Department of Health Care Services (DHCS) contract
B. In compliance with DHCS "Numbered Letters" for California Children's Services (CCS)
C. InterQual® Criteria
D. Medi-Cal Provider Manual/ Guidelines: Transplants
E. Medi-Cal Provider Manual/ Guidelines: Surgery: Eye and Ocular Adnexa

F. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs A Policy
G. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs B Policy
H. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs C Policy
I. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs D Policy
J. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs E-H Policy
K. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs I-L Policy
L. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs M Policy
M. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs N-O Policy
N. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs P-Q Policy
O. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs R-S Policy
P. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs T-Z Policy
Q. Title 42 Code of Federal Regulations (CFR) parts 405 *Federal Health Insurance for the Aged and Disabled*;, 482 *Conditions of Participation for Hospitals*;, 488 *Survey, Certification, and Enforcement Procedures*; 498 *Appeals Procedures for Determinations that Affect Participation in the Medicare Program and for Determinations that Affect the Participation of ICFs/IID and Certain NFs in the Medicaid Program*
R. Section 1138 of the Social Security Act (42 U.S.C. 1320b–8)(SSA): *Hospital Protocols for Organ Procurement and Standards for Organ Procurement Agencies.*.
S. DHCS APL 21-015 Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (10/18/2021) Attachment 2 Major Organ Transplant Requirements. (*Revised* 10/14/2022)
T. DHCS APL 25-013 Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage (09/18/2025)
U. DHCS APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (05/18/2022)
V. FDA Safety Communication: FDA Eliminates Risk Evaluation and Mitigation Strategies (REMS) for Autologous Chimeric Antigen Receptor (CAR) T cell Immunotherapies. June 26, 2025

VIII. DISTRIBUTION:
A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:
01/18/12; 02/18/15; 02/17/16; 02/15/17; *03/14/18; 09/11/19; 09/09/20; 02/10/21; 02/09/22; 02/08/23: 02/14/24; 02/12/25; 02/11/26; 06/10/26

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:
N/A

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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.

Policy/Procedure Number: MCUP3104				Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Transplant Authorization Process				☒External Policy ☐ Internal Policy	
Original Date: 04/21/2010			**Next Review Date: 06/10/2027** **Last Review Date: 06/10/2026**		
Applies to:	☐ Employees			☒ Medi-Cal	
Reviewing Entities:	☒ IQI		☐ P & T	☒ QUAC	
	☐ OPERATIONS		☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD		☐ COMPLIANCE	☐ FINANCE	☒ PAC
	☐ CEO	☐ COO	☐ CREDENTIALS	☐ DEPT. DIRECTOR/OFFICER	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date: 06/10/2026**	

I. RELATED POLICIES:

A. MCUP3124 – Referral to Specialists (RAF) Policy
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
C. MPUP3137 – Palliative Care: Intensive Program (Adult)
D. MCUP3140 – Palliative Care: Pediatric Program for Members Under the Age of 21
E. MPUP3039 – Direct Members
F. MPUP3138 – External Independent Medical Review
G. MCCP2024 – Whole Child Model for California Children’s Services (CCS)
H. MPTP2501 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)
I. MPTP2503 –Transportation-Related Travel Expenses: Lodging, Meals, Attendants, Parking and Tolls
J. MPCR700 – Assessment of Organizational Providers
K. MPPR200 – Provider Contracts

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Provider Relations
E. Transportation

III. DEFINITIONS:

A. Center of Excellence (COE): A Medi-Cal-approved transplant program which operates within a hospital setting, is certified and licensed through the Centers for Medicare and Medicaid Services (CMS), and meets Medi-Cal state and federal regulations consistent with 42 CFR, parts 405, 482, 488, 498 and Section 1138 of the Social Security Act (SSA) [42 USC section 1230b-8].
B. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status is based on the Member’s aid code, prime insurance, demographics or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see Partnership network providers and/or certified Medi-Cal providers willing to bill Partnership for covered services. However, many specialists will still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP.
C. Organ Procurement and Transplantation Network (OPTN): The OPTN is operated under contract with the Health Resources & Services Administration (HRSA) of the U.S. Department of Health and Human

Services by the United Network for Organ Sharing (UNOS). OPTN maintains the National Waitlist but only a Transplant Program can register patients on the National Wait list or remove them from the list.

D. Transplant Program: A unit within a hospital that has received approval from CMS to perform transplants for a specific type of organ and is a current beneficiary of the Organ Procurement and Transplantation Network (OPTN), which is administered by the United Network for Organ Sharing (UNOS).

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

A. The purpose of this policy is to describe the Partnership HealthPlan of California treatment authorization process for medically necessary Organ and Bone Marrow Transplant (OBMT) procedures including the following:
   1. Bone Marrow (stem cell)*
   2. Heart*
   3. Lung*
   4. Heart/lung*
   5. Liver*
   6. Combined liver/kidney*
   7. Simultaneous Pancreas/Kidney (SPK)*
   8. Pancreas After Kidney (PAK)*
   9. Small Bowel (Intestinal) Transplant*
   10. Combined liver/small bowel(intestinal)*
   11. Kidney[+]
   12. Corneal transplant[+]
   13. Autologous islet cell[+]
   14. Chimeric Antigen Receptor T-Cell (CAR T-cell) therapy

   * These transplants can only be approved when performed by a Medi-Cal approved Center of Excellence (COE) as defined in III.A.
   [+] Programs that perform corneal, autologous islet cell or kidney transplants are not required to be a Medi-Cal approved COE.

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A. Partnership authorizes, refers, and coordinates the delivery of the Medi-Cal Organ and Bone Marrow Transplant (OBMT) benefit and all medically necessary services associated with OBMTs, including, but not limited to, pre-transplantation assessments and appointments, organ procurement costs, hospitalization, surgery, discharge planning, readmissions from complications, post-operative services, medications[1], and care coordination for transplants. All medically necessary adult and pediatric major organ transplants are covered as outlined in the Medi-Cal Provider Manual, including all updates and amendments to the Provider Manual. The Transplant section of the Medi-Cal Provider Manual is available at:
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5. Once the TAR is approved, the Member, physician and facility are notified in writing.
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G. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs B Policy
H. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs C Policy
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PREVIOUSLY APPLIED TO:
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PARTNERSHIP HEALTHPLAN OF CALIFORNIA MEETING SUMMARY
(Confidential – Protected by CA. Evidence Code 1157)
*=by phone conference

Draft

Committee: Credentials Committee
Date: April 8, 2026 7:00 A.M.
Members Present: by phone conference* Steven Gwiazdowski, MD; David Gorchoff, MD*; Bradley Sandler, MD* ; Brian Montenegro, MD

PHC Staff: by phone conference* Mark Netherda, MD* Medical Director Quality Improvement; Marshall Kubota, MD*; PHC Associate Medical Director; Robert Moore, MD*, MPH, MBA, PHC Chief Medical Officer; Jeffery Ribordy, MD* Regional Medical Director; Lisa Ward, MD* Regional Medical Director; Matthew Morris, MD* Regional Medical Director; Priscila Ayala, Director of Network Services; J'aime Seale, Credentialing Team Lead; Nolan Smith, Credentialing Specialist II; Morgan Brambley, Credentialing Specialist I; Amanda Arguello, Lead Trainer Network Services

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
I. Meeting called to order. a. Voting member reminder.	I. Partnership Medical Director Quality Improvement, Mark Nethereda, MD called the meeting to order at 7:00AM. Credentials Committee roll call taken by J'aime Seale, Credentialing Specialist Lead. Dr. Netherda reminded everyone that all items discussed are confidential. a. Partnership Medical Director Quality Improvement Mark Netherda, MD, reminded The Credentials Committee of who the voting members are, and voting is restricted to non-PHC staff. Dr. Netherda reminded the committee that all information discussed is confidential in nature.			4/8/2026 4/8/2026
II. Review and approval of March 11, 2026 Credentials Meeting Summary.	II. The Credentials Committee meeting Summary for March 11, 2026 were reviewed by the Committee.	II. Summary were reviewed. First motion approved by Bradley Sandler, MD and second motion approved by Steven Gwiazdowski, MD. Motions approved by committee unanimously with no objections.		4/8/2026
III. Old Business. a. Update on practitioner	III. Old Business – a. Dr. Netherda summarized to the Credentials Committee the credentialing history of a practitioner. The practitioner was previously deferred by Dr. Netherda to await further information regarding multiple licensure actions made against them from California, Washington and Arizona State Nursing Boards. A letter was sent to the practitioner	III. Old Business a. Update on the practitioner was reviewed. A motion to defer discussion to May 13, 2026 meeting for information from legal counsel was made by David Gorchoff, MD and second motion by Steven Gwiazdowski, MD. Motions approved by committee unanimously with no objections.	5/13/2026	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	on 2/27/2026 and a response was received 3/12/2026. Dr. Netherda asks the Credentials Committee to read and review the response letter received. Dr. Netherda stated concerns regarding the provider not taking responsibility with the sanctions they received. Dr. Ribordy also commented that the provider mentioned a medical provider did not review their cases, but medical providers are shown in court notes as having reviewed. Also, many of the cases stated the provider can only work as a Registered Nurse not a Family Nurse Practitioner. Dr. Gwiazdowski asked if the items were reviewed last cycle. Dr. Netherda stated many of the providers current sanctions started after their last credentialing cycle in 2023. Dr. Netherda also noted that Partnership has credentialed other providers with probation issues and would that be fair if credentialing was denied? Dr. Gorchoff responded that is correct, however, further legal counsel would be beneficial for a final decision. Dr. Gorchoff asked why the previous request for legal counsel could not attend the meetings. Danielle Ogren with Regulatory Affairs & Compliance department stated legal counsel was not able to attend the previous meeting, but can review items with her for the May 13, 2026 meeting. Dr. Ribordy added sanctions against Registered Nurses can be different from Nurse Practitioners. Dr. Netherda asked the committee if they would like to motion for deferral. Dr. Gorchoff motioned to move to May 13, 2026 meeting for further information from legal counsel.			
b. Update on practitioner.	b. Dr. Netherda explained to the Credentials Committee a practitioner was previously presented to the March 11, 2026 Credentials Committee to discuss their request to provide primary care. The Credentials Committee voted to defer to the April 8, 2026 meeting for further information to determine if the provider will see 12–18 year-old patients for Obesity and Substance Use Disorder (SUD) services. Dr. Netherda and Dr. Ward had a discussion with the provider and the CEO of their group. In the discussion they confirmed the practitioner would	b. Update on the practitioner was reviewed. A motion for approval of credentialing with chart reviews pending receipt updated MPCR17-A form. First motion approved by David Gorchoff, MD and second motion approved by Steven Gwiazdowski, MD. Motions approved by committee unanimously with no objections.	5/13/2026	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	only practice specialty-based services for Obesity and Substance Use Disorders (SUD) for pediatrics 12-18 years old. Dr. Ward also further explained that the practitioner has a lot of experience in urgent care and is very clear of their treatment boundaries. Dr. Netherda added the provider has no board or license sanctions. Dr. Netherda stated the previous confusion within the MPCR17-A Primary Care Criteria Form was due to the way the provider completed the form. He explained this form was updated yesterday 4/7/2026 with Partnership Quality department and will be sent to the provider to reformat, with the information they provided verbally to Dr. Netherda and Dr. Ward. Dr. Gorchoff motioned to approve with chart reviews pending receipt of updated MPCR17-A form with corrections matching specific services the practitioner agreed to verbally with Dr. Netherda and Dr. Ward.			
IV. New Business a. Review and Approval of Routine Practitioner List.	IV. New Business a. Dr. Netherda referred the Credentials Committee to review the routine list of practitioners.	IV. New Business a. The Committee reviewed the list of practitioners**.** A motion to approve the list of practitioners was First approved by Steven Gwiazdowski, MD and a second motion approved by Bradley Sandler, MD. Motions approved by committee unanimously with no objections.		 4/8/2026
b. MPCR200 Clean/Routine Practitioners and Ancillary Practitioners	b. Dr. Netherda explained to the Credentials Committee the MPCR200 Clean/Routine Practitioners and Ancillary Practitioners list. These practitioners are approved by Dr. Netherda Pre-Credentials Committee meeting.	b. The Credentials Committee reviewed the MPCR200 Clean/Routine list. First motion to approve the list was approved by David Gorchoff, MD and second motion approved by Bradley Sandler, MD. Motions approved by committee unanimously with no objections.		4/8/2026
c. Review and Approval of Revised Policies.	c. Review and Approval of Revised Policies presented by Brooke Vance and Dr. Netherda. The Policies presented are: MPCR4B – Identification of HIV/AIDS Specialists, MPCR13 – Credentialing of Pain Management Specialist, MPCR13A – Credentialing of Hospice and Palliative Care Medicine Specialist, MPCR13B – Buprenorphine Prescriber Credentialing, MPCR17 – Standards for Contracted Primary Care and Urgent Care Physicians – Pages 139-147, MPCR19 – Skilled Nursing	c. The Committee reviewed the Revised Policies. A motion to approve the revised policies. First motion approved by by Steven Gwiazdowski, MD and second motion approved by Brian Montenegro, MD. Motions approved by committee unanimously with no objections.		4/8/2026

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	Facility Providers (SNFists) Credentialing Policy, MPCR101 – Ensuring Non-Discriminatory Credentialing and Re-credentialing processes, MPCR500 – Ongoing Monitoring of Sanctions, MPCR600 – Range of Actions to Improve Practitioner Performance, MPCR601 – Fair Hearing and Appeals Process for Adverse Decisions, MPCR700 – Assessment of Organizational Providers, MPCR800 – Delegation of Credentialing and Re-credentialing Activities. Brooke Vance explained that all of the policies are consent calendar or updates in NCQA language except MPCR700. Brooke Explained MPCR700 revisions include changes to Urgent Care credentialing regarding accreditation being removed from requirements and Partnership facility site reviews are now the requirement. Dr. Netherda added that this change is due to most accreditation agencies not meeting the same site review requirements for Partnership.			
V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List. a. Review and Approval of Ongoing Monitoring of Sanctions Report. b. Practitioner Monitoring List. *Information Only*	V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List. a. Review and Approval of Ongoing Monitoring of Sanctions Report. The Credentials Committee was asked to review and approve the Ongoing Monitoring of Sanctions Report. b. The Credentials Committee was asked to review the Practitioner Monitoring list. Dr. Netherda reminded the committee that the credentialing department monitors these boards for any actions regarding Partnership providers.	V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List. a. The Credentials Committee members reviewed the report. A motion for approval of the Ongoing Monitoring of Sanctions Report was made. First motion approved by Steven Gwiazdowski, MD and second motion approved by Bradley Sandler, MD. Motions approved by committee unanimously with no objections. b. *Informational only*.		4/8/2026 4/8/2026
VI. Review and Approval of Consent Calendar Items.	VI. Review and Approval of Consent Calendar Items.	VI. Review and Approval of Consent Calendar Items.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
a. Report of Long-Term Care Facility, Hospital, and Ancillary provider list. b. Annual Delegation Audits	a. Dr. Netherda asked the Credentials Committee members to review the report of Long-Term Care Facility, Hospital, and Ancillary provider list. b. Dr. Netherda presented the Annual Delegation Audits for Sutter Bay Medical Foundation dba Sutter Pacific Medical Foundation and UCSF Medical Center, UCSF Benioff Children's Hospital, UCSF Medical Group, and Bay Children's Physicians. The audit included Partnership's review and evaluation of the credentialing information integrity results.	a/b. The Credentials Committee members reviewed the list of Consent Calendar Items. The items include the Report of Long-Term Care, Facility, Hospital and Ancillary Provider list and Annual Delegation Audits. A motion for approval was made. First motion approved by Brian Montenegro, MD and second motion approved by Steven Gwiazdowski, MD. Motions approved by committee unanimously with no objections.		4/8/2026
VII. Meeting Adjourned.	VII. Meeting adjourned.			

Credentials Meeting Summary for 4/8/2026respectfully prepared and submitted by J'aime Seale, Credentialing Team Lead.

Chairman Signature of Approval **____** ***Date*****______________________________**

Mark Netherda, MD ***Credentialing Chairman***

App. Ty	Full Name	NPI Number	Provider Type C	Name/Street	County Nam	Specialty Desc	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Ca	Settlement Da
I	Afshar, Payam MD	1023192861	SPEC	Providence Medical Group-	Napa	Gastroenterolog	ABMS of Intern	10/03/2012	Yes	Admitting Agre	None	
R	Allmeyer-Green, Rita M.,PT	1043236946	Allied	Shasta Orthopedics & Sport	Shasta	Physical Therap	None		No			
R	Anderson, Jacqueline E.,FNP-C	1205245255	PCP	Providence Medical Group,	Sonoma	Family Nurse P	American Acad	05/21/2014	Yes			
I	Ando, Ivy Rose BCBA	1811699515	BHP	Intercare Therapy	Solano	BCBA	Behavior Analy	12/28/2024	Yes			
I	Argoud, Ninon V.,DO	1053378232	PCP	Round Valley Indian Health	Mendocino	Family Medicin	Meets MPCR #		No	Admitting Agre	None	
I	Babasa, Cynthia BCBA	1144848243	BHP	Kyo Autism Therapy, LLC	Solano	BCBA	Behavior Analy	12/06/2025	Yes			
R	Bach, Philip M.,MD	1376594267	SPEC	Sacramento Heart & Vascul	Yolo	Cardiovascular	ABMS of Intern	11/09/1983	Yes	Admitting Agre	None	
I	Bahnson, Frederic N.,MD	1518296847	SPEC	Synergy Surgicalists PC	Nevada	Surgery	ABMS of Surge	10/22/2013	Yes	Sierra Nevada I	Active	
I	Balliet, Melanie OT	1366963605	Allied	All Care Therapies	Solano	Occupational T	None		Not Applicable			
I	Bejarano, Samantha FNP-C	1871479402	PCP	WellSpace Health Rancho (	Placer	Family Nurse P	American Acad	09/29/2025	Yes			
I	Bernal, Charles BCBA	1235726779	BHP	California Sprout MC 1 LLC	Solano	Board Certified	Behavior Analy	12/08/2020	Yes			
R	Berney, Rhonda C.,MD	1174617708	PCP	Santa Rosa Community Hea	Sonoma	Family Medicin	ABMS of Famil	07/09/1982	Yes	Admitting Agre	None	11/14/2002
I	Blanchard, Tessa BCBA	1619444684	BHP	Intercare Therapy	Solano	BCBA	Behavior Analy	11/10/2023	Yes			
R	Bland, Donovan C.,MD	1811966898	SPEC	Sutter Lakeside Community	Lake	Surgery	ABMS of Surge	11/15/2010	Not Applica	Sutter Lakeside	Active	
I	Boone, Mikisa A.,SUDC I	1952255994	W&R	Ujima Family Recovery Ser	Solano	Substance Use	California Subs	11/12/2025	Yes			
R	Bowen, William W.,MD	1770593386	SPEC	William Bowen, MD	Mendocino	Orthopaedic Su	ABMS of Ortho	09/11/1981	Yes	Adventist - How	Active	03/02/2017
R	Bracebridge, Allen J.,FNP-C	1790441871	PCP	Stallant Health and Wellnes	Del Norte	Family Nurse P	American Acad	09/08/2021	Yes			
R	Brahma, Venkatesh L.,MD	1760877906	SPEC	Eye Care Institute, A Medica	Sonoma	Ophthalmology	ABMS of Ophth	08/30/2020	Yes	Sutter Santa R	Consulti	
R	Brushwyler, Elizabeth D.,PT	1508001165	Allied	Capuchino Therapy Group	Yolo	Physical Therap	None		No			
R	Bugbee, Jessie A.,AGACNP-BC	1710608336	PCP	WeCare at Scotia Bluffs	Humboldt	Adult-Gerontolo	American Nurse	01/07/2022	Yes			
R	Bulleit, Erin E.,MD	1639564974	BOTH	Santa Rosa Community Hea	Sonoma	Family Medicin	ABMS of Famil	06/25/2018	Yes	Sutter Santa R	Active	
I	Cabral, Brittany BCBA	1366894693	BHP	Behavioral & Educational St	Placer	BCBA	Behavior Analy	08/31/2017	Yes			
I	Cantu, Yadira SLP	1124501796	Allied	All Care Therapies	Solano	Speech Patholo	None		Not Applicable			
I	Cardona, Zulma I.,SLP	1457595241	Allied	All Care Therapies	Solano	Speech Patholo	None		Not Applicable			
R	Caryotakis, Carissa A.,FNP-C	1124570627	PCP	Elica Health Center	Placer	Family Nurse P	American Acad	12/14/2016	Yes			
I	Cervantes, Ariana L.,RN	1871466540	W&R	Drug Abuse Alternatives Ce	Sonoma	Registered Nur	None		No			
I	Chabriel, Guadalupe D.,AGPCNP-BC	1003773532	SPEC	Providence Medical Group,	Sonoma	Adult-Gerontolo	American Nurse	10/09/2025	Yes			
I	Chan, Jody BCBA	1770212060	BHP	California Sprout MC 1 LLC	Solano	BCBA	Behavior Analy	11/23/2021	Yes			
I	Chandrasekaran, Anita C.,MD	1861870651	SPEC	Telehealth Specialty Medica	Placer	Rheumatology	ABMS of Intern	10/19/2020	Yes	Admitting Agre	None	
I	Chapman, Duncan R.,MD	1437474152	PCP	NBHG: Center for Primary (	Solano	Family Medicin	ABMS of Famil	07/01/2013	Yes	NorthBay Medi	Active N	
I	Chau, Sally MD	1154959401	SPEC	West Coast Kidney	Solano	Nephrology	ABMS of Intern	10/23/2025	Yes	Admitting Agre	None	
I	Chen, William DO	1720575871	PCP	NBHG: Center for Primary (	Napa	Family Medicin	ABMS of Famil	07/01/2021	Yes	NorthBay Medi	Active N	
I	Chenowith, Bettee F.,SUDCC II	1750644605	W&R	Aegis Treatment Centers, LI	Shasta	Wellness and R	California Subs	05/08/2025	Yes			
I	Chun, Sophia MD	1104939990	PCP	Stallant Health and Wellnes	Del Norte	Internal Medicir	ABMS of Famil	08/20/2002	Yes			
I	Cisneros, Luciana N.,RD	1669195293	Allied	La Clinica - North Vallejo	Solano	Registered Diet	Commission of	08/23/2022	Yes			
I	Cluff, Robert S.,MD	1982623484	SPEC	DR ROBERT S CLUFF	Solano	Pain Managem	None		No	Adventist Healt	Affiliate	
I	Coleman, Noelle CADC I	1376418434	W&R	Archway Recovery Services	Napa	Wellness and R	California Cons	09/03/2025	Yes			
R	Dalton, Emily L.,MD	1235133737	PCP	Open Door Community Hea	Humboldt	Pediatrics	ABMS of Pedia	10/13/1993	Yes	Admitting Agre	None	
I	Demler, Megan PT	1902689938	Allied	Sports Rehab Physical Ther	Solano	Physical Therap	None		No			
I	Dhaliwal, Marvi MD	1154052751	PCP	Peach Tree Healthcare	Yuba	Family Medicin	ABMS of Famil	07/28/2025	Yes	Admitting Agre	None	
R	Dickey, Benjamin W.,MD	1932526860	PCP	Providence Medical Group,	Sonoma	Family Medicin	ABMS of Famil	07/22/2017	Yes	Admitting Agre	None	
I	Dosanjh, Rasnit S.,FNP	1376360115	PCP	Colusa Health Clinic	Colusa	Family Nurse P	None		No			
I	Dumas, Heather A.,BCBA	1275913659	BHP	Montera Health California, L	Yolo	BCBA	Behavior Analy	05/31/2017	Yes			01/08/2025
R	Ebiner, Ann B.,FNP-BC	1316264112	PCP	Adventist Health Ukiah Valle	Mendocino	Family Nurse P	American Nurse	02/04/2008	Yes			
I	Engdahl, Alle BCBA	1396236931	BHP	Behavior Frontiers, LLC	Placer	BCBA	Behavior Analy	02/26/2020	Yes			
I	Esch, Kathleen BCBA	1033466479	BHP	ACES 2020 LLC	Solano	BCBA	Behavior Analy	05/31/2012	Yes			
I	Espinosa, Tanya J.,SLP	1841668639	Allied	All Care Therapies	Solano	Speech & Lang	None		Not Applicable			
I	Estrada-Ruiz, Tanya O.,Doula	1346547049	SPEC	Da-Ta-Lu & You	Mendocino	Doula	None		Not Applicable			
I	Fairfield, Lorraine E.,LVN	1447123443	W&R	Drug Abuse Alternatives Ce	Sonoma	Licensed Vocat	None		No			
R	Fajardo, Sammantha BCBA	1437650371	BHP	Aura Behavioral Health LLC	Yolo	BCBA	Behavior Analy	02/15/2023	Yes			
I	Faley, Monsita J.,FNP-BC	1457530180	SPEC	Telehealth Specialty Medica	Placer	Family Nurse P	American Nurse	10/03/2006	Yes			
I	Farsi, Nazee MD	1386826881	SPEC	Telehealth Specialty Medica	Placer	Rheumatology	ABMS of Intern	10/01/2013	Yes	Admitting Agre	None	
R	Feidi, Rana A.,MD	1740600972	SPEC	Telehealth Specialty Medica	Placer	Infectious Disea	ABMS of Intern	10/24/2019	Yes	Admitting Agre	None	
I	Flores, Mallory A.,SLP	1184100315	Allied	All Care Therapies	Solano	Speech Patholo	None		Not Applicable			
R	Foo, Darvin C.,PA-C	1447573779	SPEC	Shriners Hospitals for Childr	Yolo	Physician Assis	National Comm	02/04/2010	Yes			
I	Foster, Ana P.,BCBA	1215577473	BHP	Peak Potential ABA, LLC	Solano	BCBA	Behavior Analy	09/14/2023	Yes			

App. Ty	Full Name	NPI Number	Provider Type C	Name/Street	County Nam	Specialty Descr	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Ca	Settlement Da
R	Galloway, Erin BCBA	1720648751	BHP	Autism Advocacy and Interv	Lake	BCBA	Behavior Analy	05/31/2019	Yes			
I	Garrett, Emily BCBA	1447983036	BHP	Intercare Therapy	Solano	Board Certified	Behavior Analy	12/30/2025	Yes			
R	Garrison, Lucas M.,LCSW	1528557378	SPEC	Ritter Health Center	Marin	Enhanced Care	None		No			
I	Gill, Talwinder K.,FNP-C	1366200891	PCP	Achieve Community Health	Yuba	Family Nurse P	American Acad	04/29/2024	Yes			
R	Glyer, John R.,MD	1801866785	PCP	Adventist Health Howard M	Mendocino	Family Medicin	Meets MPCR#1	10/30/1977	No	Adventist - How	Active	
R	Goettman, Mitchell A.,DO	1437573045	SPEC	Adventist Health Physicians	Sutter	General Surger	ABMS of Surge	10/19/2020	Yes	Adventist Healt	Active	
R	Gomez, Elaine M.,NP	1740404557	PCP	Napa Valley Medical Group,	Napa	Nurse Practitior	None		No			
I	Gomez, Melissa BCBA	1134570484	BHP	Behavioral & Educational St	Placer	BCBA	Behavior Analy	05/31/2017	Yes			
I	Green, Brandon J.,PA-C	1760358162	PCP	Providence Medical Group,	Humboldt	Physician Assis	National Comm	10/16/2025	Yes			
I	Greub, Eston BCBA	1770282709	BHP	Beyou Behavior Therapy SF	Solano	BCBA	Behavior Analy	07/15/2025	Yes			
I	Grevemberg, Sally R.,BCBA	1124360326	BHP	Behavioral & Educational St	Placer	BCBA	Behavior Analy	12/31/2002	Yes			
R	Groppo, Eli R.,MD	1245402338	SPEC	Sacramento Ear Nose and T	Yolo	Otolaryngology	ABMS of Otolar	06/01/2012	Yes	Mercy General	Active	
R	Grover, Atul MD	1639166523	SPEC	Bright Heart Health Medical	Solano	Addiction Medic	ABMS of Preve	01/01/2020	Yes	Admitting Agre	None	09/26/2025
I	Gruenberg, Alyssa M.,PA-C	1366997249	SPEC	Direct Dermatology Professi	Solano	Dermatology	None		No			
I	Guajardo, Lauren R.,OD	1245682178	SPEC	CommuniCare Ole - Davis (	Yolo	Retinal Myopatl	None		No	Admitting Agre	None	
I	Guerra, Edith Doula	1326913815	SPEC	Divine Birth Portal	Yolo	Doula	None		Not Applicable			
R	Hallett, John B.,MD	1619436995	PCP	Petaluma Health Center: Ro	Sonoma	Family Medicin	ABMS of Family	07/01/2022	Yes	Admitting Agre	None	
I	Hardy, Russell I.,MD	1558345348	SPEC	Eureka Radiation Oncology	Humboldt	Medical Oncolo	Previously Boa	11/09/1995	No	Providence St .	Provisio	
R	Harms, Debra R.,SLP	1710331871	Allied	Capuchino Therapy Group	Yolo	Speech & Lang	None		No			
R	Hawkins, Candice M.,OT	1215038294	Allied	Capuchino Therapy Group	Yolo	Occupational T	None		No			
I	Hawley, Darell DO	1295484962	PCP	Marin Community Clinic: Ca	Marin	Family Medicin	American Oste	07/01/2025	Yes	Admitting Agre	None	
R	Head, Bobbie MD	1053412403	SPEC	Marin Cancer Care Inc.	Marin	Medical Oncolo	ABMS of Intern	11/07/1989	Yes	Marin Health M	Active	
R	Heidarzadeh, Taban BCBA	1144798059	BHP	Pantogran LLC dba Center	Solano	Behavioral Hea	Behavior Analy	08/31/2019	Yes			
I	Hofmann, Gerald E.,PT	1427273549	Allied	Shasta Physical Therapy	Shasta	Physical Thera	National Board		No			
R	Holmes, Jarrod P.,MD	1013018035	SPEC	Providence Medical Group,	Sonoma	Hematology	ABMS of Intern	11/14/2007	Yes	Santa Rosa Me	Active	
I	Hougum, Andrew J.,PT	1104041219	Allied	Shasta Physical Therapy	Shasta	Physical Thera	None		No			
I	Howard, Gioanna BCBA	1811554413	BHP	Positive Behavior Supports	Yolo	BCBA	Behavior Analy	03/01/2023				
R	Howard, John H.,III, MD	1811377062	SPEC	Capital Nephrology Medical	Yolo	Nephrology	ABMS of Intern	11/18/2020	Yes	Sutter Medical (	Active	
I	Huff, Stephanie BCBA	1295093342	BHP	Behavior Matters California,	Solano	BCBA	Behavior Analy	02/08/2017	Yes			
I	Huynh, Nhu Q.,BCBA	1629586730	BHP	Intercare Therapy	Solano	BCBA	Behavior Analy	06/22/2023	Yes			
I	Irwin, Bryce A.,PA-C	1316739501	SPEC	Adventist Health Ukiah Valle	Mendocino	Physician Assis	National Comm	07/21/2025	Yes			
R	Jensen, Else M.,MD	1790754885	PCP	Providence Medical Group-	Napa	Internal Medicir	Meets MPCR#1	09/25/1991	No	Providence Qu	Provisio	07/13/2006
I	Jeon, Ye Jin MD	1811634199	PCP	Blue Stone Health & Wellne	Placer	Pediatrics	ABMS of Pedia	10/16/2025	Yes	Admitting Agre	None	
R	Jhang, Lily S.,FNP-C	1184026759	PCP	Elica Health Center	Placer	Family Nurse P	American Acad	07/23/2014	Yes			
R	Johnston, Andrew C.,MD	1710931019	PCP	Open Door Community Hea	Humboldt	Internal Medicir	ABMS of Intern	09/12/1990	Yes	Admitting Agre	None	
I	Jones, Amee BCBA	1063912418	BHP	Burnett Therapeutic Service	Napa	BCBA	Behavior Analy	04/23/2021	Yes			
I	Jones, Laybon Jr., MD	1205972296	SPEC	Laybon Jones, Jr., M.D.	Solano	Cardiovascular	Confirmed per		No	Sutter Solano M	Active	
I	Juhaszova, Katarina PA-C	1295137297	PCP	Adventist Health Clearlake	Lake	Physician Assis	National Comm	08/21/2014	Yes			
I	Kefalides, Paul T.,MD	1790883080	SPEC	Providence Medical Group,	Sonoma	Gastroenterolo	ABMS of Intern	11/07/2001	Yes	Admitting Agre	None	
R	Keslin, Lisa BCBA	1336441450	BHP	Burnett Therapeutic Service	Napa	BCBA	Behavior Analy	11/30/2008	Yes			
I	Kimani, Susan W.,LVN	1205798931	W&R	Drug Abuse Alternatives Ce	Sonoma	Licensed Vocat	None		No			
I	Kircher, John W.,MD	1427312883	SPEC	West Coast Retina Medical	Marin	Ophthalmology	ABMS of Ophth	06/10/2018	Yes	Sutter Health -	Active	
I	Kluball, Sidney BCBA	1598247488	BHP	Behavioral & Educational St	Placer	BCBA	Behavior Analy	03/01/2023	Yes			
R	Koester, Russell J.,LAc	1710479712	Allied	Sonoma County Indian Hea	Sonoma	Acupuncture	None		No			
I	Kraus, Brandi M.,PA-C	1295772234	SPEC	Enloe Surgical Oncology	Butte	Physician Assis	National Comm	09/16/2004	Yes			
I	Kurzfeld, Adam W.,LAc	1427730241	Allied	Anderson Valley Health Cer	Mendocino	Acupuncture	None		No			
R	Laird, John R.,Jr., MD	1144290636	SPEC	Adventist Health Physicians	Napa	Cardiovascular	ABMS of Intern	11/08/1989	Yes	Adventist Healt	Active	
I	Lane, Christina RADT	1821953704	W&R	Archway Recovery Services	Solano	Wellness and R	California Cons	06/21/2025	Unknown			
I	Langstaff, Rachel M.,FNP-BC	1437008232	PCP	Greenville Rancheria	Shasta	Family Nurse P	American Nurse	08/21/2025	Yes			
I	Lawhead, Angelina F.,PA-C	1194606327	PCP	Pediatric Medical Associate	Yolo	Physician Assis	National Comm	09/12/2025	Yes			
R	Lee, Bryan K.,MD	1386801330	PCP	Elica Health Centers - Mary	Placer	Internal Medicir	Meets MPCR#1	08/09/2011	No	Admitting Agre	None	
I	Leedham, Kristina E.,PA-C	1992045165	SPEC	Providence Medical Group,	Humboldt	Physician Assis	National Comm	09/06/2012	Yes			
I	Leland, Amanda BCBA	1053914010	BHP	Center for Social Dynamics	Solano	BCBA	Behavior Analy	09/08/2025	Yes			
I	Lin, Allen I.,DO	1841271814	SPEC	Davis Urgent Care Inc.	Yolo	Urgent Care	None		No	Admitting Agre	None	
I	Liu, Chunmei FNP-C	1982003141	PCP	Sacramento Community Cli	Placer	Family Medicin	American Acad	03/31/2025	Yes			
I	Liu, David M.,MD	1700975976	SPEC	New Life, LLC	Mendocino	Addiction Medic	ABMS of Preve	01/01/2018	Yes	Admitting Agre	None	

App. Ty	Full Name	NPI Number	Provider Type C	Name/Street	County Nam	Specialty Descr	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Ca	Settlement Da
I	Liu, Yi SLP	1225857311	Allied	Proficio Speech Therapy Gr	Solano	Speech & Lang	None		No			
I	Long, Charles L.,MD	1780035220	SPEC	Banner Health Clinic	Lassen	Orthopaedic Su	ABMS of Ortho	07/21/2024	Yes	Banner Lassen	Consulti	
I	Luevano, Arlene SLP	1134428584	Allied	All Care Therapies	Solano	Speech & Lang	None		Not Applicable			
R	Lunden, Lorraine A.,PA-C	1437238920	PCP	CommuniCare Ole - Davis (	Yolo	Physician Assis	National Comm	01/16/1984	Yes			
I	Luo, Jack Y.,MD	1851920854	SPEC	Solano Kidney Care	Solano	Nephrology	ABMS of Intern	10/23/2025	Yes	NorthBay Medi	Provisio	
I	Lynch, Amy L.,SUDCC	1821684234	W&R	Aegis Treatment Centers, LI	Shasta	SUDCC	California Subs	10/28/2025	Yes			
R	Mahan, Marcelle O.,MD	1245292085	PCP	Providence Medical Group,	Humboldt	Family Medicin	MP CR# 17 Re		Not Applica	Providence St .	Affiliate	
I	Mahoney, Aubrey M.,SLP	1699255836	Allied	All Care Therapies	Solano	Speech & Lang	None		Not Applicable			
R	Majlessi, Azadeh L.,MD	1871533679	SPEC	Adventist Health Ukiah Valle	Mendocino	Rheumatology	ABMS of Intern	11/04/1998	Yes	Adventist Healt	Telehea	
I	Mancinas, Sylvia LVN	1922834209	W&R	Drug Abuse Alternatives Ce	Sonoma	Licensed Vocat	None		No			
R	Martin, Joseph E.,PA-C	1649391889	PCP	Adventist Health Mendocino	Mendocino	Physician Assis	National Comm	04/19/2021	Yes			
I	Martini, Curt J.,DPM	1427583756	SPEC	Shasta Orthopedics & Sport	Shasta	Podiatry	None		Not Applica	Shasta Region	Active	
R	Marty, Talitha L.,PA-C	1952469108	PCP	Mendocino Community Hea	Mendocino	Physician Assis	National Comm	12/17/2001	Yes			
I	Mason, Makenna BCBA	1851861579	BHP	Intercare Therapy	Solano	BCBA	Behavior Analy	11/14/2024	Yes			
R	Matalon, Eran MD	1073656815	PCP	Providence Medical Group,	Sonoma	Internal Medicir	ABMS of Intern	09/25/1991	Yes	Santa Rosa Me	Active	
R	McIntyre, Paige A.,CNM	1265509863	SPEC	Mendocino Community Hea	Mendocino	Certified Nurse	American Midw	01/01/2004	Yes			
R	McKeany, Allison M.,RD	1437456217	Allied	Telehealth Specialty Medica	Placer	Registered Diet	Commission of	10/29/2010	Yes			
I	Milazzo, Alyssa BCBA	1861066474	BHP	Montera Health California, L	Yolo	BCBA	Behavior Analy	02/17/2020	Yes			
I	Min, William MD	1841495710	SPEC	Enloe Orthopedic & Trauma	Butte	Orthopaedic Su	ABMS of Ortho	07/25/2013	Yes			
R	Mirda, Daniel P.,MD	1811963317	SPEC	Providence Medical Group-	Napa	Medical Oncolo	ABMS of Intern	11/07/1989	Yes	Providence Qu	Active	
I	Mitchell, Chelsea M.,SLP	1578992236	Allied	All Care Therapies	Solano	Speech & Lang	None		No			
R	Morton, Marcie S.,DC	1376784561	SPEC	Adventist Health Clearlake	Lake	Chiropractic	None		No			
I	Mosqueda, Beverly B.,FNP-BC	1700201779	PCP	Adobe PH CA Medical Group PC		Family Nurse P	American Nurs	06/15/2019	Yes			
I	Muiruri, Annah W.,LVN	1821773649	PCP	Annah muiruri	Lake	Licensed Vocat	None		No			
I	Munoz, Ruben CADC II	1548774128	W&R	Recover Medical Group	Solano	Wellness and R	California Cons	02/01/2021	Yes			
R	Murala, Samuel S.,MD	1205210150	SPEC	Adventist Health	Butte	Pain Medicine	Confirmed per /		No	Adventist Healt	Provisio	
I	Nay, Michael R.,MD	1639306863	PCP	Feather River Tribal Health	Butte	Family Medicin	None		No	Admitting Agre	None	
I	Ndetti, Christine M.,FNP-C	1760734974	PCP	Open Door Community Hea	Humboldt	Family Nurse P	American Acad	07/01/2012	Yes			
R	Nelson, Kevin M.,PA-C	1730891284	PCP	Providence Medical Group,	Sonoma	Physician Assis	National Comm	01/13/2023	Yes			
R	Nelson, Natalie N.,MD	1275948317	PCP	SCHC: Shasta Community I	Shasta	Family Medicin	ABMS of Famil	11/10/2018	Yes	Admitting Agre	None	
I	Newberry, Hailey H.,PA-C	1699465930	SPEC	Direct Dermatology Professi	Solano	Physician Assis	National Comm	05/09/2023	Yes			
I	Nissen, Teodoro P.,MD	1699791053	SPEC	Bay Area Orthopedic Surgery & Sports M		Orthopaedic Su	ABMS of Ortho	07/14/2008	Yes	Sutter Solano I	Active	07/01/2013
I	Nix, Megan BCBA	1417309576	BHP	Behavioral & Educational St	Solano	BCBA	Behavior Analy	10/08/2025	Yes			
I	Novak, Jadyn M.,PA-C	1457245086	PCP	Trinity Community Health Cl	Trinity	Physician Assis	National Comm	05/20/2025	Yes			
I	Novak, Michael R.,MD	1972501179	PCP	NBHG: Center for Primary (	Solano	Family Medicin	ABMS of Famil	07/14/2000	Yes	NorthBay Medi	Active N	
I	O'Doran, Kayla R.,SLP	1275021438	Allied	All Care Therapies	Solano	Speech & Lang	None		Not Applicable			
I	Okraski, Ronni BCBA	1184082703	BHP	Montera Health California, L	Yolo	BCBA	Behavior Analy	05/31/2010	Yes			
I	Oleson, Elizabeth C.,AGPCNP-BC	1326592569	SPEC	Davis Sexual Health	Yolo	Adult-Gerontolc	American Nurs	08/25/2016	Yes			
R	Osborne, Loretta E.,FNP-BC	1205237179	PCP	Mendocino Community Hea	Lake	Family Nurse P	American Nurs	08/21/2014	Yes			
R	Owen, Rebecca C.,FNP-BC	1215224696	PCP	Elica Health Center	Placer	Family Nurse P	American Nurs	02/16/2015	Yes			
I	Palacios, Yesenia RD	1285428383	Allied	La Clinica De La Raza	Solano	Registered Diet	Commission of	08/22/2024	Yes			
I	Pandher, Sandeep K.,FNP-C	1144019688	PCP	Riverside Health Clinic of C	Colusa	Family Nurse P	American Acad	03/14/2025	Yes			
I	Pandullo, Deborah BCBA	1265905996	BHP	California Sprout MC 1 LLC	Solano	BCBA	Behavior Analy	02/28/2014	Yes			
I	Pangilinan, Alyssa BCBA	1346742400	BHP	Autism Spectrum Therapies	Yolo	BCBA	Behavior Analy	02/19/2026	Yes			
I	Patel, Nikita M.,MD	1932511904	SPEC	Telehealth Specialty Medica	Placer	Rheumatology	ABMS of Intern	11/03/2022	Yes	Admitting Agre	None	
R	Peak, Daniel T.,NP	1902262645	PCP	Elica Health Centers - Arder	Placer	Nurse Practitior	None		No			
R	Pelavin, Paula E.,PA-C	1821458761	PCP	Petaluma Health Center	Sonoma	Physician Assis	National Comm	02/25/2016	Yes			
I	Pelczynski-Kunda, Sarah BCBA	1356106850	BHP	Montera Health California, L	Yolo	BCBA	Behavior Analy	09/05/2024	Yes			
R	Phillips, Kevin A.,SUDRC	1104532340	W&R	Archway Recovery Services	Solano	Wellness and R	California Subs	12/16/2024	Yes			
I	Puig-Palomar, Miguel MD	1558361139	SPEC	Enloe Cardiology Services (	Butte	Thoracic & Car	ABMS of Thora	06/07/1996	Yes	Enloe Medical (	Active	09/17/2002
I	Quiralte, Ruby BCBA	1184267767	BHP	Behavioral & Educational St	Solano	BCBA	Behavior Analy	11/13/2025	Yes			
I	Rai, Navpreet K.,FNP-C	1295698504	PCP	Riverside Health Clinic of C	Colusa	Family Nurse P	American Acad	09/08/2025	Yes			
R	Rajasingh, Moses C.,MD	1801808266	SPEC	Providence Medical Group,	Humboldt	Cardiovascular	ABMS of Intern	11/06/1991	Yes	Providence St .	Active	
I	Rajmohan, Shruti BCBA	1982175774	BHP	Kadiant, LLC	Stanislaus	Board Certified	Behavior Analy	09/24/2022	Yes			
I	Ramirez, Nancy BCBA	1508369133	BHP	Kyo Autism Therapy, LLC	Solano	BCBA	Behavior Analy	11/21/2025	Yes			
I	Ramos, Yesenia BCBA	1629420740	BHP	Behavioral & Education Stra	Placer	BCBA	Behavior Analy	02/28/2018	Yes			

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Routine Practitioner List

App. Ty	Full Name	NPI Number	Provider Type C	Name/Street	County Name	Specialty Descr	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Ca	Settlement Da
R	Ranadive, Rajina MD	1447200480	PCP	Providence Medical Group,	Sonoma	Internal Medicir	Meets MPCR#1	08/19/2003	No	Petaluma Valle	Consulti	
R	Randall, Robert L.,MD	1073566717	SPEC	Shriners Hospitals for Childr	Yolo	Orthopaedic Su	ABMS of Ortho	07/12/2001	Yes	Shriners Hospit	Consulti	
I	Raphael, Jenny MD	1730243676	PCP	Ole Health	Napa	Pediatrics		10/27/2008		Admitting Agre	None	
I	Rashid, Nisreen BCBA	1609399062	BHP	Behavioral & Educational St	Placer	BCBA	Behavior Analy	04/05/2024	Yes			
I	Ratilal, Jay P.,MD	1487698585	PCP	WellSpace Health South Va	Placer	Pediatrics	ABMS of Pedia	10/28/1998	Yes	Admitting Agre	None	
I	Renteria, Luz BCBA	1366894339	BHP	Behavioral & Educational St	Placer	BCBA	Behavior Analy	06/20/2024	Yes			
I	Renteria, Scarllett A.,BCBA	1063087872	BHP	Positive Behavior Supports	Yolo	BCBA	Behavior Analy	01/16/2026	Yes			
I	Reyes, Marlin APCC	1063371581	W&R	Recover Medical Group	Solano	Associate Profe	None		No			
I	Richardson, Eva L.,SLP	1598024366	Allied	All Care Therapies	Solano	Speech & Lang	None		No			
I	Riera, Susel BCBA	1063869931	BHP	Burnett Therapeutic Service	Napa	BCBA	Behavior Analy	08/13/2021	Yes			
R	Rishi, Rahul MD	1740243930	SPEC	West Coast Kidney	Solano	Nephrology	ABMS of Intern	10/18/2006	Yes	Admitting Agre	None	
I	Rodriguez Plaud, Coral M.,SLP	1578836375	Allied	All Care Therapies	Solano	Speech & Lang	None		No			
I	Rodriguez, Yolanda RD	1548530363	Allied	La Clinica Oakley	Solano	Registered Diet	Commission of	08/17/2011	Yes			
I	Rodriguez-Jordan, Jazmin RD	1689283939	Allied	La Clinica	Solano	Registered Diet	Commission of	09/19/2013	Yes			
I	Rogers, Kristen A.,RADT	1679449763	W&R	Archway Recovery Services	Solano	Wellness and R	Addiction Coun	10/08/2025	Yes			
I	Rosa, Antonio A.,MD	1548335854	PCP	Mendocino Community Hea	Mendocino	Pediatrics	AOB of Pediatri	10/19/1999	Yes	Admitting Agre	Active	
R	Runyon, Ryan CADC CAS	1386072320	W&R	Hilltop Recovery Services -	Lake	Wellness and R	California Cons	04/02/2007	Yes			
I	Saddoris, Madison PT	1457230740	Allied	Shasta Physical Therapy	Shasta	Physical Thera	None		No			
R	Sade, Irony C.,MD	1639478290	SPEC	Fairchild Medical Clinic Spe	Siskiyou	General Surger	ABMS of Surge	04/24/2018	Yes	Fairchild Medic	Active	
I	Salley, Dermaine S.,SUDRC	1649162942	W&R	Archway Recovery Services	Solano	Wellness and R	California Subs	02/22/2026	Yes			
R	Samonte, Kimberly Claire BCBA	1538698063	BHP	Pantogran LLC dba Center	Solano	Behavioral Hea	Behavior Analy	02/28/2020	Yes			
I	Sanchez, Danya OT	1073744561	Allied	All Care Therapies	Solano	Occupational T	None		No			
I	Saroya, Manjinder S.,FNP-BC	1770273336	PCP	Colusa Indian Health Clinic	Colusa	Family Nurse P	American Nurse	04/25/2023	Yes			
I	Sawyer, Tom PT	1518996057	Allied	Amundson Physical Therap	Tehama	Physical Thera	None		No			
I	Sedgwick, Jacqueline H.,MD	1538268412	PCP	Santa Rosa Community He	Sonoma	Pediatrics	None		No	Admitting Agre	None	
I	Segura, Elizabeth Electrologist	1699668327	Allied	Eskin	Marin	Electrolysis	None		No			
R	Seiler, Anne E.,CNM	1861028011	SPEC	CommuniCare Ole - Davis (	Yolo	Certified Nurse	American Midw	01/01/2020	Yes			
I	Serr, Cheryl A.,MD	1831199744	SPEC	Cheryl Serr MD	Shasta	Obstetrics and	ABMS of Obste	01/11/2002	Yes	Mercy Medical	Active	12/14/2010
R	Sharp, Alec J.,DO	1679830590	SPEC	Sacramento Heart & Vascul	Yolo	Cardiology	None		No	Admitting Agre	None	
I	Shaw, Jill A.,MD	1790839355	PCP	Dignity Health - Mercy Fami	Shasta	Family Medicin	ABMS of Famil	07/25/2008	Yes	Mercy Medical	Active	
I	Shepard, Erica L.,LAc	1437473139	SPEC	SCHC: Enterprise Family H	Shasta	Acupuncture	None		No			
I	Shuayto, Megan BCBA	1992399059	BHP	Behavioral & Educational St	Solano	BCBA	Behavior Analy	03/24/2025	Yes			
R	Sidhu, Gurinder S.,MD	1306031315	SPEC	Providence Medical Group-	Napa	Medical Oncolo	ABMS of Intern	10/28/2008	Yes	Providence Qu	Active	
I	Sigarroa, Carlos L.,SUDCC	1275090052	W&R	Recover Medical Group	Solano	Wellness and R	California Subs	04/09/2025	Yes			
I	Skaggs, Mark SUDRC II	1265322671	W&R	Drug Abuse Alternatives Ce	Sonoma	Substance Use	California Subs	03/11/2026	Yes			
R	Smith, Maisha J.,FNP-BC	1871038489	PCP	Lassen Indian Health Cente	Lassen	Family Nurse P	American Nurse	12/01/2016	Yes			
R	Smith, Rebecca R.,CNM	1982025367	SPEC	Open Door Community Hea	Humboldt	Certified Nurse	American Midw	06/24/2013	Yes			
I	Smith, Rendy D.,SUDCC	1306291463	W&R	Ford Street Project - Ukiah I	Mendocino	Wellness and R	California Subs	12/14/2024	Yes			
I	Solache-Perez, Diana BCBA	1659851996	BHP	Behavioral & Educational St	Placer	BCBA	Behavior Analy	12/01/2023	Unknown			
I	Spalding, Bryan M.,MD	1184786857	SPEC	Providence Medical Group,	Humboldt	Cardiovascular	ABMS of Intern	11/05/2008	Yes	Admitting Agre	None	
I	Stanford, Samantha BCBA	1952048555	BHP	Behavioral & Educational St	Solano	BCBA	Behavior Analy	10/04/2025	Yes			
R	Stanton, Jessica J.,MD	1316981921	PCP	West County Health Centers	Sonoma	Family Medicin	ABMS of Famil	07/21/2005	Yes	Admitting Agre	None	
I	Stricklin, Amy D.,SLP	1447304696	Allied	All Care Therapies	Solano	Speech & Lang	None		No			
I	Suarez, Adalys OT	1972131373	Allied	All Care Therapies	Solano	Occupational T	None		No			
I	Subramanian, Subhashini MD	1043486129	SPEC	Capital Pediatric Cardiology	Yolo	Pediatric Cardi	ABMS of Pedia	11/07/2012	Yes	Admitting Agre	None	
R	Sugarman, Jeffrey L.,MD	1548255482	SPEC	Redwood Family Dermatolo	Sonoma	Dermatology	ABMS of Derm	10/14/2002	Yes	Admitting Agre	None	
I	Sulaiman, Nastassja SLP	1154745925	Allied	All Care Therapies	Solano	Speech & Lang	None		No			
I	Sunil, Gopinath S.,MD	1710937545	SPEC	Oroville Family Medicine Pr	Butte	Endocrinology	None		No	Admitting Agre	None	
I	Suresh, Sandhya BCBA	1205130903	BHP	Autism Learning Partners	Humboldt	BCBA	Behavior Analy	05/31/2013	Yes			
I	Svec, Ioana-Cristina RD	1689990129	Allied	La Clinica	Solano	Registered Diet	Commission of	10/30/2009	Yes			
I	Talseth, Ciera PT	1902526486	Allied	Western Physical Therapy,	Shasta	Physical Thera	None		No			
I	Tapp, Stephanie BCBA	1043697329	BHP	Behavioral & Educational St	Placer	BCBA	Behavior Analy	02/28/2015	Yes			
I	Tejeda, Rebeca BCBA	1538013446	BHP	Peak Potential ABA, LLC	Solano	BCBA	Behavior Analy	09/02/2025	Yes			
I	Terhaar, Maureen BCBA	1861157224	BHP	Montera Health California, L	Yolo	BCBA	Behavior Analy	01/25/2021				
I	Terram, Chelsea Doula	1437018314	SPEC	Chelsea Terram Doula Services		Doula	DONA Internati		Not Applicable			
I	Theetha Kariyanna, Pramod MD	1881005809	SPEC	Providence Medical Group,	Humboldt	Interventional C	ABMS of Intern	10/20/2022	Yes	Santa Rosa Me	Provisio	

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Routine Practitioner List

App. Ty	Full Name	NPI Number	Provider Type C	Name/Street	County Nam	Specialty Desc	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Ca	Settlement Da
I	Thompson, Hannah BCBA	1871084921	BHP	Intercare Therapy	Solano	BCBA	Behavior Analy	03/14/2024	Yes			
R	Thu, Ye MD	1306180146	SPEC	Providence Medical Group,	Sonoma	Infectious Disea	ABMS of Intern	11/15/2017	Yes	Santa Rosa Me	Active	
R	Tiana, Ahimsa LMFT	1679864805	W&R	County of Humboldt - Healtl	Humboldt	Wellness and R	None		No			
R	Torgersen, Naomi MD	1972675627	SPEC	Wound MD PC	Solano	Wound Care	None		No	Admitting Agre	None	
I	Torres, Angelina E.,SUDRC II	1194535385	W&R	Drug Abuse Alternatives Ce	Sonoma	Substance Use	California Subs	01/03/2026	Yes			
I	Tosic, Genesis M.,SLP	1043054950	Allied	All Care Therapies	Solano	Speech & Lang	None		No			
R	Trevor, Kristin FNP-BC	1043442361	SPEC	Shasta Orthopedics & Sport	Shasta	Orthopaedic Su	American Nurs	07/24/2009	Yes			
I	Unck, Karen E.,PA-C	1316389877	SPEC	Davis Urgent Care Inc.	Yolo	Physician Assis	National Comm	07/08/2013	Yes			
I	Vasi, Azeem Z.,DO	1083848535	SPEC	Telehealth Specialty Medica	Placer	Otolaryngology	AOB of Otolary	05/07/2014	Yes	Admitting Agre	None	04/19/2021
R	Ventocilla, Edwin G.,PA-C	1508934860	PCP	Elica Health Centers - Mack	Placer	Physician Assis	National Comm	04/26/2000	Yes			
R	Viswanathan, Karthikeyan DO	1396128336	PCP	Round Valley Indian Health	Mendocino	Internal Medicir	Meets MPCR #		Not Applica	Admitting Agre	None	
I	Vroege, Jamie BCBA	1386028074	BHP	Behavioral & Educational St	Placer	BCBA	Behavior Analy	05/31/2015	Yes			
I	Wagner, Tricia R.,FNP-C	1447927751	PCP	Northern Valley Indian Heal	Yolo	Family Nurse P	American Acad	06/30/2021	Yes			
I	Waldron, Kevin G.,MD	1659314540	SPEC	Providence Medical Group,	Humboldt	Neurological Su	ABMS of Neurc	11/09/2012	Yes	Admitting Agre	None	08/02/2021
I	Walker, Michelle L.,LCSW	1548665862	W&R	Visions of the Cross/ Wome	Shasta	Licensed Socia	None		No			
I	Wall, Brooke M.,SLP	1689258386	Allied	All Care Therapies	Solano	Speech & Lang	None		No			
I	Walsh, Emily PA-C	1548894157	SPEC	Providence Medical Group,	Humboldt	Physician Assis	National Comm	01/13/2020	Yes			
R	Watkins, Gail L.,PA-C	1245563816	PCP	MVHC - Big Valley Health C	Lassen	Physician Assis	National Comm	07/16/2009	Yes			
R	Weeks, Roger D.,MD	1235157611	SPEC	North Bay Eye Associates I	Sonoma	Ophthalmology	ABMS of Ophth	10/15/1978	Yes	Petaluma Valle	Consulti	
R	Wellmon, Blair BCBA	1437613684	BHP	Burnett Therapeutic Service	Napa	BCBA	Behavior Analy	08/04/2021	Yes			
R	Wessman, Dylan E.,MD	1851362933	SPEC	Providence Medical Group,	Humboldt	Cardiovascular	ABMS of Intern	09/01/2019	Yes	Providence St .	Active	
I	Whitehurst, Peregrine LAc	1316752520	SPEC	Cedar Heart Wellness		Acupuncture						
R	Wilcox-Falk, Melissa J.,MD	1245686419	PCP	Open Door Community Hea	Humboldt	Family Medicin	ABMS of Famil	07/01/2019	Yes	Providence St .	Active	
I	Wynne, Walter L.,MD	1396797817	PCP	Orchard Hospital Medical S	Butte	Internal Medicir	Meets MPCR #	08/21/1996	No			
I	Xiong, Pang BCBA	1902354970	BHP	Behavioral & Educational St	Solano	BCBA	Behavior Analy	11/19/2025	Yes			
R	Yee, Kin K.,MD	1205035144	SPEC	Retinal Consultants Medical	Yolo	Ophthalmology	ABMS of Ophth	06/08/2014	Yes	Dignity Health I	Active	
I	Yu, Arlene L.,MD	1144744772	SPEC	Providence Medical Group,	Humboldt	Hematology	ABMS of Intern	10/10/2024	Yes	Providence St.	Provisio	

MEETING MINUTES

Meeting Name: Pediatric Quality Committee (PQC)
Date: May 5, 2026 **Time:** 1:00 – 3:00 p.m.
Location: Partnership HealthPlan of California

Attendees:

Advising Members			
Alyssa Soto, LVN – Lassen		Marcie Jo Cudziol, RN – *Trinity*	
Annapurna Vishnubhotla, RN – *UCSF – CHO*		Paulomi Shah, DO – *Sonoma*	
Brenda Harris, RN - *Siskiyou*		R. Jennifer Olson, MD – *CHO*	
Carey Venglarcik, MD - *Shasta Community Health Center*		Rebekah Kim, DO – *Yolo*	x
Cheryl Losado, RN – *Napa*		Shandi Fuller, MD – *Solano*	
James Huang, MD – *UCSF*		Sharon Convery, PHN – *Mendocino*	
Katherine Estlin, MD – *Humboldt*		Stephanie Holliday, PHN – *Humboldt*	
Lael Lambert, RN – *Marin*		Steven Gwiazdowski, MD - *NorthBay Neonatology Associates*	
Lauren Burchfield, RN – *Humboldt*	x	Victoria Morgese, MD – Napa	x

Other Members			
Abigale Henderson – *Colusa*		Jill Hobbs – *Placer*	
Alexis Erwin-Mecum – *Lassen*		Kathy Cahill – *Nevada*	
Alex Rodriguez – Yuba		Jessica Johnson – *Butte*	x
Amerjit Bhattal – *Yuba*		Katie Beatty – *Nevada*	x
DeLellis York – *Butte*		Katrina Whitaker - *Sutter*	
Chelsea Linthicum – *Sutter*		Katie Magliocca – *Nevada*	
Celia Su, PHN – *Colusa*	x	Laura Medina – *Nevada*	
Charlene Weiss-Wenzl – *Nevada*		Leah Northrop – *Sutter*	
Cheryl Mosbacher – *Placer*		Linda Hunt – *Modoc*	
Chie Newsom – *Nevada*		Lisa Richardson – *Nevada*	
Debra Webb – *Butte*		Bré Whitley – *Sierra*	x
Cynthia Hawes – *Butte*		Lily Nguyen – *Yuba*	
Dana Krinsky – *Plumas*		Lorri McKey - *Colusa*	x
Dawn Pacheco – *Glenn*	x	Mariza Manson – *Colusa*	
DeAnne Blankenship – *Butte*		Melissa Shaw – *Yuba*	
Gina Pasquinelli – *Sonoma*		Michael Romero – *Placer*	
Jaime Ordonez – *Yolo*		Meredith Wolfe – *Humboldt*	
Elizabeth Corniel – *Yuba*		Monica Soderstrom - *Butte*	
Janet Pitcher – *Shasta*	x	Nicole Reinert – *Plumas*	
Ila Suplizio – *Placer*		Nellie Brasier – *Siskiyou*	x
Jeanetty Martinelli – *Trinity*	x	Norma Williams – *Del Norte*	x
Jamie Fanceschini – *Sierra*		Phuong Luu, MD – *Yuba*	
Jana McDowell – *Plumas*		Pica Hernandez – *Butte*	
Jennifer Hathaway – *Siskiyou*	x	Rebecca Giammona - *Nevada*	
Marcy Reese – *Glenn*		Ryan Gruver – *Nevada*	
Jenifer Norris – *Butte*		Sarah Ludwick – *Sutter*	
Jessica Ahmadia – *Plumas*		Terri Smith – *Plumas*	
Jessica Hamon – *Placer*		Tina Venable – *Plumas*	
Kim Tangermann – *Lake*		Twylla Abrahamson – *Placer*	
Terri Sides – *Modoc*			

Partnership Staff			
Aaron Brincko – *Provider Relations*	x	Mohamed Jalloh, PharmD – *Health equity*	
Alyssa Beard, RN – *Care Coordination*	x	Robert Moore, MD – *Medical Director*	
Amy Turnipseed – *Chief Strategy and Government*		Ron Klinger, MSN – *Enhanced Health Services*	
Annika Jensen, RN – *Care Coordination*	x	Samantha Ogston, RN – *Care Coordination*	x
Armando Romo – *Care Coordination*	x	Shannon Boyle, RN - *Care Coordination*	
Breanne Lea - Care *Coordination*		Sheba Cenzia-Saelee – *Care Coordination*	x
Brigid Gast, RN – *Sr. Director of Care Management*	x	Sitara Cavanagh – Care Coordination	x
Doreen Crume, RN – *Care Coordination*		Stan Leung, Pharm.D – *Pharmacy*	x
Jaronna Jackson - Care *Coordination*	x	Suzanne Trepoy Papadopoulos, RN – *Care Coordination*	x
Jas Singh – *Care Coordination*		Teresa Frankovich, MD – *Medical Director*	
Jeff Ribordy, MD – *Medical Director*	x	Wendi Davis – *Chief Operations Officer*	
Katherine Barresi, RN – *Chief Health Services Officer*			

Agenda Topic	Minutes	Action Items
Introductions, Roll Call and Objective of Meeting *Speaker: Jeff Ribordy, MD*	Introductions were conducted at the start of the meeting.	
Review and Approve Minutes from Previous Meeting *Speaker: Jeff Ribordy, MD*	Minutes from the previous meeting were reviewed and approved with no changes.	

Updates from Previous Family Advisory Committee Meeting
Speaker: Jaronna Jackson
	Updates from the Q4 Family Advisory Committee (FAC) meeting were shared
	
	Key highlights included:
	
	• Meeting opened with introductions and approval of August 25, 2025, minutes.
	• Lucile Packard Foundation presented the importance of family participation in advisory committees, emphasizing:
	  o Flexible scheduling
	  o Clear expectations	

	○ Use of incentives ○ Strong partnerships with care teams Family Voices of California shared engagement resources and a training curriculum to support parent participation. Transportation team introduced the Kinetic Health Member App, which allows: ○ Ride scheduling and tracking ○ Support for Non-Emergency Medical Transportation (NEMT), Non-Medical Transportation (NMT), and gas mileage reimbursement ○ Current limitations: no document upload capability and no short-notice trip scheduling Health Equity team presented annual disparities data: ○ FAC members noted declining vaccination rates ○ Concerns included scheduling barriers and knowledge gaps Update on transition of Whole Child Model members into adulthood: ○ Continued California Department of Health Care Services (DHCS) priority ○ Focus on collaboration with Medical Therapy Units ○ Enhanced age-out planning efforts No new concerns or challenges were raised by FAC family members for the quarter.	
Whole Child Model (WCM) Update *Speaker: Brigid Gast*	Updates shared regarding changes in leadership. The Senior Director of Care Coordination will remain the primary point of contact in the Memorandum of Understanding (MOU) Liaison role.	
WCM MOU Update *Speaker: Brigid Gast*	Continued increase in executed MOUs, including those supporting members with special healthcare needs.	

	MOUs include programs such as:
	• Blood screening
	• Child and maternal health programs
	• Referral coordination for pediatric members
	  ○ Partnership continues to host MOU meetings to strengthen collaboration.
	  ○ Senior Director acknowledged and appreciated participation in local health department meetings.
	Overall feedback:
	• Meetings are progressing well
	• No issues or concerns raised at this time
	• Positive feedback on Care Coordination (CC) referral strategies and collaborative forums	

DHCS CCS Advisory Group Update *Speaker: Brigid Gast*	DHCS shared updates on timelines and ongoing discussions, including: • Reviewing reset of measures between classic and WCM counties • Continued discussions on training and support for UIS • Coordination efforts between managed care plans and counties Next meeting scheduled for July	
PNA Presentation *Speaker: Hannah O'Leary*	Presentation delivered. Refer to presentation slides for full details.	

Decisions Made		
Notes	**Follow-Up Items**	**Assigned To**
n/a	n/a	n/a

Next Meeting

Date	Suggestions for Agenda
August 4, 2026	n/a

MEETING Minutes

Meeting & Project Name: Quality Improvement Health Equity Committee (QIHEC)

Date: 5/19/2026 **Time**: 7:30 a.m. – 9:00 a.m.

Facilitator: Mohamed Jalloh, Pharm D

Coordinator: Bethany Hannah

Meeting Locations:

- Webex

Attendees: Aaron Brincko; Amanda Kim; Amanda McNair; Anthony Sackett; Arlene Pena; Ben Spencer; Candy Stockton; Cathryn Couch; Bethany Hannah; Christine Smith; Dawn Cook; Denise Whitsett; DeLorean Ruffin, DrPH, MPH; Folo Akintan; Hannah O'Leary; Isaac Brown; Jason Cunningham; Jesus Hermosillo; Kermit Jones; Kimberly Robertello; Kory Watkins; Leila Romero; Liat Vaisenberg; Lilly Merino; Manleen Randhawa; Mark Bontrager; Mark Netherda; Marshall Kubota; Michele Grupe; Melissa Schumann; Mohamed Jalloh; Monika Brunkal; Naz Sattari; Nicole Curreri, MPH CHES; Sunshine Jackson; Sydni Aguirre; Valerie Padilla; Vicquita Valazquez; Stan Leung, Sue Lee; Kristine Gual; Robert Moore, MD; Sue Quichocho; Tiffany Tryan; Tony Hightower; Wendy Starr;

Absent: Sonja Bjork; Whitney Haggerson; Amanda Smith; Hendry Ton, MD; Ian Kim; Kimberly Robertello; Noemi Doohan; Rachel Newman; Rocio Rodriguez; Rebecca Stark; Shannon Boyle; Latrice Innes; Nisha Guppta; Anna Cambell; Robert Bides; Shahrukh Chishty; Nicole Escobar; Heather Eset; Greg Allen Freedman; Jaymee James; John Lemoine; Sue Quichocho; Dorian Roberts; Tim Sharp; Amy Turnipseed; Edna Villasenor; Kory Watkins; Bridget Gast; Dana Codron; Monica Ferguson; Katherine Barresi; Priscila Ayala; Katheryn Power, Vicky Klakken; Wendi Davis; Monica Ferguson; Chloe Ungaro; Kristina Coester; Ledra Guillory; Lisa Wada; Tiffani Thomas; Chloe Ungaro; Kristina Coester; Ledra Guillory; Dana Constantino; Sydni Aguirre; Denise Rivera; Emily Wellander; Eugene Durrah; Eva Julian; Jeffrey DeVido; Kelly YoungsStone; Liz Romero;

External Advisory Members

Name	Affiliation	Org Type	3/17/26	5/19/26	7/21/26	9/15/26	11/17/26
Jason Cunningham, MD Chief Executive Officer	West County Health Centers	FQHC	X	X			
Eugene Durrah Equity Services Manager	Solano County	County	X				
Ian Kim Family Physician	Communicare + Ole	FQHC					
Hendry Ton, MD Associate Vice Chancellor	UC Davis	Health System					
Shandi Fuller, MD Maternal Child and Adolescent Health	Solano County	Public Health Department					
Eva Julien Senior Manager, Quality Improvement	Providence	Health System					
Valerie Padilla Director of Quality and Patient Safety	Open Door Community Health	Health System	X	X			
Arlene Pena Senior Program of Quality Improvement	Aliados Health	Community Based Org	X	X			
Jeremy Plumb Systems Director, Quality Division	Northbay Medical Center	Hospital					
Lelia Romero Health Program Specialist - Health Equity	Lake County	Public Health Department	X	X			

Robin Schurig, MPH, CPH Executive Director	Health Alliance of Northern California	Community Based Org					
Candi Stockton, MD Health Officer of Humboldt County	Humboldt County	Public Health Department	X	X			
Tiffani Thomas Case Manager	Solano County Superior Court	Local Government					
Brandon Thornock Chief Executive Officer	Shasta Community Health Center	Health System					
Denise Whitsett Quality Improvement Coordinator	Community Medical Centers	Health System	X	X			
Cathryn Couch Chief Executive Officer	CERES Community Project	Community Based Org	X	X			

Agenda Topic	Notes	Action Item
Agenda Item 1 **Welcome/ Introductions/Roll Call/ Minutes Review** *Speaker: Mohamed Jalloh, Pharm.D*	A. Dr. Jalloh welcomed everyone to the meeting as well as took a roll-call for external members. B. Bethany confirmed that quorum had been met, as 7 external members attended. C. Motion to approve meeting minutes from March 2026. 1st: Cathryn Couch 2nd Denise Whitsett	Motion to approve meeting minutes from March 2026. 1st: Cathryn Couch 2nd Denise Whitsett
Agenda Item 2 **CMO Health Plan Updates**	A. QUAC (Quality utilization advisory committee) updates; Quality improvement programs and primary care provider quality incentive program payment for measurement year 2025. The final payments	

Agenda Topic	Notes	Action Item
Speaker: Kermit Jones MD, JD on behalf of Robert Moore, MD, MPH, MBA	will be distributed by the end of this month. The PCP QIP team is working with EDW, (the enterprise data warehouse) to process manual payment and data adjustment before they sign off on those final payments. B. The organization has been through an end-to-end assessment of our member experience with an external consultant. The consultant has given us some recommendations on how to fill gaps on our member experience. C. The regional medical director meeting series is complete. During these meetings, they met with providers and community leaders where they listened to issues and shared updates on policy, public health measures, and ways to improve relationships for the sake of our members. They had meetings in Fairfield, Chico, Santa Rosa, Ukiah, and Truckee at Tahoe Forest Hospital. D. As of April 1st, the state changed the GLP1 prior authorization criteria to not require a TAR for metabolic dysfunction. Now you just have to put the right diagnosis code on the description and it will work. E. Partnership is looking at doing a periodic review of Partnership's medical equipment distribution services (PMEDs program), this is the program where blood pressure cuffs, scales, nebulizers and so on are send directly thorough partners to members in a low cost way, working with Pharmacies to move this forward. F. Partnership is watching closely the Rural Health Transformation grant program. The application was received by CMS and $3 million will be distributed this year with 20% used by the consultants. These grants will most likely be sent out in June. Our regional directors will be working with our providers and organizations that desire to apply for	

Agenda Topic	Notes	Action Item
	these grants in these specific areas; clinical staff, IT system enhancements, and OB access.	
Agenda Item 3 **HEO Health Plan Health Equity Updates** *Speaker: Mohamed Jalloh, Pharm.D*	A. NCQA made significant changes to the Health Equity Accreditation. They changed the name from Health Equity Accreditation to Health Outcomes Accreditation. B. DHCS made it clear that they will no longer require health plans to maintain NCQA Health Equity Accreditation after the current contract period. However, DHCS appreciated the original intent of the original Health Equity Accreditation, so they are looking to hold health plans accountable to many previous expectations. The state will be assessing the need for updates to contract language to ensure some of those original elements of Health Equity Accreditation are embodied in their contract requirements. They will be working with Health Equity Officers to coordinate engagement and potential contract language changes and implementation to ensure alignment with expectations that health plans really maintain the goals of structure of the prior health equity requirements. They will share clear communication on the contract update process and notify Partnership in advance of any anticipated major modifications, timelines, or implementation expectations. C. In the interim Partnership will still be using its Health Outcomes Accreditation for the next survey year until further direction from the state is received. D. Partnership is exploring issues regarding TGI Care access. Dr. Jalloh met with some external advisory members to learn about challenges people are facing as well as what solutions have been implemented. Looking to share some of this information internally and see how we can provide support to our members externally as well.	

Agenda Topic	Notes	Action Item
Agenda Item 4 **Grand Analysis Presentation** *Speaker: Kory Watkins, MBA-HM*	A. Kory Watkins presents a grand analysis on Grievance & Appeals 2025 data. B. The Grievance & Appeals (G&A) department ensures that members' concerns are heard, addressed, and resolved in alignment with regulatory standards and health plan policies. They manage member grievances and appeals with a focus on timeliness, fairness, and improving overall member experience. C. G&A works with the Transportation department, Compliance department, Quality Improvement team, Medical directors, Member services, and Provider Relations. D. The overview of the process: A case is received, there is a clinical assessment, member is contacted and sent an acknowledgement letter, case is investigated, resolution letter is sent and phone call to the member. E. There are two types of grievances: Standard: Member complaints about dissatisfaction with services, care, or experiences. Exempt: Member concerns that are resolved quickly without the formal grievance process. F. Kory shares a 3-year comparison of the annual caseload. It is trending upwards with an 18% increase from 2024-2025.	

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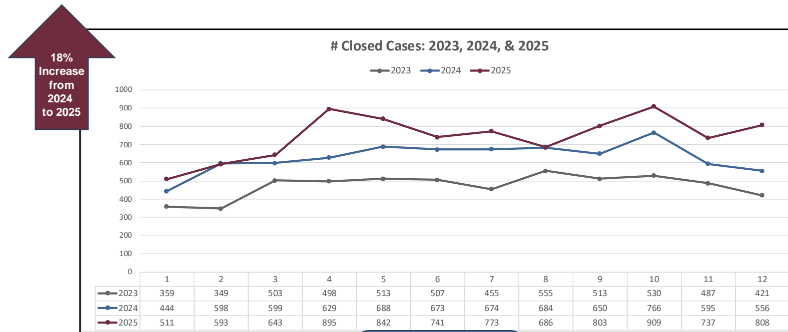
Annual Case Volume – 3 Year Comparison



G. Kory broke down the case volume by case type. In 2025 there were 5,836 grievances, 1,920 exempt, 980 appeals, and 205 state hearings.
H. Kory shares how cases were received; 90% by phone, 6.4% via email, 1.8% via mail, .8% via fax, and .1% in person.
I. Only .5% of all cases were classified as expedited in 2025
J. Clinical grievances 33% vs. non-clinical grievance 67%
K. Clinical appeals 71% vs non clinical appeals 29%
L. Kory shares a map of where members experience problems. The counties with the highest number of grievances are Trinity, Shasta, and Placer.

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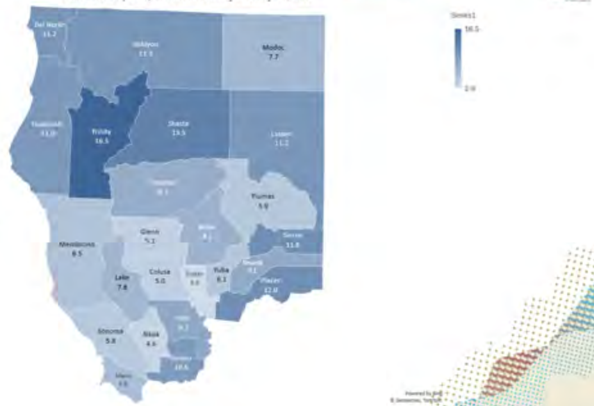
Agenda Topic	Notes	Action Item

Where Members Experience Problems

Grievances per 1,000 Members by County - 2025

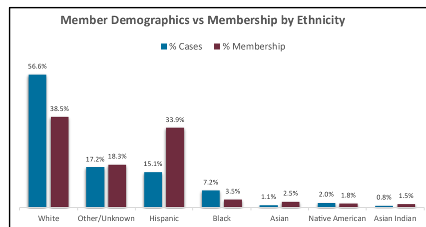


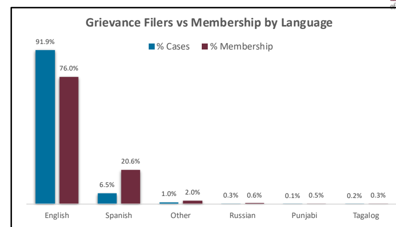
Top 3 Counties by Grievances Per 1,000 members:

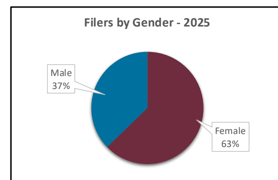
- Trinity – 16.5
- Shasta – 13.5
- Placer – 12.0

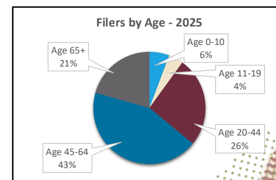
M. Kory shared the demographics of those members who filed a grievance. In 2025 63% of those who filed a grievance were female, 37% were men.

Member Demographics









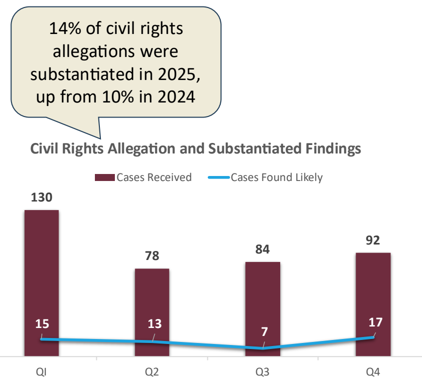
Agenda Topic	Notes	Action Item

N. The top grievance concerns by category are, Transportation 50%, Provider service 25%, Access 15%, and Partnership service: 10%

O. Transportation related grievance concerns are broken down into non-medical transport which account for 81% of the transportation related concerns and non-emergency medical transport accounted for 19% of the transportation related concerns. The 5 most common issues in both categories are: missed rides (17%), late driver arrivals (12%) driver behavior issues (11%) poor transportation company customer service (8%) and scheduling difficulties (8%). Partnership provided 1,562,928 rides in 2025 and received 5947 transportation concerns, representing less than .4% of total rides.

P. Kory shared discrimination allegations – with a civil rights focus. 14% of civil rights allegations were substantiated in 2025, up 10% from 2024.

Discrimination Allegations - Civil Rights Focus



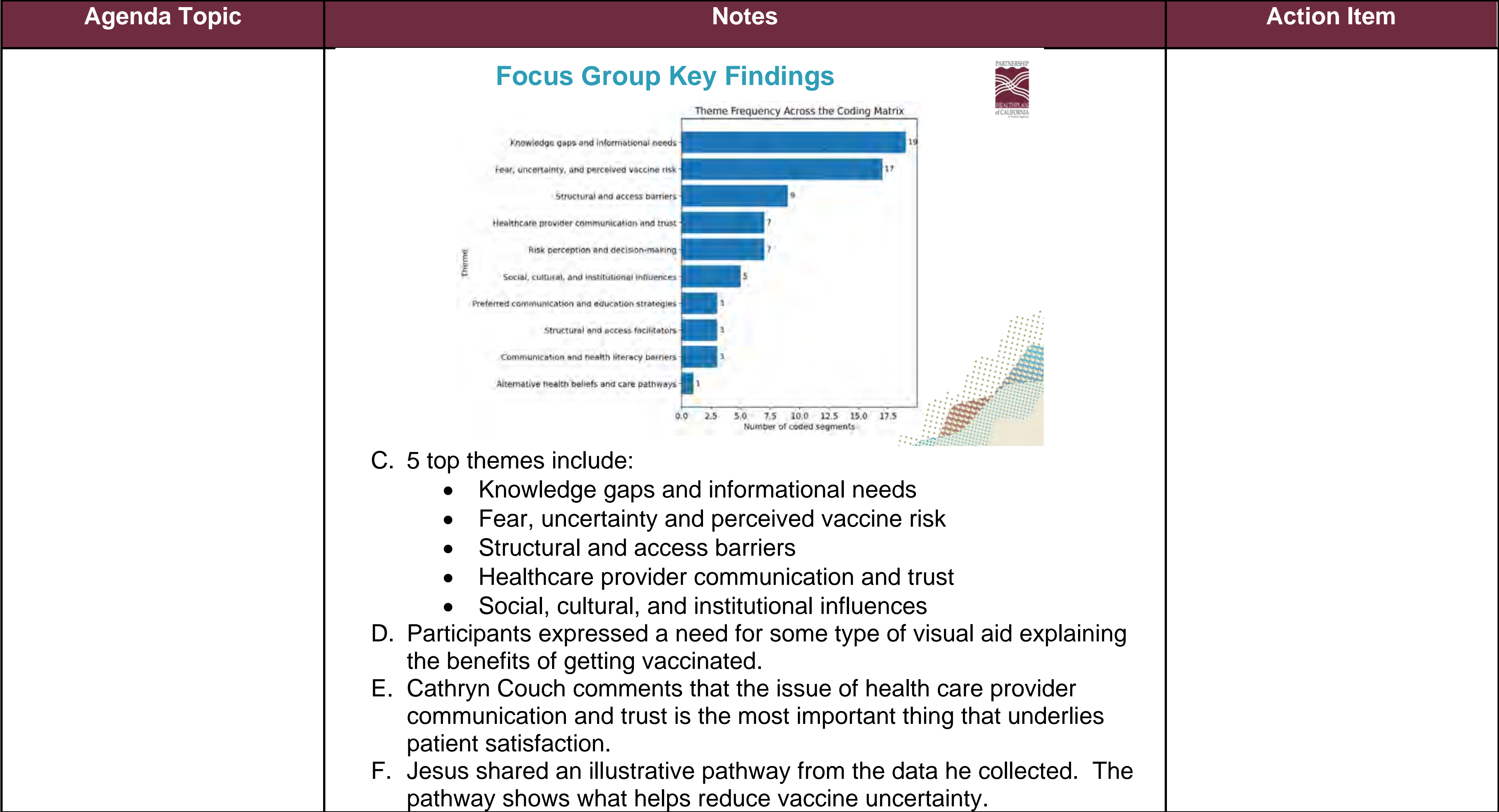
Type of Civil Rights Concern	Total Concerns Reported
Disability	135
Race or Ethnicity	89
Limited English Skills	39
Language Assistance Services	32
Age	25
Gender	14
Religion	12
Gender Identity	8
Sexual Orientation	8
Auxiliary Aids and Services	7
Basis of Sex	6
Gender Expression	3
Nationality	3
Character Associations	2
Genetic Information	1
Total	384

Note: Members May alleged discrimination for many reasons. This slide only reflects allegations that fall under federally protected civil rights laws.

Q. Dr. Jalloh raises the question of why disability is the highest on this chart. Kory states it could be because disability is a broad umbrella that

Agenda Topic	Notes	Action Item
	lots of things full under it. She gives an example of someone bringing their service animals and is denied being able to bring their animal. Dr. Netherda comments that some of disability could be temporary disability as well.	
Agenda Item 5 **Grand Analysis Discussion and Vote** *Speaker: ALL*	A. Dr. Jalloh asked QIHEC members if there is any data points they would want included in a future analysis of Grievance and Appeals. B. Cathryn Couch brought up having a separate assessment of if there is any correlation with grievances and member satisfaction scores.	Motion to approve the Grand analysis. 1st Jason Cunningham 2nd Cathryn Couch
Agenda Item 6 **Community and Member Voice Presentation** *Speaker: Jesus Hermosillo, MPH*	A. Jesus conducted two focus groups on Vaccine hesitancy in the Santa Rosa region on 4/24/26 and 5/01/26. The setting was at Alliance Medical Center, in person. The demographics of the 9 participants is Hispanic/Latino ages from 23-55+. Topics discussed were knowledge and perceptions around vaccines, decision making processes around vaccines, and communication and trusted sources around vaccines. Key findings were fear of side effects or long-term harm, low trust in provider communication, and access and system navigation. Facilitators to vaccination involve simple direct bilingual vaccine information, trusted provider or CHW conversations, and community based education. B. The focus groups brought about Key themes across the coding Matrix.	

Agenda Topic	Notes	Action Item



C. 5 top themes include:
   - Knowledge gaps and informational needs
   - Fear, uncertainty and perceived vaccine risk
   - Structural and access barriers
   - Healthcare provider communication and trust
   - Social, cultural, and institutional influences

D. Participants expressed a need for some type of visual aid explaining the benefits of getting vaccinated.

E. Cathryn Couch comments that the issue of health care provider communication and trust is the most important thing that underlies patient satisfaction.

F. Jesus shared an illustrative pathway from the data he collected. The pathway shows what helps reduce vaccine uncertainty.

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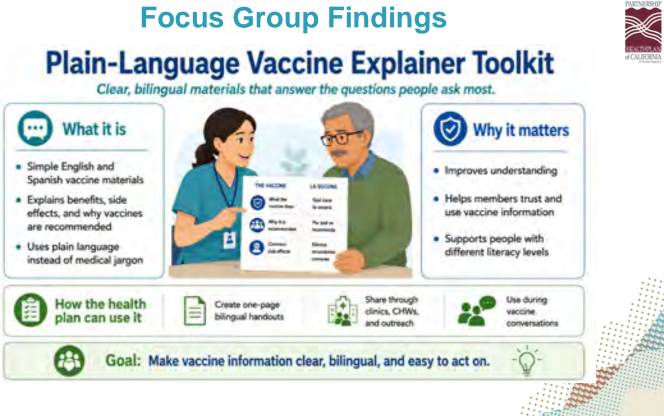
G. Jesus shared a graphic of what the focus group attendees are asking for – a toolkit with visual illustrations to reduce vaccine hesitancy.



H. Dr. Jalloh asked Jesus if anyone has provided feedback on the VIS forms that are handed out after the vaccine is given. Jesus shares that they mentioned that the material they received was written material that lacked the visual aid component that they were wanting to be included.
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Agenda Topic	Notes	Action Item
	I. Candy Stockton comments that they are required to give out VIS pages, which are issued by the federal government CDC and they could be changed or updated to include information that does not align with California recommendations. She cautions building on those documents because it is unknown if they will remain reliable. Dr. Jalloh asks if Dr. Stockton has heard of anyone making their own versions of these documents, to which Dr. Stockton was unsure. Dr. Stockton said they are thinking about their options on what paperwork they could hand out in addition to the VIS page.	
Agenda Item 7 **Health Equity Policy Discussion** *Speaker: Mohamed Jalloh, Pharm.D*	A. On a year-to-year basis, QIHEC will provide an “equity” review of policies/procedures. B. Dr. Jalloh shared the Committee Charter with the committee. C. Candy Stockton asked to be able to get more time to read the document. D. Dr. Jalloh stated that we could vote on the committee charter at the next QIHEC meeting to give members a chance to review it. E. Dr. Jalloh asked the group if there were any policies that they would like reviewed by QIHEC, to which there were none.	
Agenda Item 8 **Tribal Disparities Projects Updates** *Speaker: Tribal Liaison, Sunshine Jackson*	A. Sunshine introduces the Tribal Perinatal Program (TPP) The goal of the program is to support Tribal communities and achieve the best possible outcomes for Native Americans in Northern California. B. There are currently 6 Tribal health programs fully contracted, 3 contracts in process and one in the application process. C. This upcoming year will be focusing on PPC 1st visit within 21 days and 2 postpartum visits. D. Sunshine will be setting up a meeting cadence with each Tribal Health Program to discuss 2023-2024 data, PPC measures, future trainings, impacts and continued support.	

Agenda Topic	Notes	Action Item
	E. Sunshine is developing a Partnership prenatal and postpartum passport. F. Sunshine is working with Amanda McNair and Aja Monroe to create a Tribal Maternal photoshoot. G. Sunshine is working with Dr. Moore and Dr. Townsend to create a more detailed PP on the PHPS program to deliver Tribal Health Programs.	
Agenda Item 10 **Disparities Projects Updates** *Speaker: Mohamed Jalloh, PharmD*	A. Dr. Jalloh introduced the Barbershop CHW Program (CLIPS). The purpose of this project is to train local barbers to act as community health workers and screen clients for high blood pressure. They key things they will be doing is screening people for high blood pressure, providing basic health education, and reconnecting them back to the medical home. B. Our vendor: Oben Health/Roots Clinic – Identifies Barbershops and trains barbers as CHWs, provides EHR software and directly pays Barber C. We have trained 14 Barbers already in Solano County, we are looking to train more Barbers and beauticians this upcoming June. D. There are two options of referral pathways: 1. Oben → Clinic. We screen patients in Barbershops; Route them directly to your clinic 2. Clinic → Oben. You refer patients with uncontrolled conditions; we engage and support them in the community. E. Dr. Jalloh shares the cycles for the Barbershop project.	Motion to approve Barbershop CHW Program (CLIPS) project 1st Jason Cunningham 2nd Densie Whitsett

Agenda Topic	Notes	Action Item
	Cycle 1 Pilot & Foundations Do: launch pilot; establish workflow flow Study: Number of Barbers Trained Act: Update Training Material and finalize Barber/Beauty Training **Cycle 2** Refine current CHW workflow Do: Submit 25 Claims (1 per barber) Study: Survey and Assess Barber Barriers Act: Establish Network of Barbers/Beauty Salons **Cycle 3** CHW Integration Do: Submit 25 claims Study: Provider or PCP follow-up Act: Identify 1 health campaign to share simultaneously **Cycle 4** CHW Expansion Do: Submit 50 claims Study: Provider Survey and Campaign Results Act: Expand to other non-traditional settings 14 F. Cathryn Couch feels it is important to continue to share this information. G. Jason really likes the project and wonders how we can standardize this as it grows and takes off, he feels it will be hard to have consistent implementation. H. Dr. Jalloh shares that it has been challenging to get people into the clinics. I. Cathryn states that Series and Providence in Sonoma County has a 5-year grant to reduce health disparities and cardiovascular disease, and this is a program they have been talking about, she would like to meet offline and discuss further with Dr. Jalloh. She can also connect Dr. Jalloh with Dr. Monica Ferguson at Providence to discuss it further. J. Dr. Kubota brings up the point that those who are being screened but don’t have hypertension still need to be seen and may have other needs.	

Agenda Topic	Notes	Action Item
Agenda Item 13 **New Committee Member Vote** *Speaker: Mohamed Jalloh, Pharm.D*	• There were no new members to vote in at this time.	
Agenda Item 14 **Adjournment** *Speaker: Mohamed Jalloh, Pharm.D*	Next meeting: **July 21, 2026** • **7:30 a.m. -9:00 a.m.**	

AGENDA ITEM: II.C.1
DATE: 06/10/2026

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

TO: Physician Advisory Committee

FROM: Robert Moore, MD, MPH, MBA, Chief Medical Officer

DATE: 06/10/2026

SUBJECT: Partnership Committee Memberships

Resignation

Physician Advisory Committee

Dr. Vanessa Walker, Chief Medical Executive, Sutter-Roseville, resigns her position as a PAC voting member.

The Physician Advisory Committee thanks Dr. Walker for her support of PAC.

AGENDA ITEM: II.C.2
DATE: 06/10/2026

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

TO: Physician Advisory Committee

FROM: Robert Moore, MD, MPH, MBA, Chief Medical Officer

DATE: 06/10/2026

SUBJECT: Partnership Committee Memberships

Appointment

Physician Advisory Committee

Dr. Leigh Vall-Spinosa, Family Medicine, Medical Director for Santa Rosa Community Health Center, Dutton Clinic, volunteers to serve as a PAC voting member.

Her appointment as a voting member is recommended.

B. Leigh Vall-Spinosa, MD, MPH

Experience

SANTA ROSA COMMUNITY HEALTH CENTER, SANTA ROSA, CA — FEB 2017- PRESENT

Medical Director, Dutton Clinic 3/24-present: Medical Director of busy clinic within Santa Rosa Community Health. In addition to work as a primary care physician, responsible for: supervision of physicians, nurse practitioners and physicians assistants at the site, recruitment and hiring of clinicians, overseeing efforts at improving quality of care and patient access through working closely with the operations team and the Chief Medical Officer.

Staff Physician 2/17-2/24: Physician in urban community health center. Full scope Family Medicine - prenatal care , addiction treatment, high resolution anoscopy and other procedures. Clinical preceptor for Family Medicine and Nurse Practitioner residents. Site Lead Physician reporting to the Medical Director with duties including the evaluation and mentoring of clinicians and creating strategies to meet quality goals and improve patient care.

Clinical Faculty Sutter Santa Rosa Family Medicine Residency Jan 2022-present

Clinical Faculty Sutter Santa Rosa Addiction Medicine Fellowship Program Aug 2024-present

MEDICATION ASSISTED TREATMENT TEAM, SANTA ROSA COMMUNITY HEALTH — NOV 2017 - PRESENT

Physician member of multidisciplinary team providing evaluation and treatment for patients with substance use disorders. Provide substance use disorder consultations to clinicians in my organization. As of 3/2024 lead clinician for the team which entails reviewing and approving clinical workflows, making sure clinics are appropriately staffed, and representing the needs of our patients to the CMO and CEO.

KAISER PERMANENTE SANTA ROSA, SANTA ROSA, CA — SEPT 2016-JAN 2017

Pool physician for Adult and Family Medicine Department ambulatory clinic.

FIRST CHOICE COMMUNITY HEALTHCARE, ALBUQUERQUE, NM — 2004-2016

Physician in community health center. Served as site Medical Director of the North Valley site. Practiced full scope Family Medicine in the outpatient setting, including prenatal care and procedures. Taught medical students. Appointed Clinical Assistant Professor at the University of New Mexico School of Medicine.

UNIVERSITY OF NEW MEXICO SCHOOL OF MEDICINE, ALBUQUERQUE, NM — 2006-2008

Inpatient labor and delivery attending physician for low risk deliveries for the University of New Mexico Family Medicine Residency.

UNIVERSITY OF NEW MEXICO PROJECT ECHO RHEUMATOLOGY CLINIC — SEPT 2006-MAY 2016

Evaluated and treated patients without ready access to specialty care for rheumatologic conditions including rheumatoid arthritis and systemic lupus. Presented cases weekly in a teleconference setting and devised treatment plans with UNM Rheumatologist.

SOUTHERN COLORADO FAMILY MEDICINE RESIDENCY, PUEBLO, CO — OCT 1999-FEB 2004

Clinical Instructor in full scope family medicine including obstetrics, inpatient adult medicine, pediatrics and procedures. Gave presentations to the residents on various Family Medicine topics. Coordinated the resident procedure clinic. Supervised colposcopy, cryotherapy, LEEP, endometrial biopsy, skin biopsy and other procedures. Developed cervical dysplasia management guidelines for the residency and faculty practice. Co-developed and co-taught the behavioral science curriculum for second and third year residents. Appointed Senior Clinical Instructor at University of Colorado Health Sciences Center, School of Medicine, Department of Family Medicine June 2001.

COMPREHENSIVE FAMILY CARE CENTER, PUEBLO, CO — OCT 1999-FEB 2004

Private practice at Comprehensive Family Care Center, the faculty practice for SCFM Residency faculty. Full scope family medicine including obstetrics, inpatient adult and pediatric medicine and procedures.

PUEBLO CHILD ADVOCACY CENTER, PUEBLO, CO — MARCH 2001-FEB 2004

Interviewed and examined children referred for suspected physical abuse and neglect. Prepared and delivered testimony for court cases on physical and sexual abuse. Gave presentations to the community and to other professionals. Participated in organizing a regional conference on child abuse for child protection professionals.

Education

UNIVERSITY OF MASSACHUSETTS, AMHERST, MA — MPH 2016

SUTTER SANTA ROSA /UNIVERSITY OF CALIFORNIA AT SAN FRANCISCO FAMILY PRACTICE RESIDENCY PROGRAM, SANTA ROSA, CA — 1996-1999

UNIVERSITY OF NEW MEXICO SCHOOL OF MEDICINE, ALBUQUERQUE, NM — MD, 1996

BROWN UNIVERSITY, PROVIDENCE, RI — BA, 1988

Certification

- Licensed by California State Medical Board
- American Board of Family Medicine, Board Certified, July 1999
- Board Certified in Addiction Medicine by the American Board of Preventive Medicine, 1/1/2025

Honors

- Alpha Omega Alpha medical honor society
- David F. Vanderryn Award for Community Service, Sutter Santa Rosa Family Practice Residency Program, June 1999

Additional Training

- High resolution anoscopy, completed training - 2018
- Train New Trainers Primary Care Psychiatry Fellowship, UC Irvine. Jan - Dec 2019
- Completion of the American College of Rheumatology's Advanced Rheumatology Course Oct 2012
- Colposcopy Mentorship Program, American Society of Colposcopy and Cervical Pathology. Dec 2001
- Preceptorship in Child Abuse, Children's Hospital and Health Center, San Diego, CA. Dec 2000

Professional Memberships

- American Academy of Family Physicians, 1992-present
- American Society of Colposcopy and Cervical Pathology, 1997-present
- International Anal Neoplasia Society, 2018-present

Activities

- California Academy of Family Physicians North Bay Chapter, Member, Board of Directors, Jan 2018 - present
- New Mexico Academy of Family Physicians, Member, Board of Directors Nov 2012 to May 2016

- Member, Healthcare Advisory Council for New Mexico Congresswoman Michelle Lujan Grisham Oct 2014-May 2016

- Breast Cancer and Cervical Screening, Member, Medical Advisory Board, Albuquerque, NM Jan 2010 to May 2016

- Planned Parenthood of New Mexico, Member, Board of Directors Nov 2006 - June 2012

- Member, Bilingual Parents Advisory Committee, Alvarado Elementary, Albuquerque, NM Aug 2007 - May 2014

- Migrant Health Clinic, Avondale, CO. Volunteer physician in community health clinic serving Spanish speaking migrant farm workers. May 2000 - Feb 2004

- "Pensando en Su Salud" radio talk show, KBBF Spanish language radio station, Santa Rosa, CA. Physician guest in over thirty Spanish radio programs discussing important health issues impacting the Latino community. Santa Rosa, CA, 1997-1999

- Ethics Committee Member, Sutter Santa Rosa Medical Center. Multidisciplinary group addressing hospital policy and specific patient cases, 1997-1999

Languages

- Spanish, fluent

Proposed 2027
Perinatal Quality Improvement Program (PQIP)
Measurement Set

I. Summary of Current and Proposed Measures and/or Measure Changes

(A) Gateway Measure – Measure 1

DataLink allows for data exchange from Provider Electronic Health Records to PARTNERSHIP to capture depression screening and follow-up care. DataLink implementation is a vital component of furthering PQIP technical advancement through the capture of claims and electronic data directly exported from participating providers Electronic Health Records (EHR) systems.

(B) Clinical Measures – Measures 2-6

PHPS practices and select perinatal providers who provide quality and timely prenatal and postpartum care to PARTNERSHIP members have the option to earn additional financial incentives. The PQIP framework offers a simple and meaningful measurement set developed for PCPs and OB/GYNs and includes the following clinical measures: Timely Immunization Status - Tdap and Influenza Vaccine, Timely Prenatal Care, Late Entry to Care with Depression Screening ≥14 weeks gestation, Timely Postpartum Care and Timely Assessments.

Key:
New Proposed Measures **||** Change to Measure Design

Current 2026 6-month Bridge Measures	Proposed 2027 Measures
ECDS & Clinical Domains	
Perinatal Medicine: 1. Electronic Clinical Data Systems (ECDS) 2. Prenatal Immunization 3. Timely Prenatal Care 4. Depression Screening 5. Timely Postpartum Care 6. Timely Comprehensive (Monitoring Only)	**Perinatal Medicine:** 1. Electronic Clinical Data Systems (ECDS) 2. Prenatal Immunization 3. Timely Prenatal Care 4. Depression Screening 5. Timely Postpartum Care 6. Timely Comprehensive Assessments

PROPOSED CHANGES FOR THE PQIP 2027 MEASURE SET

Programmatic Changes:

Due to a new federal regulation that went into effect at the end of 2025, the Perinatal Quality Incentive Program must transition to a calendar year program by January 2027. Therefore, the proposed changes below pertain to the proposed 2027 Measurement Year covering the period of January 1, 2027, through December 31, 2027.

In general, all the reporting timelines for any measures included in this set have been adjusted to correlate to a calendar year period. Those revisions are not presented here. What follows are the proposed measure changes with their rationales.

A. GATEWAY MEASURE 1: ELECTRONIC CLINICAL DATA SYSTEMS (ECDS) – DATALINK IMPLEMENTATION

This measure supports the allowance of data exchange from provider Electronic Health Records to Partnership to capture clinical screenings, follow-up care and outcomes. ECDS participation is a vital component of furthering the quality of care for covered Partnership members. Note that NCQA is converting most hybrid measures to ECDS measures in the coming years. DHCS continues to make Partnership accountable for several ECDS measures. Partnership partnered with DataLink (a qualified HEDIS data aggregator) who can pull a much larger scope of measures than what is currently required for the Perinatal QIP. The DataLink process will continue to increase in emphasis and is now a gateway measure to the Perinatal QIP.

Proposal: It is proposed that contracting and connection with DataLink remain a gateway measure for 2027. It is recommended that a June 30th deadline be set to give any new providers adequate time to complete the extraction process.

Measure Requirements

All providers with existing DataLink connectivity must maintain those connections and extractions throughout the measurement year to be eligible to receive their 2027 PQIP incentive payment.

All participants new to the PQIP in 2027 must complete all ***Implementation Phases*** and ***Participation Requirement Steps*** by **June 30, 2027**, to be eligible to receive their 2027 PQIP incentive payment.

B. CLINICAL MEASURES

I. Measure 3. Timely Prenatal Care (<14 Weeks of Gestation)

Measure Summary:

Timely prenatal care services rendered to pregnant Partnership members in the first trimester, as defined as less than 14 weeks of gestation, or within 42 days of enrollment in the organization.

Proposal:

Since DataLInk connections and extractions have occurred for PQIP providers during the previous year, it is proposed to add monthly DataLink extractions be the only option for submitting visit and depression screening data. The manual submission option would be removed, but Partnership would retain the right to request manual submissions as a means of data validation if needed. Below is the suggested language change for the reporting section of the measure.

Reporting (Applies to Measures 3 & 4)

Monthly DataLink Extractions

Counts of qualifying prenatal visits will be gathered through the DataLink extraction process. Partnership reserves the right to periodically request manual submissions to validate extracted data.

A timely prenatal visit is a comprehensive ***FIRST*** prenatal visit with a clinical provider of obstetrics services (MD/DO/CNM/LM/NP/PA-c) that occurs in the first trimester of the pregnancy or within 42 days of Partnership enrollment.

Note: New providers entering the PQIP in 2027 that are not yet connected to DataLink may provide manual submissions on the provided Excel template by the tenth of each month for January through June but must complete the implementation process by June 30, 2027, to be eligible to receive incentive payment. To request a template and instructions, email perinatalqip@partnershiphp.org.

II. Measure 4: Depression Screening at First Prenatal Visit with Late Entry to Care (≥14 weeks Gestation)

Measure Summary:

Prenatal care visits to an OB/GYN or other perinatal care practitioner or PCP after the first trimester (equal to or greater than 14 weeks of gestation, as documented in the medical record) will be eligible for the incentive payment. A diagnosis of pregnancy must be present.

Proposal:

It is also proposed that Measure 4 have the same changes as noted in Measure 3.

III. Measure 6: Timely Comprehensive Assessments

Measure summary

Providers will perform Comprehensive Health Assessments that included psychosocial, nutrition and health education assessments at the initiation of care, in each trimester and in the post-partum period.

Proposal

It is proposed that this measure move from a monitoring measure to an incentivized measure as noted below.

Measure Target Specifications

Providers will earn a $100 incentive for members who gave birth during the measurement year and received the following assessments:

1. Initial Assessment with code Z6500 or code Z6200 + Z6300 + Z6402 billed on claim(s)
   And
2. Three subsequent follow-up visits: one in the second trimester, one in third trimester and one postpartum. No incentive earned if all visits are not completed.