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.
Leigh Vall-Spinosa, 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.
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
Vacant	Redding - Siskiyou, Modoc, Shasta, Lassen, Trinity & Tehama	Jayme Botke
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: September 4, 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, September 9, 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

Winters Healthcare
172 E. Grant Ave.
Winters, CA 95694

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

Marin Community Clinic
3260 Kerner Blvd.
San Rafael, CA 949013

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

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: September 9, 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

Partnership - Chico
1000 Fortress St.
Chico, CA 95973

Winters Healthcare
172 E. Grant Ave.
Winters, CA 95694

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

Marin Community Clinic
3260 Kerner Blvd.
San Rafael, CA 949013

Aliados Health
1310 Redwood Way
Petaluma, CA 94999

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 June 10, 2026, PAC Minutes**	**Dr. Brennan**	**5**	**7:55**
B.	**A**	**Consent Review: Agenda Items II. B.1, B.2, B.5, and B.7.** **Consent review allows multiple agenda items to be approved with one motion.*	**Dr. Brennan**	**21 - 426**	**7:58**

1	**C**	**Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments –**
		
		August 2026
		Acceptance of Meeting Materials
		• Internal Quality Improvement Meetings, August 11, 2026
		  • Agenda
		  • Minutes
		• Quality / Utilization Advisory Committee, August 19, 2026
		  • Agenda
		  • Minutes
		  • Quality Improvement Update
		
		Special Presentations (not included in the packet, for reference only)
		• *Population Health Grand Analysis Report (Q/UAC July 2026)*
		• *Population Health Management Workplan (Q/UAC July 2026)*
			Dr. Brennan	**21**
				23
				
				33
				35
				45
					7:58

<table>
<tr><th>II.B</th><th>C</th><th>MOTIONS FOR APPROVAL, Continued</th><th>LEAD</th><th>PG</th><th>TIME</th></tr>
<tr><td>2</td><td>C</td><td>
<table>
<tr><th colspan="2"><u>Policies/Procedures/Guidelines for Action</u></th></tr>
<tr><td colspan="2">Care Coordination</td></tr>
<tr><td>MPCP2007</td><td>Complex Case Management</td></tr>
<tr><td colspan="2">Health Equity</td></tr>
<tr><td>MCED6001</td><td>Health Equity and Community Reinvestment Strategy and Program Description</td></tr>
<tr><td colspan="2">Member Services</td></tr>
<tr><td>MP301</td><td>Assisting Providers with Missed Appointments</td></tr>
<tr><td colspan="2">Population Health Management</td></tr>
<tr><td>MPND9001</td><td>Population Health Management Strategy & Program Description</td></tr>
<tr><td>MCNP9004</td><td>Regulatory Required Notices</td></tr>
<tr><td colspan="2">Quality Improvement</td></tr>
<tr><td>MPQD1001</td><td>Quality Improvement Program Description</td></tr>
<tr><td>MPQP1048</td><td>Reporting Communicable Diseases</td></tr>
<tr><td colspan="2">Utilization Management</td></tr>
<tr><td>MCUP3012</td><td>Discharge Planning (Non-capitated Members)</td></tr>
<tr><td>MCUP3050</td><td>Medication Abortion in the First Trimester</td></tr>
<tr><td>MCUP3052</td><td>Medical Nutrition Therapy (MNT) Services</td></tr>
<tr><td>MCUP3119</td><td>Sterilization Consent Protocol</td></tr>
<tr><td>MPUP3035</td><td>Preoperative Day Review</td></tr>
</table>
Policy Summary
Detailed Synopsis of Changes
</td><td>Dr. Brennan</td><td>61
70
111
115
176
191
352
354
358
371
385
391
57
58</td><td>7:58</td></tr>
<tr><td>3</td><td>C</td><td>Pharmacy & Therapeutics Committee</td><td>Dr. Stan Leung</td><td></td><td></td></tr>
<tr><td>4</td><td>C</td><td>Provider Education & Networking (PEN) Meeting</td><td>Mr. Brincko</td><td></td><td></td></tr>
<tr><td>5</td><td>C</td><td>Credentials Committee Meeting
• Summary, July 8, 2026
• Credentialed List, July 8, 2026</td><td>Dr. Netherda</td><td>394
398</td><td>7:58</td></tr>
<tr><td>6</td><td>C</td><td>Pediatric Quality Committee</td><td>Dr. Ribordy</td><td></td><td></td></tr>
<tr><td>7</td><td>C</td><td>Quality Improvement Health Equity Committee
• Summary, July 21, 2026</td><td>Dr. Jalloh</td><td>408</td><td>7:58</td></tr>
<tr><td>C.</td><td>A</td><td>Physician Advisory Committee Membership
• Nomination of Dr. Harry Ko, Feather River Tribal Health
• Resume</td><td>Dr. Brennan</td><td>427
428</td><td>8:00</td></tr>
<tr><th>III.</th><th>I</th><th>EXECUTIVE MEMBER UPDATE</th><th>LEAD</th><th>PG</th><th>TIME</th></tr>
<tr><td>A.</td><td>I</td><td>Clinical Efficiency Adjustments
CY 2027 Rate Development – DHCS Final Decisions, July 2026</td><td>Dr. Jones</td><td>1050</td><td>8:00</td></tr>
</table>

IV.	I	REGIONAL MEDICAL DIRECTOR REPORTS	LEAD		TIME
A.	I	**Napa, Yolo & Solano**	**Ms. Power**		**8:12**
B.	I	**Marin & Sonoma**	**Dr. Ward**		**8:15**
C.	I	**Del Norte, Humboldt, Mendocino & Lake**	**Dr. Ribordy**		**8:18**
D.	I	**Glenn, Butte, Sutter, Colusa & Yuba,**	**Dr. Matthews**		**8:21**
E.	I	**Siskiyou, Modoc, Shasta, Lassen, Trinity & Tehama**	**Dr. Matthews**		**8:24**
F.	I	**Plumas, Sierra, Nevada & Placer**	**Dr. Morris**		**8:27**
V.	*I*	*Old Business*	*LEAD*	*PG*	*TIME*
VI.	**I**	**SPECIAL PRESENTATIONS**	**LEAD**	**PG**	**TIME**
A.	**A**	**Enhanced Care Management Quality Incentive Program** Proposed Measurement Set, Measurement Year 2027	**Ms. Beltran-Nampraseut**	**430**	**8:30**
B.	**A**	**Extended Care Center Quality Incentive Program** Proposed Measurement Set, Measurement Year 2027	**Ms. Gual**	**432**	**8:32**
C.	**A**	**Hospital Quality Incentive Program** Proposed Measurement Set, Measurement Year 2027	**Mr. Foster**	**435**	**8:35**

D.	**A**	**Quality Improvement Trilogy**
		• Closeout Summary of FY 2025-2026 QI Work Plan
		• Summary of QI Trilogy Documents
		• **QI Trilogy Documents**
		  • 2025-2026 QI Evaluation
		  • 2026-2027 QI Work Plan
		  • 2026-2027 QI Program Description *(p. 191)*
			Mr. Brown	**444**
				457
				
				460
				1035
				(191)
					8:40

VII.	**I**	**ADJOURNMENT**	**LEAD**		**9:00**
		Next PAC on October 14, 2026 at 7:30 a.m.	**Dr. Brennan**		

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 can also be found online at the Physician Advisory Committee webpage, linked here. 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 any materials distributed at the meeting, should contact Partnership 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: **August 12, 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)*	Candy Stockton, MD *(E)*	Mills Matheson, MD *(OMM)*	*FF Fairfield*	*MCC Marin Community Clinics*
	Brian Montenegro, MD *(FF)*	Chris Myers, MD, *(E)*	Derice Seid, MD *(MCC)*	*SR Santa Rosa*	*OMM Office of Dr. Matheson*
	Michelle Herman, MD *(FF)*	Malia Honda, MD *(E)*		*E Eureka*	*SL Sutter Health Lakeside*
	Steven Gwiazdowski, MD *(FF)*	John McDermott, FNP *(C)*		*R Redding*	
	Teresa Shinder, MD *(FF)*	Darrick Nelson, MD *(R)*		*C Chico*	
	Zoe Cappe, MD *(FF)*	Leigh Vall-Spinosa, MD *(SR)*		*AU Auburn*	
Members Excused:	Karen Sprague, MSN, CFNP	Matthew Zavod, MD	Christina Lasich, MD		
	Chester Austin, MD	Betzabel Kunkel, MD			
Members Absent:	Danielle Oryn, DO				
	Karina Gookin, MD				

Partnership Staff:	Sonja Bjork, Chief Executive Officer	Katherine Barresi, RN, Chief Health Services Officer	Irem Conery, Director of Member Experience
	Jennifer Lopez, Chief Financial Officer	Robert Moore, MD, Chief Medical Officer	DeLorean Ruffin, DrPH, Director, Population Health
	Wendi Davis, Chief Operating Officer	Kermit Jones, MD, Deputy Chief Medical Officer	Mohamed Jalloh, Pharm.D., Director, Health Equity
	Leigha Andrews, Region Director	Colleen Townsend, MD, Region Medical Director	Isaac Brown, Sr. Dir., Quality & Performance Improvement
	Vicky Klakken, Region Director	Jeffrey Ribordy, MD, Region Medical Director	Vacant, Director, Quality Management
	Brigid Gast, RN, Sr. Dir., Care Management	Bradley Cox, MD, Region Medical Director	Kristine Gual, Director, Quality Measurement
	Aaron Brincko, Sr. Dir., Provider Relations	R. Doug Matthews, MD, Region Medical Director	Vacant, Manager of QI Programs
	Lisa O'Connell, Dir. Enhanced Health Services	Matthew Morris, MD, Region Medical Director	Sue Quichocho, Mgr., Quality Measurement
		Lisa Ward, MD, Region Medical Director	Megan Shelton, Project Manager, Quality Improvement
	Doreen Crume, RN, Mgr. Care Coord.	Mark Netherda, MD, Medical Director for Quality	Vacant, RN, Director, Utilization Mgmt. (UM)
	Stephanie Nakatani, Supervisor Provider Relations Representatives	Jeffrey DeVido, MD, Behavioral Health Clinical Dir.	Kevin Jarret-Lee, RN, Assoc. Dir. of UM
		Stan Leung, Pharm.D., Director, Pharmacy Services	Robby Potter, RN, Supervisor of Inpatient UM
		Marshall Kubota, MD, Associate Medical Director	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	14/21 – PAC	Committee quorum requirements met (14).	08/12/26

DRAFT

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

I.A. Chief Executive Officer (CEO) Report	**Partnership's Chief Human Resources Officer presented an administrative update on behalf of the Chief Executive Officer.**
	
	Unsatisfactory Immigration Status (UIS) Transition to Medi-Cal Fee for Service (FFS)
	• Effective January 1, 2027, members in UIS status will transition out of managed care for general Medi-Cal benefits and into the state Medi-Cal fee-for-service delivery system.
	• The change affects approximately 2 million members statewide and, based on Partnership data as of August 1, approximately 84,000 Partnership members.
	• The transition is a delivery-system change, not a loss of Medi-Cal eligibility for general medical benefits.
	• Members affected by the transition will no longer be assigned to Partnership HealthPlan, managed care plans, or primary care providers through managed care.
	• Members may seek care from any Medi-Cal fee-for-service enrolled provider who is accepting patients.
	• Pharmacy benefits will continue through Medi-Cal Rx.
	• Specialty mental health services and substance use disorder treatment will continue through county behavioral health systems.
	• Members moving to fee-for-service will no longer be eligible for Enhanced Care Management or Community Supports.
	• DHCS has released a UIS transition policy guide and is coordinating with Partnership and other managed care plans to support the transition.
	• Partnership is taking the following actions in preparation for the transition:
	  • Identifying high-risk members, including members receiving dialysis, transplant patients, members in skilled nursing facilities, and members receiving CCS services.
	  • Conducting outreach to high-risk members to explain upcoming changes, available options, and provider availability after January 1, 2027.
	  • Working with DHCS to determine what meaningful data can be shared to support continuity of care, including authorization data and patient census information.
	  • Advocating for DHCS to establish an escalation pathway so health plans, providers, and counties can quickly address urgent transition issues.
	• An internal Partnership workgroup is coordinating across the organization to support timely planning and communication with members, providers, and community stakeholders.
	• Providers and members are encouraged to keep their contact information current with their county Medi-Cal eligibility office.
	• Providers should ensure medically necessary treatment plans, referrals, and medication regimens are requested and reviewed before the transition date.
	• Providers who want to continue serving affected members must be enrolled in Medi-Cal fee-for-service through PAVE, the Provider Application and Validation for Enrollment process through DHCS.
	• Partnership provides a county-by-county list of resources on its Community webpage that may be helpful to members and providers during the transition.
	
	Questions
	
	Will Medi-Cal fee-for-service cover eConsult and telemedicine services after members transition out of managed care?
	Partnership will verify and follow up. Individual providers may be able to contract directly with eConsult vendors for multiple insurance statuses, including uninsured patients, which may be a potential workaround if Medi-Cal fee-for-service does not cover comparable services.
	
	Will specialists currently contracted with Partnership be expected or required to continue seeing members after the members transition to Medi-Cal fee-for-service?
	Contracted specialists are required to be PAVE enrolled and therefore are Medi-Cal providers; however, there is no direct requirement that they accept Medi-Cal fee-for-service rates. Continuity-of-care and patient-abandonment considerations may apply, but enforcement would likely fall to the state.

DRAFT

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
I.A Chief Executive Officer (CEO) Report, Continued	**Rural Workforce Development, Recruitment, and Retention Funding Opportunity** • CalAIM/CalAIM-related workforce guidance had been released for a new rural workforce funding opportunity focused on workforce development, recruitment, and retention. • The opportunity is intended to support recruitment and retention of professionals serving rural California communities. • Approximately $54.2 million is available statewide. • Funding may be available up to approximately $1 million per organization or $2 million per consortium. • Individual provider-related support may exceed $150,000 and is tied to a five-year service commitment. • Eligible applicants include rural-serving organizations, rural hospitals, clinics, federally qualified health centers, tribal health organizations, rural collaboratives, and controlled hubs. • Qualifying sites must be physically located in rural areas as defined by HRSA. • Priority clinical personnel include professionals in primary care, maternity care, nursing, and community-based direct care, with additional eligible positions identified in the full guidance. • Applications are open and close on August 31, 2026. • Awards are anticipated in September or October 2026. • Partnership's immediate focus is helping eligible organizations understand and pursue the funds so as much investment as possible remains in the region. • Partnership will monitor how award dollars are distributed, identify remaining workforce gaps, and evaluate how Partnership's provider recruitment and retention initiatives can best complement the new funding. *No questions asked.*
I.B Chief Medical Officer (CMO) Health Services Report	**Partnership's Chief Medical Officer presented the following Health Services report.** **Strategic Planning** • Partnership is beginning its every three-year strategic planning process. • The strategic planning process begins with internal review of the prior strategic plan and staff input regarding potential new focus areas, including community involvement, stakeholder interviews, input from the Community Advisory Committee, and eventual Board review and approval. • Board approval of the updated strategic plan is anticipated in April. **Rural Health Transformation Funding** • Funding opportunities are being released periodically, approximately one or two per month, requiring organizations to remain attentive to deadlines. • Partnership is not applying for grants itself and is not positioned to receive grant money; instead, Partnership is supporting efforts to bring resources into the community. • There are concerns among some rural hospitals that portions of the funding may be redirected to state-level administration, consultants, or non-hospital entities rather than directly supporting hospitals affected by federal funding changes. • Continued support for small rural hospitals remains critical. **Developmental Screening for Children and Follow-up Care** • A partnership between Chapa-De Indian Health and the UC Davis MIND Institute has a promising pilot with lessons that may be useful to the broader network. • A webinar on developmental screening and follow-up is planned for Monday, September 21, 2026, from noon to 1:00 p.m. • Organizations are encouraged to send clinical or administrative staff involved in pediatrics or pediatric developmental care.

DRAFT

AGENDA ITEM	MOTIONS FOR APPROVAL	RECOMMENDATIONS / ACTION	DATE RESOLVED
II.A.	**June 10, 2026, PAC minutes were presented for approval.**	**MOTION:** Dr. Herman moved to approve Agenda II.A as presented, seconded by, seconded by Dr. Gwiazdowski. **ACTION SUMMARY:** [14] yes, [0] no, [0] abstentions.	08/12/26 Motion carried.
II.B. II.B.1 II.B.2 II.B.3 II.B.5	**Consent Calendar Review** • Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – June & July 2026 • Policies, Procedures, and Guidelines for Action Policy Summary, August 12, 2026 • Pharmacy & Therapeutics Advisory Committee Summary, July 9, 2026 • Credentials Committee Meeting Summary & Credentialed List, May 13, 2026 Summary & Credentialed List, June 10, 2026	**MOTION:** Dr. Montenegro moved to approve Agenda II.B.1, II.B.2, II.B.3, and II.B.5 as presented, seconded by Dr. Herman. **ACTION SUMMARY:** [14] yes, [0] no, [0] abstentions.	08/12/26 Motion carried.
VI.A	Proposed 2027 Perinatal Quality Improvement Program (QIP) Measure Set	**MOTION:** Dr. Herman moved to approve Agenda item VI.A as presented, seconded by Dr. Montenegro **ACTION SUMMARY:** [14] yes, [0] no, [0] abstentions.	08/12/26 Motion carried

DRAFT

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
III. Executive Leadership Update, Deputy Chief Medical Officer	**Partnership's Deputy Chief Medical Officer provided a brief report discussing additional Partnership activities.** **DHCS Clinical Efficiency Review** • The review uses inpatient, outpatient, pharmacy, and encounter data from a prior 12-month period to make prospective adjustments to managed care capitation rates. For the current review cycle, DHCS is using data from July 2024 through June 2025 to inform capitation rates beginning in 2027. • DHCS reviews selected areas where data suggest care may be delivered more efficiently. Some perceived inefficiencies may reflect missing data rather than true clinical inefficiency, such as missing documentation of seven-day or 30-day outpatient follow-up after hospital or emergency department visits. • Initial areas reviewed by DHCS included low-acuity non-emergent emergency department utilization, medically unnecessary cesarean sections, durable medical equipment, radiology, short inpatient stays, and cellulitis treatment. After several rounds of engagement with Partnership and other managed care plans in February, May, and June, DHCS held back on applying efficiencies related to cellulitis treatment, short inpatient stays, durable medical equipment, and radiology. Some efficiency categories may be clinically reasonable in theory, such as outpatient treatment of cellulitis, while others may function more like a broad capitation reduction; for example, DHCS identified a statewide percentage of cesarean sections it considered potentially unjustified or medically unnecessary, with regional variation across California. • DHCS applies global exclusions to remove certain complex members from efficiency calculations, including members with HIV, trauma, extensive burns treated in the ICU, and metastatic cancer. • For the current period, the targeted efficiency level was set at 50%, meaning that if a potential efficiency amount was calculated at $1 million, the capitation adjustment would withhold $500,000. • The targeted efficiency level is expected to increase for 2028. • Partnership will continue meeting with DHCS regarding clinical efficiencies and more detailed report will be provided at the next PAC meeting. **Enhanced Provider Engagement Program** • The program originally began in 2023 and focuses on providers across the network who earned less than 25% of available PCP QIP incentives. • Targeted engagement includes additional tools, coaching, monthly engagement, and quality improvement support. • The program goal is to help participating providers improve performance to at least the 50% incentive level. • Some providers in the network have already begun engaging with Partnership through the program.

IV.A Status Update, Regional Medical	**Partnership's Regional Medical Director for Napa, Solano, and Yolo Counties presented a brief update on activities.**
	• CommuniCare+OLE recently appointed a new Chief Medical Officer.
	• La Clinica held a successful kindergarten roundup event in Vallejo, serving close to 100 children for preschool and kindergarten, which included exams, screening services, and support for children preparing to enter school.
	  • Compared with early post-COVID kindergarten roundup events, children appeared to be presenting with fewer previously undetected developmental and physical findings.
	  • In prior years, many children had delayed or missed care during the COVID period, resulting in significant developmental and physical concerns identified at school-entry exams.
	  • This year, children with developmental concerns were more likely to already be connected to services and were reportedly doing well with those services.
	  • Developing a toolkit with Touro and other health centers to help practices implement similar events that would identify staffing, clinical, host-organization, and operational resources needed to conduct a successful kindergarten roundup.
	• The NorthBay–Providence Queen of the Valley merger continues to move forward, with implementation still anticipated for January 2027.

DRAFT

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
IV.B Status Update, Regional Medical	**Partnership's Regional Medical Director for Marin and Sonoma Counties presented a brief update on activities.** • The next Santa Rosa regional quality meeting is scheduled for September 3. The meeting theme will be chronic disease management, with a focus on the role of nursing in supporting blood pressure control. • The region is moving forward on Community Health Assessment/Community Health Improvement Plan (CHA/CHIP) goals related to vaccine uptake, focused on influenza vaccine uptake among children ages zero to five. • Dr. Mia Shim has been appointed Public Health Officer for Sonoma County. • The region welcomed new family medicine resident classes at Kaiser and Sutter Santa Rosa through a dinner gathering sponsored by the Sonoma-Mendocino-Lake chapter of the California Medical Association. • Partnership staff recently met with the Sonoma County Economic Development Agency and Sonoma County Human Services Department regarding enrollment and work requirements. The new collaboration is intended to help coordinate efforts so members can keep Medi-Cal applications, enrollment, and reenrollment moving efficiently. • Two large clinics in the area that have been providing gender-affirming care are either organizing changes to their services or have ceased providing that care because of the current federal health policy environment. Those clinics are working to develop alternative collaboration and care-management pathways so affected patients can be connected to other sources of care. • Petaluma Health Center is opening a new site with 27 exam rooms, supported by Partnership access grant funding earlier in the year. Petaluma Health Center is also opening a new pharmacy in West Marin. Petaluma Health Center's interim CMO is stepping down. Dr. Melissa Marshall will serve as a consultant to support Petaluma Health Center in developing the new CMO search process and job description. • Two clinics held back-to-school events, one at Ritter Center and one at Sonoma Valley Community Health Center. More than 350 children received backpacks, school supplies, and gift certificates through these events. Partnership member services staff attended the events to distribute Keep Your Medi-Cal campaign materials and speak with families about benefits. • Marin Community Clinics is closing its Larkspur site and consolidating patients into the nearby Greenbrae site. • Alexander Valley Healthcare reported hiring six new staff members, including two family nurse practitioners and two licensed marriage and family therapists in behavioral health. There are two promising Chief Medical Officer candidates under review after more than a year without a permanent CMO.
IV.C Status Update, Regional Medical	**Partnership's Regional Medical Director for Lake, Mendocino, Humboldt, and Del Norte Counties presented a brief update on activities.** • Lake County is seeking a part-time public health officer. • In Mendocino County, Darcy Antle, the recent Director of Health and Human Services, is returning in a part-time deputy director role. • Mendocino County currently has an interim Health and Human Services Director and is seeking a permanent director. • Mendocino Community Health Clinic also has a Chief Executive Officer opening. • The Yurok Tribe broke ground in July on a health and wellness center near Martin's Ferry Bridge, north of the Hoopa area. The center is expected to include inpatient and outpatient substance use disorder treatment, as well as a broad range of health and wellness services for tribal members. • The project was described as a significant new resource for the community. • The Eureka region recently hosted a long-term care appreciation luncheon for long-term care providers. The luncheon recognized the work of long-term care providers and provided an opportunity to discuss upcoming changes affecting long-term care. • Several small fires in the region have been contained or knocked down quickly by Cal Fire and other responding agencies. A larger fire in Hoopa Valley was reported at approximately 2,800 acres and about 10% contained as of midnight. The fire was not believed to be threatening many structures at the time of the report, but it was affecting air quality in Hoopa Valley. Agencies were working to provide air purifiers and other available support to the area. • The United Indian Health Services clinic in Weitchpec temporarily closed for one or two days because the highway was closed due to the fire's proximity. Alternative routes remained available, and the clinic had reopened, although air quality remained a concern. • The Eureka region held its first maternity photo shoot at Sequoia Park in Eureka. The event invited pregnant members, recently postpartum members, and their families to participate in a professional photo shoot. Approximately 29 mothers and families attended. The event was conducted in coordination with the Population Health Department and supported by Population Health staff and the Eureka office team.

DRAFT

AGENDA ITEM	DISCUSSION / CONCLUSIONS ACTION REQUIRED
IV.D Status Update, Regional Medical	**Partnership's Regional Medical Director for Glenn, Butte, Sutter, and Colusa Counties presented a brief update on activities.** • Pediatric expansion discussions are underway in the Gridley area. Chukwuemeka Ndulue MD, a private-practice pediatrician in Gridley, is expanding office hours into the evening. • The AAM/Orchard Hospital clinics, formerly associated with Glenn Medical Center, are also hoping to expand pediatric capacity. • The Enloe Health Gonzales Comprehensive Cancer Center in Chico recently held its ribbon cutting. The center intends to begin seeing patients the following month. • A federal bankruptcy court judge extended the timeline for Oroville Hospital's restructuring and/or sale. The original round of bids did not satisfy the debtors, and the institution was not sold through that initial process. Hospital leadership is reportedly hoping that operational changes will allow the current system to continue functioning longer while the restructuring process proceeds. Additional news indicated that the hospital and its parent organization opened a lawsuit against the prior chief executive officer related to organizational challenges. Oroville Hospital is expected to remain in a difficult and uncertain situation for the near future. • In the five-county Chico region, current clinical-efficiency challenges appear clustered around hospital readmissions. The most prominent readmission diagnoses identified were diabetes and congestive heart failure. The region will work with hospitals, clinics, and potentially third parties to identify patients at risk for readmission. The goal of the effort is to determine how additional outpatient supports can be provided to keep patients stable in the outpatient setting and reduce avoidable readmissions.
IV.E Status Update, Regional Medical	**Partnership's Regional Medical Director for Glenn, Butte, Sutter, and Colusa Counties presented a brief update on activities on behalf of Siskiyou, Modoc, Shasta, Lassen, Trinity, and Tehama Counties.** • Dr. Kirk, a Redding region OB/GYN, is transitioning from private practice to a hospital-based practice through the Mercy/St. Elizabeth system. Dr. Kirk is expected to continue seeing Partnership members in the new setting but appears likely to serve more in a hospitalist role while continuing to see Partnership patients. • The Redding Mercy cancer center is scheduled to open on Tuesday, August 18. The center is expected to support stabilization of oncology services, including both medical oncology and radiation oncology. • Partnership has been working closely with Shasta Regional Medical Center to expand outpatient radiology capacity in the Redding area. • Potential additional outpatient radiology access may include outpatient MRI, additional outpatient mammography, and possible DEXA scan availability.
IV.F Status Update, Regional Medical	**Partnership's Regional Medical Director for Plumas, Sierra, Nevada, Yuba, and Placer Counties presented a brief update on activities.** • Tahoe Forest in Nevada County is opening a mobile clinic for primary and urgent care as well as expanding those services in a new building. Dr. Brian Evans has stepped away from his role as CMO and Tahoe Forest to serve as Public Health Officer for Nevada County. • Partnership recently convened a Nevada County Enhanced Care Management Provider forum to facilitate network engagement and coordination. • Crisis stabilization unit temporarily closed during vendor transition but expected to reopen October 1, 2026. • Joint Leadership Initiative meetings are ongoing with area clinics in Placer County. • Partnered with Vision to Learn in Lincoln to perform eye screenings and exams as well as provide glasses for more than 50 school-age children. • Placer County Health and Human Services received three national awards for recognition from the National Association of Counties, which recognizes innovative county government programs: The Harbor, a 16-bed recovery unit designed to help bridge the gap for individuals that are waiting for residential substance abuse treatment; Eat Well, an app connecting local businesses with excess food to low-income individuals, and Placer County Dashboard for coordinating local services across the county in real time. • All region counties received Partnership Expansion County Reinvestment Grants and will focus on well-care visits, immunizations, and prenatal care. • Partnership's Chronic Disease Quality Measurements for Improvement team has been providing education to members regarding high blood pressure.
V. Old Business	*No old business.*

DRAFT

AGENDA ITEM	DISCUSSION / CONCLUSIONS
VI.A Proposed 2027 Primary Care Provider Quality Incentive Program (PCPQIP) Measurement Set, Continued	**Summary of Proposed Measure Changes for Measurement Year 2027** **(A) Core Measurement Set Measures** Providers have the potential to earn a total of 100 points in two measurement areas: Clinical Domain and Non-Clinical Domain. Individual measure values will be assigned to the final and approved measurement set. **Changes to Existing Clinical Measures:** • Chlamydia Screening (Clinical, All Practice Types) – Retire and make a monitoring measure with HEDIS criteria. • Diabetes Management: Retinal Eye Exams (Clinical, Family Practice, and Internal Medicine) – Retire and make a monitoring measure. Maintaining this measure in a monitoring capacity supports early identification of care gaps, helps target interventions for high-risk members, and preserves visibility into an important clinical service without requiring it to drive formal stars scoring. • Reducing Healthcare Disparity (Optional Clinical, All Practice Types) – Retire. DHCS changed approach for plan and expectations for reducing healthcare disparities. **<u>New Additions as Monitoring Measures</u>** **Clinical** • Development Screening (Clinical, Family and Pediatric Practice) • First Timely Prenatal Care Visit (Clinical, Family and Pediatric Practice) • Adult Immunizations (Clinical, Family Practice, and Internal Medicine) • Follow-up after Acute and Urgent Care Visits for Asthma (Clinical, All Practice Types) • Asthma Medication Ratio (Clinical, All Practice Types) **Non-Clinical** • Tobacco Use Screening and Cessation (All Practice Types) • Ambulatory Care Sensitive Admissions (Family Practice and Internal Medicine) • Avoidable Emergency Department (ED) Visits (All Practice Types)

Key:

New Measure || Change to Measure Design || ~~Measure removed~~

2026 Measures	2027 Recommendations
Clinical Domain	
Family Medicine: 1. Breast Cancer Screening (40-74yo) 2. Cervical Cancer Screening 3. Child and Adolescent Well Care Visits 4. Childhood Immunization Status: Combo 10 5. Colorectal Cancer Screening 6. Comprehensive Diabetes Management: HbA1c Good Control 7. Comprehensive Diabetes Management: Retinal Eye Exams 8. Controlling High Blood Pressure 9. Immunizations for Adolescents – Combo 2 10. Well-Child Visits in the First 15 Months of Life 11. Lead Screening in Children 12. Chlamydia Screening (16-24yo) 13. Kidney Health Evaluation for Patients with Diabetes 14. Well-Child Visits in the first 15-30 months of life – **Monitoring** 15. Topical fluoride in Children – **Monitoring** 16. Reducing Healthcare Disparity (**Participation is Optional**)	**Family Medicine:** 1. Breast Cancer Screening (40-74yo) 2. Cervical Cancer Screening 3. Child and Adolescent Well Care Visits 4. Childhood Immunization Status: Combo 10 5. Colorectal Cancer Screening 6. Comprehensive Diabetes Management: HbA1c Good Control 7. ~~Comprehensive Diabetes Management: Retinal Eye Exams – **Retire to Monitoring Status**~~ 8. Controlling High Blood Pressure 9. Immunizations for Adolescents – Combo 2 10. Well-Child Visits in the First 15 Months of Life 11. Lead Screening in Children 12. ~~Chlamydia Screening (16-24yo) – **Retire to Monitoring Status**~~ 13. Kidney Health Evaluation for Patients with Diabetes 14. Well-Child Visits in the first 15-30 months of life – **Keep as Monitoring** 15. Topical fluoride in Children – **Keep as Monitoring** 16. Developmental Screening – **New Monitoring** 17. First Timely Prenatal Care Visit – **New Monitoring** 18. Adult Immunization – **New Monitoring** 19. Follow-up after Acute and Urgent Care Visits for Asthma – **New Monitoring** 20. Asthma Medication Ratio – **New Monitoring**
	21. Tobacco Use Screening and Cessation – **New Monitoring** 22. ~~Reducing Healthcare Disparity (**Participation is Optional**)~~

DRAFT

AGENDA ITEM	DISCUSSION / CONCLUSIONS
VI.A Proposed 2027 Primary Care Provider Quality Incentive Program (PCPQIP) Measurement Set Continued	

Clinical Domain	
Internal Medicine: 1. Breast Cancer Screening (40-74yo) 2. Cervical Cancer Screening 3. Colorectal Cancer Screening 4. Controlling High Blood Pressure 5. Comprehensive Diabetes Management: HbA1c Good Control 6. Comprehensive Diabetes Management: Retinal Eye Exams 7. Chlamydia Screening (21-24yo) 8. Reducing Healthcare Disparity (**Participation is Optional**) 9. Kidney Health Evaluation for Patients with Diabetes	**Internal Medicine:** 1. Breast Cancer Screening (40-74yo) 2. Cervical Cancer Screening 3. Colorectal Cancer Screening 4. Controlling High Blood Pressure 5. Comprehensive Diabetes Management: HbA1c Good Control 6. ~~Comprehensive Diabetes Management: Retinal Eye Exams~~ – ~~**Retire to Monitoring Status**~~ 7. ~~Chlamydia Screening (21-24yo)~~ – ~~**Retire to Monitoring Status**~~ 8. Kidney Health Evaluation for Patients with Diabetes 9. First Timely Prenatal Care Visit – **New Monitoring** 10. Adult Immunization – **New Monitoring** 11. Follow-up after Acute and Urgent Care Visits for Asthma – **New Monitoring** 12. Asthma Medication Ratio – **New Monitoring** 13. Tobacco Use Screening and Cessation – **New Monitoring** 14. ~~Reducing Healthcare Disparity (**Participation is Optional**)~~

Clinical Domain	
Pediatric Medicine: 1. Child and Adolescent Well Care Visits 2. Childhood Immunization Status: Combo 10 3. Immunizations for Adolescents – Combo 2 4. Well-Child Visits in the First 15 Months of Life	**Pediatric Medicine:** 1. Child and Adolescent Well Care Visits 2. Childhood Immunization Status: Combo 10 3. Immunizations for Adolescents – Combo 2 4. Well-Child Visits in the First 15 Months of Life
6. Well-Child Visits in the first 15-30 months of life 7. Chlamydia Screening (16-20yo) 8. Topical fluoride in Children – **Monitoring** 9. Reducing Healthcare Disparity (**Participation is Optional**)	6. Well-Child Visits in the first 15-30 months of life 7. ~~Chlamydia Screening (16-20yo)~~ – ~~**Retire to Monitoring Status**~~ 8. Topical fluoride in Children – **Keep as Monitoring** 9. Developmental Screening – **New Monitoring** 10. Follow-up after Acute and Urgent Care Visits for Asthma – **New Monitoring** 11. Asthma Medication Ratio – **New Monitoring** 12. Tobacco Use Screening and Cessation – **New Monitoring** 13. ~~Reducing Healthcare Disparity (**Participation is Optional**)~~

Changes to Existing Non-Clinical Measures

- Patient Experience (Non-Clinical) – Redesign to Consumer Assessment of Healthcare Providers and Systems (CAHPS) measure requirements, includes a robust improvement plan and ongoing monthly reporting. The two composite measures for the CG-CAHPS survey are access and communication, which are key drivers to patient satisfaction.
- Ambulatory Care Sensitive Admissions (Family Practice and Internal Medicine) – Measure name change for reporting purposes.
- Avoidable Emergency Department (ED) Visits (All Practice Types) – Measure name change for reporting purposes.

2026 Measures	2027 Recommendations
Non-Clinical Domain	
Family Medicine & Internal Medicine: 1. Ambulatory Care Sensitive Admissions 2. Follow-up within 7 days after Hospital Discharge 3. Avoidable ED Visits 4. PCP Office Visits 5. Patient Experience	**Family Medicine & Internal Medicine:** 1. Potentially Preventable Admissions 2. Follow-up within 7 days after Hospital Discharge 3. Low-Acuity Non-Emergent ED Visits 4. PCP Office Visits 5. Patient Experience
Non-Clinical Domain	
Pediatric Medicine: 1. Avoidable ED Visits 2. PCP Office Visits 3. Patient Experience	**Pediatric Medicine:** 1. Low-Acuity Non-Emergent ED Visits 2. PCP Office Visits 3. Patient Experience

DRAFT

AGENDA ITEM	DISCUSSION / CONCLUSIONS
VI.A Proposed 2027 Primary Care Provider Quality Incentive Program (PCPQIP) Measurement Set, Continued	**Unit of Service Measures** **Providers receive payment for each unit of service they provide.** <u>Changes to Existing Unit of Service Measures:</u> • Tobacco Use Screening – Retire and make monitoring measure which adopts HEDIS criteria. Newly added MY2026 HEDIS measure includes both adolescents (12 years of age and older) and adults along with a requirement for cessation intervention. • ECDS – Retire. * No uploads will be allowed for the following core clinical measures: BCS, CCS, COL, LSC, IMA, and CIS10. NCQA and MCAS measures will be transitioning to ECDS reporting only (i.e., no manual uploads will be permitted) by 2029. This data exchange from the provider's Electronic Health Records to Datalink (a qualified HEDIS data aggregator), allows Partnership to capture clinical screenings, immunization records, follow-up care, and outcomes. *Proposed measurement set was approved by PAC voting members.*
VI.B Healthcare Effectiveness Data Information Set (HEDIS ®) Annual Summary of Performance	**Healthcare Effectiveness Data Information Set (HEDIS ®) Annual Summary of Performance**

Unit of Service	
All Sites:	**All Sites:**
1. Clinician Education on Improving Medication Management 2. Advance Care Planning 3. Extended Office Hours 4. PCMH Certification 5. Peer-led and Pediatric Group Visits 6. Health Information Exchange 7. Health Equity 8. Tobacco Use Screening 9. Electronic Clinical Data Systems (ECDS)	1. Clinician Education on Improving Medication Management 2. Advance Care Planning 3. Extended Office Hours 4. PCMH Certification 5. Peer-led and Pediatric Group Visits 6. Health Information Exchange 7. Health Equity 8. ~~Tobacco Use Screening – Retire~~ 9. ~~Electronic Clinical Data Systems (ECDS) – Retire~~

DRAFT

AGENDA ITEM	DISCUSSION / CONCLUSIONS
VI.B Healthcare Effectiveness Data Information Set (HEDIS ®) Annual Summary of Performance	**Healthcare Effectiveness Data Information Set (HEDIS ®) Annual Summary of Performance** Presentation reviewed Partnership's results in the context of DHCS accountability programs, including the measures and performance expectations DHCS uses to prioritize member health and clinical care statewide. The goal is to help provider organizations understand what is most important from a performance and accountability standpoint and to support local priority-setting. **Partnership's Quality Accountability Programs** • DHCS has rolled out a number of additional accountability programs that look at HEDIS performance and have financial consequences for the plan. • Overview is very high level because the programs are complex. Regional and county measure rates are growing in importance and Partnership is focused on the regional priorities and goals seen as the best path towards high performance in all programs. • Partnership has between $70-80M in financial risk annually in DHCS accountability programs. • **Quality Withholds and Incentives**: subset of MCAS measures, dollars of income withheld and earned back by high performance OR year-over-year significant improvement on measures at the Quality Rating Region level. • **Clinical Efficiencies**: Penalizes plan for high inpatient utilization, one key driver is unmanaged complex chronic conditions. • **Community Reinvestments for Quality**: looks at MCAS performance at the County level, additional percentage of Partnership's profit given to counties with multiple measures in any measure domain below 50th • **Sanctions**: our original accountability program, any MCAS measure < 50th • **Quality Factor Score**: our composite performance rate compared to other California Managed Care Plans (MCP).

Program	Geographic Impact	Financial Impact	Low Performance Trigger	Path to High Performance
Quality Withholds and Incentive Program	Quality Rating Regions	$Tens of Millions	<67th percentile performance AND <25% YoY improvement	North Bay Area: **Achievement** Rural Upper North and Rural Upper Central: **Year-over year improvement**
Clinical Efficiencies	Plan Wide	$Tens of Millions	High inpatient utilization by members with complex chronic conditions	Intensive **case management of high-risk members**
Community Reinvestments - Quality	County	$Millions	2+ measures <50th percentile in any measure domain	County-level **measure prioritization**
Quality Sanctions	County	$100k - $500k	<50th percentile performance	**Data completeness,** impact of high performance in other programs
Quality Factor Score	Plan Wide	None	None	n/a
NCQA Health Plan Rating	Plan Wide	None	None	n/a

AGENDA ITEM	DISCUSSION / CONCLUSIONS
VI.B Healthcare Effectiveness Data Information Set (HEDIS ®) Annual Summary of Performance	**Managed Care Accountability Set (MCAS) Results** **Accountable Measures for MY2025**

- 18 measures in MY2025
- All 18 measures from MY2024 continue in MY2025
- Accountable measures must meet or exceed the Minimum Performance Level (MPL) (i.e. 50th percentile national Medicaid percentile) to avoid sanctions
- Quality Withhold Measures must show significant year-over-year improvement or exceed 67th percentile for full points
- Community Reinvestment additional 5% triggered by 1+ measure < MPL in each measure domain

Domain	Measure	
Behavioral Health	FUA-30	F-Up after ED Visit for Substance Use
	FUM-30	F-Up after ED Visit for Mental Illness
Pediatric	WCV	**Child & Adolescent Well Care Visits****
	CIS-E	**Childhood Immunizations****
	DEV	Developmental Screening in 0-3yrs
	IMA-E	**Immunizations for Adolescents****
	LSC	Lead Screening in Children
	TFL-CH	Topical Fluoride for Children
	W30+6	**Well Child Visits: 0-15 Months****
	W30+2	**Well Child Visits: 15-30 Months****

Domain	Measure	
Chronic Disease	GSD	**Hemoglobin A1c Poor Control (>9%)****
	CBP	**Controlling High BP****
	AMR	Asthma Medication Ratio
Reproductive /Cancer Prevention	BCS-E	Breast Cancer Screening
	CCS-E	Cervical Cancer Screening
	CHL	Chlamydia Screening
	PPC-Pre	**Timeliness of Prenatal Care****
	PPC-Post	**Postpartum Care****

**** Designates a Quality Withhold measure**

Accountability Programs Emphasize Local Performance

- Path to high performance on DHCS accountability programs is through county and regional measure rate improvement
- North Bay Area (Fairfield & Santa Rosa): sustaining high achievement
  - >67th percentile on all MCAS measures
- Rural Upper North (Redding and Eureka) and Rural Upper Central (Auburn and Chico): continuous improvement on prioritized measures
  - Rural North: Moving towards 67th percentile on Withhold measures
  - Rural Central: Moving towards 50th percentile on Withhold measures

DRAFT

AGENDA ITEM	DISCUSSION / CONCLUSIONS
VI.B Healthcare Effectiveness Data Information Set (HEDIS ®) Annual Summary of Performance	**MY2025 Plan-Wide MCAS Performance** Twelve measures met or exceeded the minimum performance level or the > 50th percentile, one at 90th (PPC), five at 75th, six measures < 50th

Measure	MY2025 RATE
Behavioral Health Domain	
Follow-Up After Emergency Department Visit for Substance Use - 30-Days (FUA-30)	41.35%
Follow-Up After Emergency Department Visit for Mental Illness - 30-Days (FUM-30)	50.26%
Children's Health Domain	
Child and Adolescent Well-Care Visits (WCV) **	52.57%
Childhood Immunization Status - Combination 10 (CIS-E) **	26.74%
Developmental Screening in the First Three Years of Life (DEV)	39.42%
Immunizations for Adolescents - Combination 2 (IMA-E) **	39.39%
Lead Screening in Children (LSC)	74.94%
Topical Fluoride for Children (TFL)	21.07%
Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months (W30-2) **	76.64%
Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months (W30-6) **	64.64%

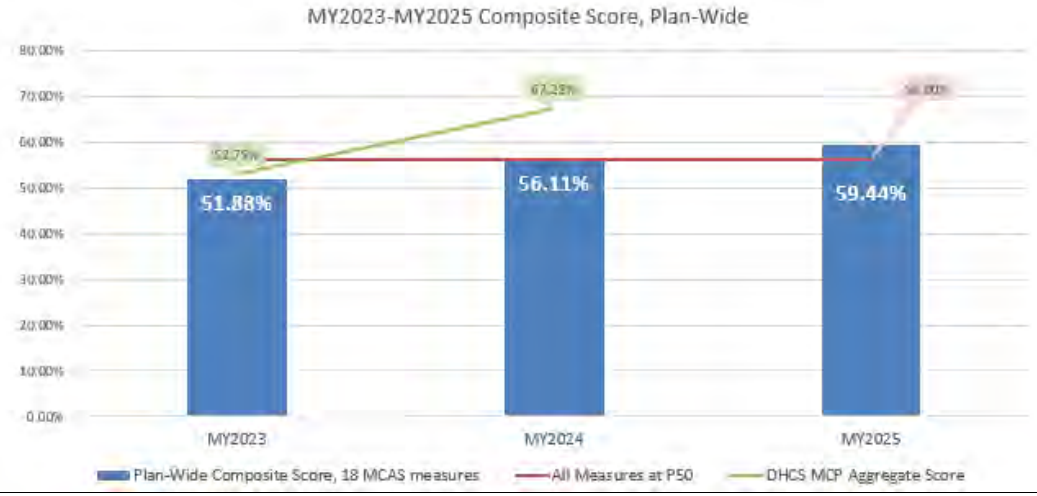
Measure	MY2025 RATE
Chronic Disease Domain	
Asthma Medication Ratio (AMR)	73.33%
Controlling High Blood Pressure (CBP) **	67.40%
Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD) ** ^	27.74%
Reproductive Health and Cancer Prevention Domain	
Breast Cancer Screening (BCS-E)	53.43%
Cervical Cancer Screening (CCS-E)	48.08%
Chlamydia Screening in Women (CHL)	58.98%
Prenatal and Postpartum Care: Postpartum Care (PPC-Post) **	90.02%
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre) **	87.10%

**** Quality Withhold measure**
^ Inverse measure, lower rate is better

Benchmark
90th
67th or 75th
50th – MPL or >50th (CMS)
25th or 33rd
<25th or <50th (CMS)

MCAS Composite Score, MY2023 – MY2025

- Composite score represents Partnership's aggregated performance on all 18 MCAS measures (measure benchmarks met in points / highest possible benchmarks in points)
- Preliminary version of DHCS Quality Factor Score, published in Fall 2026

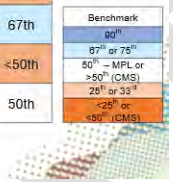


Quality Compass Benchmark	Points Awarded per Measure's Performance
90th	10
82.5th	9
75th	8
62.5th	7
50th – MPL or >50th (CMS)	6
37.5th	5
25th	4
17.5th	3
10th	2
<10th or <50th (CMS)	1

AGENDA ITEM	DISCUSSION / CONCLUSIONS
VI.B Healthcare Effectiveness Data Information Set (HEDIS ®) Annual Summary of Performance	**MCAS Performance: Regional Opportunities** Table shows additional MCAS measures that have opportunities for improvement: Development Screening in the 1st three years of life (DEV), Lead Screening in Children (LSC), Topical Fluoride for Children (TFL): we encourage providers to focus on access for well child visits, which is a priority and is a driver here, AND include the required screenings and referrals in these visits. Cervical Cancer Screening (CCS-E): transitioned to an ECDS measure in MY2025, so rates went down in some, though not all regions. This as an opportunity for Northbay Area to bring their rates up and pilot some new innovations such as self-swab testing to scale throughout the network.

	Plan-Wide		North Bay Area Rating Region		Rural Upper Central Rating Region		Rural Upper North Rating Region	
Measure Description	MY2024	MY2025 YoY points change	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Developmental Screening in the First Three Years of Life (DEV) ^	<50th	50th +9.77%	<50th	50th	50th	<50th	<50th	<50th
Lead Screening in Children (LSC)	75th	67th +3.16%	50th	50th	50th	33rd	75th	67th
Topical Fluoride for Children (TFL) ^	<50th	<50th +8.67%	<50th	50th	50th	50th	<50th	<50th
Cervical Cancer Screening (CCS-E)	50th (Hybrid)	25th -11.04%	75th (Hybrid)	50th	<25th (Hybrid)	<25th	25th (Hybrid)	50th

^ CMS measure, 50th percentile is highest benchmark
Improvement opportunity



MCAS Performance: Data Completeness/Measure Limitations

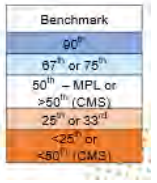
There were two measures with data completeness and measure limitation issues:

- Follow-Up After Emergency Department Visit for Mental Illness (FUM): though improved over 20 points, Partnership still falls under the 25th percentile. The measure definition changed and expanded the services counted towards the numerator, benefiting Partnership. Data completeness issues around this measure and are actively working on alternative data sources in MY2026
- Breast Cancer Screening (BCS): This is an example of a measure limitation: age range expanded to 40-75 years, but benchmark was created for 50-75 year age range, so we're applying an inappropriate benchmark to this year's rate. We've advocated with DHCS for a workaround to this or to not hold the measure accountable.

Significant Data Completeness and Measure Limitation Issues

DHCS: No sanctions on FUM-30 or BCS-E in MY2025

	Plan-Wide		North Bay Area Rating Region		Rural Upper Central Rating Region		Rural Upper North Rating Region	
Measure Description	MY2024	MY2025 YoY points change	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Follow-Up After Emergency Department Visit for Mental Illness - 30-Days (FUM-30)	<25th	<25th +21.25%	<25th	<25th	<25th	<25th	<25th	33rd
Breast Cancer Screening (BCS-E)	50th	33rd -2.86%	50th	50th	<25th	<25th	25th	<25th



DRAFT

AGENDA ITEM	DISCUSSION / CONCLUSIONS
VI.B Healthcare Effectiveness Data Information Set (HEDIS ®) Annual Summary of Performance	**Key Takeaways** • High achievement or year-over-year improvement on MCAS Withhold measures at the Regional Level is the highest priority for network – this will drive success in all DHCS Accountability Programs and Partnership's NCQA Star Rating. • 2026 Priority Improvement Areas for Rating Regions, provider specific priorities will be aligned with the strategy shown below.

North Bay Area (Marin, Napa, Solano, Sonoma, Yolo)	**Rural Upper Central** (Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba)	**Rural Upper North** (Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Trinity)
Towards Regional 67th percentile: 1. Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD) 2. Child and Adolescent Well-Care Visits (WCV) 3. Lead Screening in Children (LSC) 4. Cervical Cancer Screening (CCS-E) 5. Follow-Up After Emergency Department Visit for Substance Use - 30-Days (FUA-30) 6. Colorectal Cancer Screening (COL) – New in MY2026!	Towards Regional 50th percentile: 1. Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD) – select counties towards 67th 2. Controlling High Blood Pressure (CBP) 3. Child and Adolescent Well-Care Visits (WCV) 4. Immunizations for Adolescents - Combination 2 (IMA-E) 5. Timeliness of Prenatal Care (PPC-Pre) 6. Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months (W30-6)	Towards Regional 67th percentile: 1. Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD) 2. Controlling High Blood Pressure (CBP) 3. Child and Adolescent Well-Care Visits (WCV) 4. Immunizations for Adolescents - Combination 2 (IMA-E) 5. Timeliness of Prenatal Care (PPC-Pre) 6. Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months (W30-2)

Discussion

Data availability and completeness are significant factors for follow-up after emergency department visits for mental illness. It was noted Rural Upper North appeared to perform comparatively well, possibly due to the Wellness and Recovery (W&R) benefit may contributing to the result, but (W&R) implementation differs by region with some counties administering the program. There were concerns performance could worsen in the next year depending on how the benefit is administered and whether comparable support is available across regions.

Questions can be directed to

HEDIS Team: hedisteam@partnershiphp.org

MY2025 MCAS Annual Summary of Performance

MY2025 NCQA HPA Annual Summary of Performance

DRAFT

AGENDA ITEM	ADJOURMENT
PAC adjourned at 9:03 a.m.	**Next Physician Advisory Committee announced for September 12, 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, Aug. 11, 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**			
I	Approval of Internal Quality Improvement (IQI) Committee Meeting Minutes of July 7, 2026	Robert Moore, MD, MPH, MBA	1:30	5 – 13
II.	**Old Business**			
1	QI 1D Factor 5 Follow-up on the Preventive Care Bridge Project Quality Improvement Initiative – *for an in-depth look, see the evaluation included under FYI beginning p. 1,181*	Isaac Brown, MHA/MBA	1:37	15
III.	**New Business – Consent Calendar**			
Health Services Policies	Consent Calendar	All	1:45	17
	Potential Quality Issue/Provider Preventable Conditions QI/Q2 2026 Report – *direct any questions to Robert Bides, RN; the Data Analysis begins on p. 25*			19 – 29
	Care Coordination			
	MPCP2007 – Complex Case Management			31 – 39
	Population Health Management			
	MCNP9004 – Regulatory Required Notices			41 – 55
	Quality Improvement			
	MPQP1048 – Reporting Communicable Diseases			57 – 58
	Utilization Management			
	MCUP3050 – Medication Abortion in the First Trimester			59 – 71
	MCUP3119 – Sterilization Consent Protocol			73 – 78
	MPUP3035 – Preoperative Day Review			79 – 81
Non-HS Policies	**Member Services**			
	MP301 – Assisting Providers with Missed Appointments – *CLEAN copy begins on p. 87*			83 – 88
	Network Services – Compliance			
	MPNET103 – DHCS Subcontractor Network Certification			89 – 104
	Network Services – Credentialing			
	MPCR12 – Credentialing of Individual and Private Duty Nurses Under EPSDT			105 – 108
	MPCR15 – Doula Credentialing and Re-credentialing Criteria			109 – 113
	MPCR200 – Credentials Committee and CMO Credentialing Program Responsibilities			115 – 118
IV.	**New Business – Discussion Policies**			

	Item	Lead	Time	Page #
	Synopsis of Changes		--	119 – 120
HS Policies	**Health Equity**			
	MCED6001 – Health Equity and Community Reinvestment Strategy and Program Description – **NEW TITLE** - *CLEAN copy begins on p. 159*	Mohamed Jalloh, Pharm.D	1:50	121 – 192
	Utilization Management			
	MCUP3012 – Discharge Planning (Non-capitated Members)	Tony Hightower, CPhT	1:57	193 – 196
	MCUP3052 – Medical Nutrition Services - *CLEAN copy begins on p. 211*	Colleen Townsend, MD	2:04	197 – 223
V.	**Presentations**			
1	Quality Improvement Update	Issac Brown, MHA/MBA	2:11	225 – 236
2	Enhanced Care Management Quality Incentive Program (ECM QIP) CY 2027 Proposed Measure Set	Deanna Watson	2:16	237 – 239
3	Primary Care Provider QIP (PCP QIP) CY 2027 Proposed Measure Set – *the narrative only and not the presentation slide deck is included in the packet*	Athena Beltran-Nampraseut, CPhT	2:26	241 – 247
4	Closeout Summary of FY 2025-2026 QI Work Plan – *approval required* *Excel spreadsheet included under FYI begins on p. 1,147*	Isaac Brown, MHA/MBA	2:41	249 – 261
5	Summary of QI Trilogy Documents		2:47	263 – 265
QI Trilogy	*Approval will be required on the following documents:* • 2025-2026 QI Evaluation – *begins on p. 267* • 2026-1027 QI Program Description – *synopsis of changes begins on p. 841; MPQD1001 begins on p. 843; CLEAN copy begins on p. 1,003* • 2026-2027 QI Work Plan – *begins on p. 1,129*		2:55	267 – 1147
VI. FYI	2025-2026 QI Program Work Plan Final – Excel spreadsheet – *direct questions to Isaac Brown*			1149 – 1182
	Preventive Care Bridge Evaluation – *direct questions to Tasha Krongard*			1183 – 1195
	Mobile Mammography Program Flyer – *direct questions to Areli Carrillo; circulate flyer to colleagues*			1197
	Mobile Mammography Program Provider Site Eligibility – *direct questions to mobilemammography@partnershiphp.org*			1198
	Adjournment by 3:30 p.m. to 1:30 p.m. Tuesday, Sept. 8, 2026			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, Aug. 11, 2026 / 1:32 – 3:30 PM

Members Present:	Innes, Latrice, Compliance Manager, Grievance & Appeals
Andrews, Leigha, Regional Director (SW)	Jalloh, Mohamed, Pharm.D, Dir. of Health Equity (Health Equity Officer)
Ayala, Priscila, Director of Network Services	Jensen, Annika, RN, Assoc. Dir. of Clinical Integration, Care Coordination
Barresi, Katherine, RN, BSN, PHN, Chief Health Services Officer	Jones, Kermit, MD, JD, Deputy CMO/Medical Director for Medicare Services
Beard, Alyssa, RN, Manager of CC Regulatory Performance	Moore, Robert, MD, MPH, MBA, Chief Medical Officer (Chair)
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations	Netherda, Mark, MD, Medical Director for Quality (Vice Chair)
Brincko, Aaron, Director of Provider Relations	Newman, Rachel, RN, BSN, Associate Director, Credentialing
Brown, Isaac, MHA/MBA, Senior Director, Q & PI	O'Connell, Lisa Brundage, MHA, Director, Enhanced Health Services
Brunkal, Monika, RPh, Associate Director of Population Health	Ruffin, DeLorean, DrPH, Director of Population Health
Campbell, Anna, MPH, Policy Analyst, Utilization Management	Townsend, Colleen, MD, Regional Medical Director (SE-Fairfield)
Devan, James, Director of Quality Improvement, QI	Villasenor, Edna, Senior Director, Member Services and Grievance
Guevarra, Angela, RN, *Interim* Director of Care Coordination	Vaisenberg, Liat, Director of Health Analytics
Gual, Kristine, PMP, CPHQ, Director of Quality Measurement, QI	Ward, Lisa, MD, Regional Medical Director (SW-Santa Rosa)
Hanusiak, Kenzie, Assoc. Dir., Regulatory Affairs & Compliance	
Members Absent:	Hightower, Tony, CPhT, Associate Director, UM Regulations
Bjork, Sonja, JD, Chief Executive Officer	Klakken, Vicky, Regional Director (NW-Eureka)
Bontrager, Mark, Senior Director of Behavioral Health, Health Services	Krznarich, Jackie, RN, *Interim* Mgr, Member Safety – Quality Inspections
Davis, Wendi, Chief Operating Officer	Leung, Stan, Pharm.D, Director of Pharmacy Services
DeVido, Jeffrey, MD, Behavioral Health Clinical Director	Matthews, R. Douglas, "Doug," MD, Regional Medical Director (Chico)
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management	Randhawa, Manleen, Senior Health Educator, Population Health
Guests:	Leung, Paul, Sr. Health Data Analyst I, Finance
Akintan, Folo, MBBS/MD, MPH, MBA, Epidemiologist, Pop Health	Mednick, Christy, Sr. Health Data Analyst I, Finance
Allen, Angier, Sr. Data Scientist I, Finance	Moore, Jordan, Moraghebi, Roudabeh, Manager of Health Analysts, Finance
Allen, Angier, senior Data Analyst I, Finance	Morris, Matthew, MD, Regional Medical Director (Auburn)
Beltran-Nampraseut, Athena, Program Manager II, QI (PCP QIP)	Muncy, Kellie, Manager, Change Management & Configuration, Configuration
Bikila, Dejene, Manager of Data Science, Finance	Newell, Amber, CPhT, Program Manager I, QI
Bottke, Jayme, Regional Director (NE)	Nguyen, Tom, Manager of Health Analytics, Finance
Brackett, Jacquelyn, Administrative Assistant I, Pharmacy	O'Leary, Hannah, MPH, CHES, Manager of Population Health
Chishty, Shahrukh, Sr. Mgr., Child Welfare Programs, Behavioral Health	Power, Kathryn, Regional Director (SE)
Clark, Kristen, Manager of Quality & Training, Member Services	Rathnayake, Rasitha, Sr. Health Data Analyst I, Finance
Cunningham, Aryana, Policy Analyst, Care Coordination	Roach, Erika, Program Manager II, Network Services
Durst, Jennifer, Senior Manager of Performance Improvement, QI	Robertello, Kimberly, Senior Medicare QI Program Manager, QI
Elder, Alaina, Manager of Provider Network Teams, Provider Relations	Rushing, Eric, Manager, Mental Health Programs, Behavioral Health
Gerona, Nicole, RN, Quality Investigator, Quality Improvement	Seale, J'aime, PR Lead, Network Services
Harris, Vander, Senior Health Data Analyst I, Finance	Selig, Barbara, Manager, Quality Improvement Programs, Quality Improvement
Isola, Brandy, Manager of Performance Improvement, QI (Chico)	Sivasankar, Shivani, Sr. Data Scientist, Finance
Kim, Amanda, Improvement Advisor, QI (Redding)	Smith, Christine, Community Health Needs Liaison, Population Health
Kubota, Marshall, Associate Medical Director	Thomas, Penny, Senior Health Data Analyst I, Finance
Kulkarni, Shreya, JD, Policy Analyst, Regulatory Affairs & Compliance	Vance, Brooke, Program Manager I, Network Services
Lee, Donna, Manager of Claims, Claims	Watson, Deanna, Program Manager I, QI (ECM QIP)
Ling, Samuel, Sr. Health Data Analyst I, Finance	Yu, Fei, Sr. Data Scientist I, Finance
Lockhart, Brandi, LCSW, Sr Mgr, Behavioral Health Access, Behavioral Health	Zhao, Li Sr. Health Data Analyst I, Finance

Lopez, Eva, CPhT, Program Manager I, Quality Improvement

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order • Approval of Minutes • Announcements	Chief Medical Officer Robert Moore, MD, MPH, MBA, called the meeting to order at 1:32 p.m. from the Fairfield-West office. He congratulated Jackie Krznarich, RN, in her new role as Manager, Member Safety – Quality Investigations, replacing Rachel Newman, RN, who has assumed the position of Associate Director of Credentialing in Network Services. • The July 7 IQI Minutes were approved as presented. • Dr. Moore announced that each policy business owner is expected to notify Claims, Configuration, Member Services, and/or Provider Relations as necessary to ensure full implementation of any internal systemic changes following final policy approval. (Kenzie Hanusiak noted that this may be a specific policy analyst, although some departments do not have one. Any person needing Power DMS training, should contact Marcus Wilson in Regulatory Affairs.) The structure to close the loops has yet to be determined, Dr. Moore said. He concluded that some polices that have not come to IQI may start to do so, and some policies that have had annual IQI review may no longer require it. Kenzie noted the Compliance Committee will be discussing this further in September as they look at by-laws and other guidance. ***Post IQI update**: Meanwhile, Anna Campbell and Leslie Erickson devised the following table to be utilized with such policies to be discussed at IQI and the Quality/Utilization Advisory Committee (Q/UAC). This table is to lead the policy's synopsis of changes to be captured in both meeting packets and minutes. It was first used with UM's MCUP3052 presented at Aug. 19 Q/UAC and is subject to change.*	Motion to approve IQI minutes: Isaac Brown Second: Kristine Gual

The department policy owner/designee must ensure the approved changes are appropriately followed up (check all that apply for <u>each</u> discussion policy): [1]

☐ Important Provider Notice (IPN)	☐ Provider Education/Training	☐ Provider Fax Blast *(specify provider type(s):*
☐ Member Notice *(specify education/training, external webpage, mailing, member meeting, Member Newsletter, Member Handbook/Evidence of Coverage, etc.):*		
☐ Call Center Script Change	☐ Update of TAR Requirements (MCUP041-A)	☐ Other *(specify below):*
☐ Configuration of HRP and/or Claims Editor System (CES)	☐ Configuration of Essette/Jiva	

II. Old Business – QI 1D Factor 5 Follow-up on the Preventive Bridge project Quality Improvement Initiative *Presenter: Isaac Brown*

The second and final phase of the **Preventive Care Bridge Project Quality Improvement Initiative (previously known as the Locum Tenens Project)** is now complete. Four provider organizations located in Partnership Health Plan of California's Rural Upper North and Rural Upper Central [Department of Health Care Services' (DHCS) designations for Healthcare Effectiveness Data Information Set (HEDIS®) purposes] areas tested locum-based strategies to expand access to preventive services, with a focus on child and adolescent Well-Child Visits (WCV) and Cervical Cancer Screenings (CCS).

Building on lessons learned from the first Locum Project conducted in 2024, the Partnership grant-funded Preventive Care Bridge Project ("Project") was proposed and agreed upon in 2025. The Project aimed to specifically address WCV and CCS measures through strategic deployment of locum clinicians in underserved areas. Pilot findings were used to develop implementation resources for network providers, including a ROI calculator, readiness checklist, self-serve training materials and a field

[1] This information will be captured in the meeting minutes.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

guide to identify risks and implementation considerations. These resources are intended to support provider decision-making, improve operational readiness, and strengthen implementation success. The resources were presented during quality regional meetings to support broad provider engagement. This Quality Improvement Initiative translated pilot learnings into scalable support for improving access and closing preventive care gaps.

Ampla Health, Open Door, Shasta Community, and Western Sierra Medical each utilized Physician Assistants or Primary Nurse Practitioners during rolling 12-week periods in the second half of 2025 to close identified primary care gaps. In all, 1,818 Partnership members received care from these locums. When no-shows and cancellations occurred two of the four Providers Organizations (POs) utilized their locums to provide other services to Partnership members. Collectively, nearly 1,500 WCV and 350 CCS visits were complete, moving the Provider Organizations closer to target HEDIS® benchmarks.

In addition to the QI project team, Improvement Advisors and Performance Improvement Managers played a key role in working with the Provider sites to support operational challenges and to help refine workflows. The collective effort of plan-level involvement offers insight into the type and intensity of support that may be required when introducing POs to a new intervention model.

To conclude, the Project provided valuable insight into both the potential and challenges of a locum-supported preventive care intervention. While the model can support practices in advancing preventive care measures, the Project demonstrated that success depends on having the right organizational conditions, operational capacity, and leadership in place. The intervention is not a straightforward "plug-and-play" solution and yet it may offer guidance for Providers that are well-prepared to implement the model. The Project also pinpointed key lessons about readiness, operational alignment, and the conditions necessary for success, which can support broader adoption efforts.

Isaac thanked Tasha Krongard and Barb Selig for their "terrific work scaling up the pilot." Those interested in learning more are advised to read the full evaluation included as FYI in today's packet.

For more information, contact Tasha Krongard at tkrongard@partnershiphp.org

III. New Business Consent Calendar (Committee Members as applicable)

Potential Quality Issue/Provider Preventable Conditions QI/Q2 2026 Report – *direct any questions to Robert Bides, RN*

Health Services Policies
Care Coordination
MPCP2007 – Complex Case Management
Population Health
MPND9004 – Regulatory Required Notices
Quality Improvement
MPQP1048 – Reporting Communicable Diseases
Utilization Management
MCUP3050 – Medication Abortion in the First Trimester
MCUP3119 – Sterilization Consent Protocol
MPUP3035 – preoperative Day Review

Non-Health Services Policies
Member Services
MP301 – Assisting Providers with Missed Appointments
Network Services - Compliance
MPNET103 – HCS Subcontractor Network Certification
Network Services - Credentialing
MPCR12 – Credentialing of Individual and Private Duty Nurses Under EPSDT - ***pulled***

Motion to **approve the slate without the 3 Credentialing policies:** Mark Netherda, MD Second: Mohamed Jalloh, Pharm.D

Next Steps Health Services Policies:
- Aug. 11 Q/UAC
- Sept. 9 PAC

Meeting Postscript It has been decided that Credentialing policies will now go from IQI to the following month's Credentials Committee to PAC. MPCR12 and MPCR200 will come back to IQI Sept. 8. MPCR15 has yet to be re-calendared.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
MPCR15 – Doula Credentialing and Re-credentialing Criteria - ***pulled*** MPCR200 – Credentials Committee and CMO Credentialing Program Responsibilities - ***pulled*** The three Credentialing policies were pulled because Network Services is discussing changing what entities going forward should review and approve these policies. They will come back in a future meeting. **Colleen Townsend, MD, remarked that MPCR15's doula definition is a good one that she would like to see used in other policies as necessary. She will send her remarks to Associate Director of Credentialing Rachel Newman, RN.**		
IV. New Business – Discussion Policies		
Policy Owner: Health Equity – *Presenter: Mohamed Jalloh, Pharm.D, Director, Health Equity (Health Equity Officer)*		
MCED6001 – Health Equity and Community Reinvestment Strategy and Program Description – **NEW TITLE**	• **Name Change on Page 1:** The Program Description name is changed from the "Quality Improvement and Health Equity Transformation (QIHEPT) Program Description" to the "Health Equity and Community Reinvestment Strategy and Program Description" to increase ease of communication to internal team members. • Health Equity Accreditation name change on Page 10: The National Committee for Quality Assurance's HEA (Health Equity Accreditation) is changed to HOA (Health Outcomes Accreditation) to reflect new NCQA terminology, effective Jan. 15, 2026. • Quality Improvement Priorities on Page 11, 13: Update includes the top Quality Improvement Priorities and how Partnership clarified its health disparity priorities. • Health Disparity Measures on Page 14: Update reflects which annual QIHETP administrative measures will be measured per department (e.g., Quality Improvement, Population Health, Human Resources, etc.). • Community Reinvestment Updates on Page 17: Update reflects changes in community reinvestment management. Specifically, Public Health Directors and Behavioral Health Directors will lead their county's selection efforts versus Partnership providing a specified list from which the counties could pick. **After Dr. Jalloh presented, it was suggested and Dr. Jalloh agreed that all references to the now-defunct (IQI subcommittee) Population Needs Assessment be removed and that the UM Communication section be updated**.	Motion to **approve as amended:** Mark Netherda, MD Second: Anna Campbell Next Steps: Aug. 19 Q/UAC Sept. 9 PAC.
Policy Owner: Utilization Management – *Presenter: Anna Campbell, MPH, Policy Analyst, UM Regulations*		
MCUP302 – Discharge Planning (Non-capitated Members)	**VI.B.2.:** Clarified that "Nurse Coordinator" refers to Partnership staff. **VI.B.3.a.:** Listed additional types of "Alternate Medical Services" including subacute, LTAC, and acute rehab. **VI.B.3.a.5):** Added policy MCUG3024 Inpatient Utilization Management to the list of policies with more information regarding authorization of alternate medical services. **VI.B.4.a.:** Deleted duplicative language regarding notification process when the service provider notifies Partnership's Nurse Coordinator to obtain precertification for any services included in the patient's discharge plan. **VI.B.4.a.:** Added language from APL 26-011 to say "Approval for pediatric subacute care services ceases once the Member turns 21 years of age. Authorization requests for pediatric Members should not exceed the	Motion to **approve as presented:** Isaac Brown Second: Colleen Townsend, MD Next Steps: Aug. 19 Q/UAC Sept. 9 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Member's 21st birthday; therefore, discharge planning to an appropriate adult level of care must be completed at least two months prior to the Member's 21st birthday." **VII.C.:** Added a Reference for APL 26-011, Subacute Care Facilities – Long-Term Care Benefit Under Managed Care After Anna noted that the forthcoming APL 26-011 changes are now reflected in VI.B.4.a. language, Dr. Moore, although he said he didn't see procedural changes, asked if Configuration would need to be involved. Anna thought no, although UM training would be necessary. Change Management and Configuration Manager Kellie Muncy, however, thought otherwise, remarking that the APL calls out how and when a soon-to-be 21-year-old pediatric patient would need to be transferred to an adult bed, if one was available in the same facility. Chief Health Services Officer Katherine Barresi, RN, however, thought such instances would be rare and that Configuration would not be unduly affected.	
Policy Owner: Utilization Management – *Presenter: Colleen Townsend, MD, Regional Medical Director (Southeast)*		
MCUP3052 – Medical Nutrition Therapy (MNT) Services – **NEW TITLE**	**This policy, last approved in February 2026, is under review again to resolve conflicts that have arisen between new DHCS criteria and Partnership's existing policy criteria for Medical Nutrition Therapy services.** **Title:** Title of this policy was updated to include the word "Therapy" and the acronym (MNT) as follows: Medical Nutrition Therapy (MNT) Services. **IV.B.:** Attachment B was Archived and the Adult Criteria information from that document was combined with Attachment A's Child/Adolescent Criteria. Attachment C then became Attachment B. **V. Purpose:** Information regarding the Affordable Care Act requirements to cover USPSTF Class A or B recommendations was removed from the Purpose statement and added to the main policy at section VI.B. instead. Additionally, this statement was added to the Purpose section: "This policy uses evidence-based guidelines and currently recognized national standards of care to ensure access to MNT in the treatment and prevention of chronic diseases." **VI.B.1. and 2.:** Language regarding the Affordable Care Act requirements to cover USPSTF Class A or B recommendations was added here. Specific recommendations were removed, as was a statement that previously said MNT was covered as an enhanced benefit for children. A new statement was added to say "Children, adolescents, and adults are covered under this policy." **VI.C.1.:** Section C.1. was added to define requirements for Authorization and Billing of MNT Services. Specifically, no RAF is required, and no TAR is required unless visits exceed recommendations listed in VI.C.2. **VI.C.2.:** Section C.2. was updated throughout to specify billing units and recommended frequencies for types of visits according to CPT codes. Some of these changes to recommended frequencies will require amendments to previous BREW decisions, specifically for codes 98970- 98972, G01018, G0109, and Z codes for perinatal services. **VII. Refences:** New References were added at VII.B. – K. as guidance for the recommended criteria and frequencies updated in this policy. **Attachments A and B:** Attachment B was Archived and the information was combined into one document, Attachment A. Attachment A now lists and defines ICD-10 codes that are considered to be criteria for MNT	Motion to **approve as amended:** Colleen Townsend, MD Second: Anna Campbell Next Steps: Aug. 19 Q/UAC Sept. 9 PAC • Note: PR/Claims special decision payments claim payment back dated to first denials (Oct 2025) • Claims/ Config update volume/limits Provider Education (PCPs, MNTs, MTM) to note that our policy has been revised with a change in visit limits

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	visits for children, adolescents and/or adults. Recommended frequencies were removed from this document because they have been detailed in the main policy at VI.C.2. **Attachments B and C:** Previous Attachment C is now Attachment B. Dr. Townsend said these changes should create more transparency and some efficiencies too. Anna Campbell added that utilization is changing from a calendar year to a rolling 12-month period, so **Configuration will need to make some changes.** A long conversation ensued: • Southwest Regional Manager Leigha Andrews asked if once a "no Treatment Authorization Request" limit is exhausted if TAR continuations could occur on a case-by-case basis? Dr. Townsend said yes. • Several persons wondered whether or not members getting Medically Tailored Meals (MTM) through Community Supports could simultaneously enjoy MNT benefits? The general answer was no, although it was noted that MNT is often a precursor to the initiation of MTM. • Provider Relations has not processed all outstanding claims: any adjustments need to occur as soon as possible. • Dr. Moore concluded by saying MNT is a "vastly under-utilized" benefit. In the end, **IQI agreed to add two Related Policies at I.E. and F.:** E. MCUP3041 - Treatment Authorization Request (TAR) Review Process F. MPAP7003 - CalAIM Community Supports (CS)	

V. Presentations

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

- The initial pilot of the new Performance Improvement in Action Program will launch Sept. 8 and span six structured sessions. Targeted participant feedback will be gathered to evaluate and refine the program curriculum prior to the official cohort launch in 2027. The program training is designed to help participants move from identifying real problems/challenges at their specific site to testing real solutions.
- New federal requirements stipulate that we now state how much QIP participating providers can earn, so these figures will be stated in all Quality Incentive Program proposals going forward.
- Ten counties have applied and eight of these have already received funds as part of the three-phase Expansion Counties Reinvestment in Quality program.
- Congratulations to the Member Safety – Clinical Investigations team for closing a record number of Potential Quality Issues (PQIs): 46 cases (a majority of which came through Grievance & Appeals) were processed and closed. Another 108 remain open.

Enhanced Care Management Quality Incentive Program (ECM QIP) CY 2027 Proposed Measure Set – *Deanna Watson, Program Manager I, QI*

Partnership's ECM QIP is an extension of the Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) multi-year initiative to improve quality of life and health outcomes for California's most vulnerable residents (e.g., individuals experiencing homelessness, behavioral health care access, children with complex care needs, the growing justice-involved population, etc.). ECM providers are incentivized for meeting program measures.

DHCS is now making changes to ECM and thus there are no changes from the current program to the CY 2027 proposal; however, Deanna noted that changes may occur in CY 2028. The CY 2027 measure set includes the following:

- Gateway measure: Timely reporting
- Measure 1: Care plan and ROI upload into PointClickCare within 60 days of a Treatment Authorization Request (TAR) request date

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

- Measure 2: Depression screening
- Measure 3: Blood pressure screening
- Measure 4: Timely review of emergency department and admissions notifications in PointClickCare (This measure was introduced in Q4 2024.)

The program's gateway measure, which requires the timely submission of three monthly reports, determines the size of the incentive pool available for earning through the program's remaining performance measures. (For 2025, Providers meeting the gateway measure generated $18.16 million in available incentive pool dollars, earning 76% – $13.74 million – of that pool.)

Director of Quality Measurement Kristine Gual said she would like to work with the QIP team to design a reporting mechanism for measures 2 and 3 that could be used by the Healthcare Effectiveness Data and Information Set (HEDIS®) team. It would be of special help looking at controlling high blood pressure, Kristine noted.

Primary Care Provider Quality Incentive Program (PCP QIP) CY 2027 Proposed Measure Set – *Athena Beltran-Nampraseut, CPhT, Program Manager II, QI*

Athena went through a slide show, noting that some measure names have changed in alignment with DHCS's nomenclature and that each practice type has its own measurement set based on its population. Chlamydia screening is being retired from the clinical domain of all practice types as it is no longer required in the DHCS Managed Care Accountability Set (MCAS). Asthma Medication Ratio (AMR), retired from the PCP QIP in 2024, is being brought back for monitoring purposes.

- Family Medicine is retiring three and adding six *clinical* monitoring measures:
  Retiring Comprehensive Diabetes Managements Retinal Eye Exams; Chlamydia Screening (16-24 y-o); and Reducing Healthcare Disparity.
  New Monitoring: Developmental Screening; First Timely Prenatal Care Visit; Adult Immunization; Follow-up after Acute and Urgent Care Visits for Asthma; AMR; and Tobacco Use Screening and Cessation.
- Internal Medicine is retiring the same three and adding the same *new monitoring* (but for Development Screening), as proposed for Family Medicine.
- In the clinical Pediatric domain, Topical Fluoride in Children will remain a monitoring measure, to be joined by the Developmental Screening, asthma and tobacco screening and cessation monitoring measures.

"Patient Experience" will be redesigned in both the Family Medicine/Internal Medicine and Pediatric *non-clinical* domain. In the *Unit of Service*, tobacco use screening is being retired, and Electronic Clinica Data Systems (ECDS) is being retired as a *gateway* measure. Kristine Gual said continuing to call the ECDS measure a "gateway" would be tough yet she asked if it wasn't still needed if we are to end uploads? Athena too wondered, if this measure is retired, how do we onboard new provider participants into Datalink? This will be an administrative burden for the QIP team, Kristine said. **Dr. Moore agreed that we do not want to exclude those providers who are having trouble using Datalink, and so the IQI discussed options. IQI agreed with Dr. Moore that there would be no uploads so that data flows. This will be called out as an "important note on uploads."**

Director of Health Equity Mohamed Jallon said he wanted more feedback on the retirement of the health equity measure, adding that we have had some success with an older equity measure. He and Dr. Moore then discussed the financial resources that once existed behind this measure but no longer do.

Close-out Summary of FY 2025-2026 QI Work Plan – *Isaac Brown, Senior Director, Quality & Performance Improvement*

Fifty-nine of our 72 goals were met during the fiscal year. The 13 unmet goals (nine terminated and four delayed or incomplete) were not realized for one of three reasons: Health Rules Payor (HRP) did not go live when scheduled as Partnership's new core claims system; our new Medicare program did not go live as Dual-eligible Special Needs Plan (D-SNP) was delayed to 2028, and/or new Contract amendments forced two QIP programs to go from fiscal year to calendar year reporting.

Isaac called out some special accomplishments:

- Many thanks to Quality Training Specialist and Dental Liaison Rose Aarons and the Site Review Inspections team (*aka* the Member Safety – Clinical Inspections team) for creating a comprehensive directory of Medi-Cal Dental providers that captures provider type, staffing demographics and estimated monthly patient volume

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

with a desktop to ensure that this information is maintained for accuracy. Not only will this directory aid Care Coordination in working with members, it also will be used to support updates to the Smile California provider directory.

- The HEDIS® team significantly expanded their use of clinical data acquired through the use of DataLink for MY2025 HEDIS measure rate generation, increasing participating practices from six to more than 30. This is an important step towards ECDS measure readiness and will support Center for Medicare and Medicaid (CMS) Interoperability Framework.
- The PCP QIP team is making great strides toward expanding our Mobile Mammography events into "Well Care Days."

Mark Netherda, MD / Mohamed Jalloh, Pharm.D, motioned and seconded approval of the Work Plan Close-out Summary. Motion unanimously carried.

Summary of "QI Trilogy" Documents – *Isaac Brown*

Annually, the Quality and Performance Improvement Team updates three documents that reflect past, present, and future work related to quality improvement at Partnership HealthPlan of California (Partnership):

1. Quality Improvement Program Description
2. Quality Improvement Program Evaluation
3. Quality Improvement Work Plan

Each document is a regulatory and NCQA Accreditation requirement. Each captures quality-related work done across the entire organization. If part of the quality program changes, Partnership will experience structural change. **The Partnership FY 2026-2027 QI PD reflects revisions** completed through interdepartmental review and collaboration. To wit:

1) Program Scope & Strategic Direction

- Updated language to reflect removal of a committed D-SNP launch year, while retaining references to future Medicare/D-SNP integration to align with current organizational planning and leadership direction.
- Updated language to reflect inclusion of dental services in quality oversight, acknowledging dental as a state-carved-out benefit with monitored quality components.
- Updated language to reflect the planned transition/unwinding of the Wellness and Recovery Program, while retaining program content for 2026–2027 due to ongoing administrative and quality responsibilities.

2) Governance & Committee Structure

- Updated language to reflect removal of the Population Needs Assessment (PNA) Committee, following its formal disbandment in Q1 2026.
- Updated language to reflect addition of the Quality D-SNP Sub-Committee, including defined purpose, membership, meeting cadence, and reporting structure to support future Medicare/D-SNP Model of Care and CMS/DHCS quality requirements.
- Updated to reflect refined delegation oversight, explicitly removing credentialing from delegated activities and clarifying Carelon Behavioral Health as the sole delegated entity for quality improvement functions.
- Updated language to reflect revised committee membership compositions, including removal of obsolete roles and alignment of attendance lists with current governance practices.
- Updated to reflect standardized meeting frequency for the Credentials Committee, removing seasonal exceptions to align with current operational practice.

3) Leadership & Accountability

- Updated to reflect creation of the Deputy Chief Medical Officer role, including defined authority related to quality oversight, clinical leadership, and Medicare/D-SNP readiness.
- Updated language to reflect continued designation of a Medical Director for Medicare Services, with clarified scope focused on future D-SNP implementation and Medicare quality oversight.
- Updated language to reflect revised organizational chart and leadership accountability, including alignment of role titles and updates to Appendix D resumes to address prior audit expectations.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

4) Health Equity & Accreditation Alignment

- Updated language to reflect NCQA's renaming of Health Equity Accreditation to Health Outcomes Accreditation, effective January 15, 2026.
- Updated language to reflect removal of DEI committee survey requirements as an accreditation expectation, while clarifying that such activities may continue as discretionary business practices rather than compliance obligations.

5) Behavioral Health Oversight & Delegation

- Updated language to reflect de-delegation of Behavioral Health member-facing functions from Carelon Behavioral Health, including access line, grievances and appeals, and care coordination.
- Updated language to reflect Carelon Behavioral Health's retained responsibilities, limited to network administration, claims processing, and delegated behavioral health quality activities.
- Updated language to reflect current DHCS regulatory guidance, including revised citations to APL 26-002 and BHIN 26-002.

6) Value-Based Payment Programs

- Updated to reflect re-establishment of the Extended Care Center (EXT) Quality Incentive Program effective January 2026, following sunset of the state Skilled Nursing Facility Workforce QIP.
- Updated to reflect completion of the Behavioral Health Quality Incentive Program, revising tense and placement to avoid mischaracterization as an active program.

7) Pathway to Excellence (P2E)

- Updated to reflect substantial expansion of the Pathway to Excellence framework, transitioning from a high-level description to a detailed model for continuous learning, implementation science, and spread of quality improvement interventions.
- Updated language to reflect enhanced emphasis on organizational learning, knowledge management, leadership accountability, and sustainability of improvement efforts, with corresponding expansion of Appendix content.

The **QI Evaluation** captures whether the program structure worked as envisioned. Did we have the outcomes that were expected? What, if anything, do we modify or stop if impacts are less than intended? In preparing the 2025-2026 Evaluation, the following items were given greater consideration:

1. Continued analysis of the QI program structure and how the roles defined within the QI department and senior leadership/physician roles fulfill it.
2. Enhanced trend analysis and implementation of interventions for measurements related to clinical quality, member safety, and member experience outcomes, reflecting the most recent 12-month period compared to the prior year.
3. Continued assessment of barriers in quality improvement with corresponding health plan adaptations to member and provider engagement strategies and tactics.
4. Member Experience priorities, including the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), access, transportation, and benefit understanding.
5. Health equity and disparity reduction by maintaining both Health Plan Accreditation (HPA) and Health Outcomes Accreditation (HOA) readiness and compliance through NCQA and DHCS priorities.
6. Assessment of resources and organization of quality and performance improvement activities to accommodate the growing scope and complexity of quality measurement and reporting under both DHCS and NCQA accreditation. In FY 2025-2026, of particular focus was the preparation for the implementation of Partnership's D-SNP program and HRP, evaluation of achieving at least a 3.5 STAR health plan rating as an NCQA accredited health plan, and achievement of NCQA HOA requirements.

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

- Yearly planned QI activities and objectives for improving:
  - Quality of clinical care
  - Safety of clinical care

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

- Quality of service
- Members' experience

- Time frame for each activity's completion
- Staff members responsible for each activity
- Monitoring of previously identified issues
- Evaluation of the QI program

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

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

Annually, the process for completing the trilogy documents is assessed for improvement. In developing the 2026-2027 Work Plan, QI leadership worked to proactively identify new and adapted projects and programs based on the closeout of the 2025-2026 Work Plan. This led to greater dialog among sponsors, business owners and contributors on lessons learned, which correlates to the accomplishments and challenges cited in the 2025-2026 QI Evaluation. Ultimately, this refined approach aided the work plan change process and led to sound goal setting and deliverable identification in the 2026-2027 Work Plan.

Isaac ended his remarks by thanking everyone who contributed to the QI Trilogy documents. UM Policy Analyst Anna Campbell noted that the QI PD is likely incorrect in one organizational chart showing that the Peer Review Committee reports to Credentials but not to Q/UAC. Is the PRC really a "subcommittee" of Q/UAC? **Dr. Moore said the confidential PRC cannot "report" to the Q/UAC, which is a public-facing committee under federal Brown Act guidelines, and as such the first should not be a "subcommittee" of the second. Rather, the PRC might be thought of as a "subset" of the Q/UAC because Q/UAC's external clinicians also comprise the external voting members of the PRC. This change will be made in the next iteration of the QI PD. This change will also be reflected in MPQP1002 – Quality/Utilization Advisory Committee and in MPQP1053 – Peer Review Committee policies** now scheduled to come back on consent to Sept. 8 IQI and Sept. 16 Q/UAC.

Mark Netherda, MD / Kristine Gual motioned and seconded approval of the QI Trilogy documents. Motion unanimously carried.

VI. Adjournment

Dr. Moore adjourned the meeting at 3:30 p.m. IQI will meet next Tuesday, Sept. 8, 2026.

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

Approval Signature: *Date:*

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

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

Date: Aug. 19, 2026 **Time: 7:30 – 9:00 a.m.**

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

Other Locations:
Open Door Community Health Center, 770 10th St., Arcata
Chapa-de Indian Health, 11670 Atwood Road, Auburn

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* July 15, 2026 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Mark Netherda, MD	7:30	5 – 14
2	*Acknowledgment and acceptance of draft minutes of the* • July 7 Internal Quality Improvement (IQI) Committee			15 – 23
3	Announcements			--
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Isaac Brown, MHA/MBA	7:36	25 – 36
2	HealthPlan Update	Kermit Jones, MD, JD	7:41	--
III.	**Old Business –**			
1	QI 1D Factor 5 Follow-up on the Preventive Care Bridge Project Quality Improvement Initiative – *for an in-depth look, see the evaluation included under FYI beginning p. 1,161*	Isaac Brown	7:46	37
IV.	**Consent Calendar**			
Health Services' Programs and Policies	Consent Calendar	All	7:50	39
	Potential Quality Issue/Provider Preventable Conditions QI/Q2 2026 Report – *direct questions to Robert Bides, RN; the Data Analysis begins on p. 47*			41 – 51
	Enhanced Care Management Quality Incentive Program (ECM QIP) CY 2027 Proposed Measure Set – *direct questions to Deanna Watson*			53 – 55
	Primary Care Provider QIP (PCP QIP) CY 2027 Proposed Measure Set – *direct questions to Athena Beltran-Nampraseut, CPhT*			57 – 64
	Care Coordination			
	MPCP2007 – Complex Case Management			65 – 73
	Population Health Management			

	Item	Lead	Time	Page #
	MCNP9004 – Regulatory Required Notices			75 – 89
	Quality Improvement			
	MPQP1048 – Reporting Communicable Diseases			91 – 92
	Utilization Management			
	MCUP3050 – Medication Abortion in the First Trimester			93 – 105
	MCUP3119 – Sterilization Consent Protocol			107 – 112
	MPUP3035 – Preoperative Day Review			113 – 115
Non HS	**Member Services**			
	MP301 – Assisting Providers with Missed Appointments – *CLEAN copy begins on p. 121*			117 – 122
V.	**New Business – Health Services Discussion Policies**			
	Synopsis of Changes		--	123 – 125
	Health Equity			
	MCED6001 – Health Equity and Community Reinvestment Strategy and Program Description – **NEW TITLE** - *CLEAN copy begins on p. 169*	Mohamed Jalloh, Pharm.D	7:55	127 – 200
	Utilization Management			
	MCUP3012 – Discharge Planning (Non-capitated Members)	Tony Hightower, CPhT	8:03	201 – 204
	MCUP3052 – Medical Nutrition Services - *CLEAN copy begins on p. 219*	Colleen Townsend, MD	8:11	205 – 223
VI.	**Presentations**			
1	Closeout Summary of FY 2025-2026 QI Work Plan – *approval required* *Excel spreadsheet included under FYI begins on p. 1,123*	Isaac Brown	8:20	225 – 237
2	Summary of QI Trilogy Documents		8:27	239 – 241
QI Trilogy	*Approval will be required on the following documents:* • 2025-2026 QI Evaluation – *begins on p. 243* • 2026-1027 QI Program Description – *synopsis of changes begins on p. 819; MPQD1001 begins on p. 821; CLEAN copy begins on p. 981* • 2026-2027 QI Work Plan – *begins on p. 1,107*		8:34	243 – 1121
VII. FYI	2025-2026 QI Program Work Plan Final – Excel spreadsheet – *direct questions to Isaac Brown*			1123 – 1156
	Preventive Care Bridge Evaluation – *direct questions to Tasha Krongard*			1157 - 1169
	Mobile Mammography Program Flyer – *direct questions to Areli Carrillo; circulate flyer to colleagues*			1171
	Mobile Mammography Program Provider Site Eligibility – *direct questions to mobilemammography@partnershiphp.org*			1172
	Adjournment scheduled for 9:00 a.m. Q/UAC next meets 7:30 a.m. Wednesday, Sept. 16, 2026			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

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

Wednesday, Aug. 19, 2026 / 7:32 a.m. – 8:26 a.m.

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

Voting Members Present:		
Gwiazdowski, Steven, MD, FAAP	Brian Montenegro, MD	Quon, Robert, MD, FACP
Hackett, Emma, MD, FACOG	Mulligan, Meagan, FNP-BC	Strain, Michael, Consumer Member
	Murphy, John, MD	Swales, Chris, MD
		Thomas, Randy, MD
Voting Members Absent: Sara Choudhry, MD; Brandy Lane, Consumer Member; Jennifer Wilson, MD, MPH		
Partnership *Ex-Officio* Members Present:		
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI	Jones, Kermit, MD, JD, Deputy CMO/Medical Director for Medicare Srvcs	
Bontrager, Mark, Senior Director of Behavioral Health	Netherda, Mark, MD, Medical Director for Quality – Vice Chair	
Brown, Isaac, MBA/MHA, Senior Director of Q & P Improvement	Newman, Rachel, RN, BSN, Assoc. Dir., Credentialing	
Cox, Bradley, DO, Regional Medical Director (Northeast)	O'Connell, Lisa, Director, Enhanced Health Services	
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management	Ribordy, Jeff, MD, Regional Medical Director (Northwest)	
Glickstein, Mark, MD, Associate Medical Director	Spiller, Bettina, MD, Associate Medical Director	
Hightower, Tony, CPhT, Associate Director, UM Regulations	Townsend, Colleen, MD, Regional Medical Director (Southeast)	
Jalloh, Mohamed "Moe", Pharm.D, Dir. of Health Equity (Health Equity Officer)	Ward, Lisa, MD, Regional Medical Director (Southwest)	
Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination	Watkins, Kory, MBA-HM, Director, Grievance & Appeals	
Partnership *Ex-Officio* Members Absent:		
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer	Leung, Stan, Pharm.D, Director of Pharmacy Services	
DeVido, Jeff, MD, Behavioral Health Clinical Director	Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair	
Guillory, Ledra, Senior Manager of Provider Relations Representatives	Randhawa, Manleen, Senior Health Educator, Population Health	
Katz, Dave, MD, Associate Medical Director	Ruffin, DeLorean, DrPH, MPH, Director of Population Health	
Guests:		
Beard, Alyssa, RN, Manager of CC Regulatory Performance	Isola, Brandy, Manager of Performance Improvement (Chico)	
Brackett, Jacquelyn, Administrative Assistant I, Pharmacy	Krznarich, Jackie, RN, Mgr, Member Safety – Quality Inspections	
Brunkal, Monika, Associate Director, Population Health	Kubota, Marshall, MD, Reg. Medical Director	
Campbell, Anna, Health Policy Analyst, UM Regulations	Morris, Matthew, MD, Regional Medical Director (Auburn)	
Cunningham, Aryana, Policy Analyst, Care Coordination	O'Leary, Hannah, Manager of Population Health, Pop Health	
Devan, James, Director of Quality Management	Ribordy, Jeff, MD, Regional Medical Director (Northeast)	
Durst, Jennifer, Senior Manager, Quality Incentive Programs	Shamoiel, Shantal, County Child Welfare Liaison, Behavioral Health	
Elder, Alaina, Manager of Provider Network Services, Provider Relations	Smith, Christine, Community Health Needs Liaison, Pop Health	
Frankovich, Terry, MD, Associate Medical Director	Stites, Jaylyn, Program Manager II, Provider Relations	
Guevarra, Angelea, RN, Director of Care Coordination	Thornton, Aaron, MD, Associate Medical Director	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *none made* Approval/ Acceptance of Minutes Announcements	Medical Director for Quality and Q/UAC Vice Chair Mark Netherda, MD, called the meeting to order at 7:32 a.m. in the planned absence of Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA. • The July 15 Q/UAC Minutes were approved without any corrections. • *Acknowledgment and acceptance of draft meeting minutes of the* o July 7 Internal Quality Improvement (IQI) Committee • Announcements: o Congratulations to former Improvement Advisor Jennifer Durst, who has accepted the position of Senior Manager, Quality Incentive Programs. o Congratulations to both former Clinical Nurse Investigator Jackie Krzanarich, RN, who has accepted the position of Manager, Member Safety – Clinical Investigations, and to the former team Manager Rachel Newman, RN, who is now the Associate Director of Credentialing. o Welcome to Interim Director of Care Coordination Angela Guevarra, RN, and to Pharmacy Admin Assistant Jacquelyn Brackett who today are attending their first Q/UAC meeting.	Motion to **approve the Q/UAC minutes:** Brian Montenegro, MD Second: Robert Quon, MD *Approved unanimously* Motion to **accept IQI minutes:** Steven Gwiazdowski, MD Second: Robert Quon, MD *Accepted unanimously*

II. Standing Updates

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

- On Aug. 12, the various QIP measure sets were taken through our Physician Advisory Committee and approved there. (Two of these measure sets are on today's Q/UAC consent calendar.) This is a precursor for getting out our contract amendments that are now required each year. We have annual contract amendments that are required by the federal government that basically explain the measure set and the amount of money that a provider can earn through our performance programs. In the next few weeks, we will be getting out those amendments, and we encourage the providers to review and get those back to us so they can participate in our upcoming QIP program this next year (Jan. 1, 2027).
- Our team will be providing a new training to those of our providers who have been trying to figure out how to address some problems. So, in addition to our ABCs of Quality, we will be providing a "performance improvement in action" course to help providers identify problems, test solutions, *etc.* We will launch the pilot in September and then officially launch this training at the beginning of 2027. This will be for all providers: community-based organizations (CBOs), skilled nursing facilities (SNFs), anybody who wants to join in. We are hoping to have a large cohort.
- There has been some discussion of our community reinvestments in the past couple of months. This is money that we are reinvesting back in the communities based off any income that we earn as an organization. Our expansion counties, or Eastern Region, were not a part of those initial dollars and so Partnership decided we would appropriate some monies there. We are in the middle of Phases One and Two, providing roughly $2M to providers in the Eastern Region, many of whom have already received awards. We are excited to provide those dollars to the network.

There were no questions.

Health Plan Update – *Kermit Jones, MD, JD – Deputy Chief Medical Officer & Medical Director for Medicare Services*

- Partnership has started our internal cross functional meetings to prepare for the federal and state mandated transition of the Unsatisfactory Immigration Status (UIS) population from managed care to fee-for-service (FFS), effective Jan. 1, 2027, at which time roughly two million Californians will face "a managed care and continuity of care cliff."
  - There will be a stoppage of benefits associated with CalAIM (California Advancing and Innovating Medi-Cal): transportation, community supports and other care managed/case managed programs.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

- The continuity of care aspect, while not enforceable, is something that we care about for our members, and referrals and Treatment Authorization Requests (TARs) that have been approved and are effective all the way to the end of this year will have to be resubmitted from whichever primary care provider the member will fall into or who will accept FFS in Medi-Cal at that time.
- Initially, Enhanced Care Management (ECM) and Community Supports (CS) will terminate. There is no FFS equivalent at this time.
- The Whole Child Model California Children's Services (CCS) cohort is probably one of our most challenging populations to help transition. The WCM went live in 2019 for 14 of our counties and then in January 2025 for the other 10 counties. For those that transitioned in 2019 specifically, much of the infrastructure for referrals is not there and will have to be re-stood up or re-exercised. So, they will go back on Jan. 1 to the county FFS, which will be a challenge. The providers that participate must be enrolled in the Medi-Cal Provider Application and Validation for Enrollment (PAVE) program to get reimbursed and for their prescriptions to be accepted. This is going to become an access issue.
- We are working on those Department of Health Care Services (DHCS) deliverables, which run from Aug. 21 through our Nov. 25 attestation. (The authorization test file is due Sept. 15.)

- The Rural Health Transformation Grant program is a sensitive topic for many rural communities, mostly because of the way that HCAI (Department of Health Care Access and Information) has been defining "rural" as kind of adjacent to urban areas: that has been a challenge to some of the frontier communities getting access to the grants. Partnership has been providing letters of support and also encouraging hospitals and health centers to apply. Four of the six letters we have drafted thus far are for maternity-related programs. Another concerns a pediatric-related program, and another, an AI decision support program.

QUAC voter John Murphy, MD, asked if Partnership has given some written guidance to the clinics facing this UIS transition. His La Clinica has just received some guidance from a health plan in a different county. Dr. Jones replied that this has yet to be done but that he will take back the suggestion. Such guidance, he said, may be forthcoming in the Medical Directors' Newsletter and other outlets.

III. Old Business

QI 1D Factor 5 Follow-up: *Isaac Brown, MBA/MHA, Senior Director of Quality & Process Improvement*

Isaac summarized the following, which was first outlined at QI committees in September 2025

The second and final phase of the **Preventive Care Bridge Project Quality Improvement Initiative (previously known as the Locum Tenens Project)** is now complete. Four provider organizations located in Partnership Health Plan of California's Rural Upper North and Rural Upper Central [Department of Health Care Services' (DHCS) designations for Healthcare Effectiveness Data Information Set (HEDIS®) purposes] areas tested locum-based strategies to expand access to preventive services, with a focus on child and adolescent Well-Child Visits (WCV) and Cervical Cancer Screenings (CCS).

Building on lessons learned from the first Locum Project conducted in 2024, the Partnership grant-funded Preventive Care Bridge Project ("Project") was proposed and agreed upon in 2025. The Project aimed to specifically address WCV and CCS measures through strategic deployment of locum clinicians in underserved areas. Pilot findings were used to develop implementation resources for network providers, including a ROI calculator, readiness checklist, self-serve training materials and a field guide to identify risks and implementation considerations. These resources are intended to support provider decision-making, improve operational readiness, and strengthen implementation success. The resources were presented during quality regional meetings to support broad provider engagement. This Quality Improvement Initiative translated pilot learnings into scalable support for improving access and closing preventive care gaps.

Ampla Health, Open Door, Shasta Community, and Western Sierra Medical each utilized Physician Assistants or Primary Nurse Practitioners during rolling 12-week periods in the second half of 2025 to close identified primary care gaps. In all, 1,818 Partnership members received care from these locums. When no-shows and cancellations occurred two of the four Providers Organizations (POs) utilized their locums to provide other services to Partnership members. Collectively, nearly 1,500 WCV and 350 CCS visits were complete, moving the Provider Organizations closer to target HEDIS® benchmarks.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
In addition to the QI project team, Improvement Advisors and Performance Improvement Managers played a key role in working with the Provider sites to support operational challenges and to help refine workflows. The collective effort of plan-level involvement offers insight into the type and intensity of support that may be required when introducing POs to a new intervention model. To conclude, the Project provided valuable insight into both the potential and challenges of a locum-supported preventive care intervention. While the model can support practices in advancing preventive care measures, the Project demonstrated that success depends on having the right organizational conditions, operational capacity, and leadership in place. The intervention is not a straightforward "plug-and-play" solution and yet it may offer guidance for Providers that are well-prepared to implement the model. The Project also pinpointed key lessons about readiness, operational alignment, and the conditions necessary for success, which can support broader adoption efforts. ***Q/UAC voters posed no questions. Those interested in learning more were directed to the full analysis included as FYI in the meeting packet. Questions may be directed to Tasha Krongard at tkrongard@partnershiphp.org.***		
IV. New Business – Consent Calendar (Committee Members as Applicable)		
Potential Quality Issue/Provider Preventable Conditions Q1/Q2 2026 Report – *direct questions to Robert Bides, RN* Enhanced Care Management Quality incentive Program (ECM QIP) CY 2027 Proposed Measure Set – *direct questions to Deanna Watson* Primary Care Provider Quality Incentive Program (PCP QIP) CY 2027 Proposed Measure Set- *direct questions to Athena Beltran-Nampraseut, CPhT* **Health Services Policies** <u>Care Coordination</u> MPCP2007 – Complex Case Management <u>Population Health Management</u> MCNP9004 – Regulatory Required Notices <u>Quality Improvement</u> MPQP1048 – Reporting Communicable Diseases <u>Utilization Management</u> MCUP3050 – Medication Abortion in the First Trimester MCUP3119 – Sterilization Consent Protocol MPUP3055 – Preoperative Fay Review **Non-Health Services Policies** <u>Member Services</u> MP301 Assisting Providers with Missed Appointments		*Q/UAC voters posed no questions.* Motion to **approve the slate as presented:** Robert Quon, MD Second: Steven Gwiazdowski, MD *Approved unanimously* <u>Next Steps</u>: Sept. 9 Physician Advisory Committee (PAC)
V. New Business – Discussion Policies		
Policy Owner: Health Equity – *Presenter: Mohammed Jalloh, Pharm.D, Director of Health Equity (Health Equity Officer)*		
MCED6001 – Health Equity and Community	• **Name Change on Page 1:** The Program Description name is changed from the "Quality Improvement and Health Equity Transformation (QIHEPT) Program Description" to the "Health Equity and Community Reinvestment Strategy and Program Description" to increase ease of	*QUAC voters posed no questions.* Motion to **approve as**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Reinvestment Strategy and Program Description **NEW TITLE**	communication to internal team members. • Health Equity Accreditation Name Change on Page 10: The National Committee for Quality Assurance's HEA (Health Equity Accreditation) is changed to HOA (Health Outcomes Accreditation) to reflect new NCQA terminology, effective Jan. 15, 2026. • Quality Improvement Priorities on Page 11, 13: Update includes the top Quality Improvement Priorities and how Partnership clarified its health disparity priorities. • Health Disparity Measures on Page 14: Update reflects which annual QIHETP administrative measures will be measured per department (e.g. Quality Improvement, Population Health, Human Resources, etc.). • Community Reinvestment Updates on Page 17: Update reflects changes in community reinvestment management. Specifically, Public Health Directors and Behavioral Health Directors will lead their county's selection efforts versus Partnership providing a specified list from which the counties could pick. • Reference to the Population Needs Assessment Committee (PNA defunct Spring 2026) has been deleted. • The Deputy Chief Medical Officer's role has been added. • Statement re conflict of interest policy added. • The Non-Discrimination Statement has been updated. Dr. Jalloh briefly summarized the edits, remarking that the policy name change results from Health Equity taking lead on community reinvestments. The counties' public health officers and behavioral health directors have more autonomy to decide on what to spend their community reinvestments dollars.	**presented:** Robert Quon, MD Second: Brian Montenegro, MD *Approved unanimously* Next Step: Sept. 9 PAC
Policy Owner: Utilization Management – *Presenter: Anna Campbell, MPH, Policy Analyst, UM Regulations*		
MCUP3012 – Discharge Planning (Non-capitated Members)	**VI.B.2.:** Clarified that "Nurse Coordinator" refers to Partnership staff. **VI.B.3.a.:** Listed additional types of "Alternate Medical Services" including subacute, LTAC, and acute rehab. **VI.B.3.a.5):** Added policy MCUG3024 Inpatient Utilization Management to the list of policies with more information regarding authorization of alternate medical services. **VI.B.4.a.:** Deleted duplicative language regarding notification process when the service provider notifies Partnership's Nurse Coordinator to obtain precertification for any services included in the patient's discharge plan. **VI.B.4.a.:** Added language from APL 26-011 to say "Approval for pediatric subacute care services ceases once the Member turns 21 years of age. Authorization requests for pediatric Members should not exceed the Member's 21st birthday; therefore, discharge planning to an appropriate adult level of care must be completed at least two months prior to the Member's 21st birthday." **VII.C.:** Added a Reference for APL 26-011, Subacute Care Facilities – Long-Term Care Benefit Under Managed Care	*QUAC voters posed no questions.* Motion to **approve as presented:** Steven Gwiazdowski, MD Second: Brian Montenegro, MD *Approved unanimously* Next Step: Sept. 9 PAC
Policy Owner: Utilization Management – *Presenter: Colleen Townsend, MD, Regional Medical Director (Southeast)*		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
MCUP3052 – Medical Nutrition Therapy (MNT) Services – **NEW TITLE**	This policy, last approved in February 2026, is under review again to resolve conflicts that have arisen between new DHCS criteria and Partnership's existing policy criteria for Medical Nutrition Therapy services. **Title:** Title of this policy was updated to include the word "Therapy" and the acronym (MNT) as follows: Medical Nutrition Therapy (MNT) Services. **I.E. and F:** Two Related Policies are added as follows: MCUP3041 - Treatment Authorization Request (TAR) Review Process MPAP7003 - CalAIM Community Supports (CS) **IV.B.:** Attachment B was Archived and the Adult Criteria information from that document was combined with Attachment A's Child/Adolescent Criteria. Attachment C then became Attachment B. **V. Purpose:** Information regarding the Affordable Care Act requirements to cover USPSTF Class A or B recommendations was removed from the Purpose statement and added to the main policy at section VI.B. instead. Additionally, this statement was added to the Purpose section: "This policy uses evidence-based guidelines and currently recognized national standards of care to ensure access to MNT in the treatment and prevention of chronic diseases." **VI.B.1. and 2.:** Language regarding the Affordable Care Act requirements to cover USPSTF Class A or B recommendations was added here. Specific recommendations were removed, as was a statement that previously said MNT was covered as an enhanced benefit for children. A new statement was added to say "Children, adolescents, and adults are covered under this policy." **VI.C.1.:** Section C.1. was added to define requirements for Authorization and Billing of MNT Services. Specifically, no RAF is required, and no TAR is required unless visits exceed recommendations listed in VI.C.2. **VI.C.2.:** Section C.2. was updated throughout to specify billing units and recommended frequencies for types of visits according to CPT codes. Some of these changes to recommended frequencies will require amendments to previous BREW decisions, specifically for codes 98970- 98972, G01018, G0109, and Z codes for perinatal services. **VII. Refences:** New References were added at VII.B. – K. as guidance for the recommended criteria and frequencies updated in this policy. **Attachments A and B:** Attachment B was Archived and the information was combined into one document, Attachment A. Attachment A now lists and defines ICD-10 codes that are considered to be criteria for MNT visits for children, adolescents and/or adults. Recommended frequencies were removed from this document because they have been detailed in the main policy at VI.C.2. **Attachments B and C:** Previous Attachment C is now Attachment B. Dr. Townsend said we have made some clarifications with regard to identifying an optimal amount of visits available to our members with a variety of conditions that are responsive to nutrition therapy. We cleaned up the actual diagnoses for which medical nutrition therapy can be applied and made a uniform per year allowance of visits and then combined the attachments outlining which diagnoses for which	Motion to **approve as amended:** Brian Montengro, MD Second: Randy Thomas, MD *Approved unanimously* Next Step: Sept. 9 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	MNT is available without a TAR. Dr. Netherda clarified that MNT means education, meeting with dieticians and nutritionists. It does not include any food or IV food. Dr. Townsend concurred: MNT is health education that is specific to nutrition offered by registered nutritionists or CDEs. If you have diabetes, it can include specific diabetes education. It can include medical instruction therapy for diagnoses like hypertension, coronary artery disease, hyperlipidemia, obesity, etc. It does not include the distribution of food products, but it can include counseling around how to best shop and how to prepare meals. **Q/UAC voter and pediatrician Randy Thomas, MD, asked about the Attachment A definition of obesity in the pediatric population, noting that rather than 85%, it should read 95%. Dr. Townsend and Anna Campbell took this under advisement and later amended Attachment A to differentiate "overweight" from "obesity" in the pediatric population:** • **Obesity:** Pediatric: Ages 2 – 19 years: > 95th percentile by weight for height OR by BMI, using the appropriate growth chart for age (NCHS) • **Overweight:** Pediatric: Ages 2 – 19 years: > 85th and < 95th percentile by weight for height OR by BMI, using the appropriate growth chart for age (NCHS)	

In an effort to ensure that Health Services policy changes are communicated to Claims, Member Services, Network Services and/or Provider Relations when their additional work will be required for full policy change implementation, CMO Robert Moore, MD, following the July 7 IQI innovated the following script. (When this extra work is required, that fact will be captured in the IQI and Q/UAC minutes.) **MCUP3052 presented above is the first policy to test this.**

The department policy owner/designee must ensure the approved changes are appropriately followed up (check all that apply):

☐ Important Provider Notice (IPN)	☒ **Provider Education/Training**	☐ Provider Fax Blast *(specify provider type(s):*
☐ Member Notice *(specify education/training, external webpage, mailing, member meeting, Member Newsletter, Member Handbook/Evidence of Coverage, etc.):*		
☐ Call Center Script Change	☐ Update of TAR Requirements (MCUP041-A)	☒ Other *(specify):* **PR/Claims special decision payments: back date to first denials (October 2025); Claims/Config update volume/limits; Provider Education to PCPs, MNTs, MTMs: note new policy with change in visit limits**
☒ **Configuration of HRP and/or Claims Editor System (CES)**	☐ Configuration of Essette/Jiva	

V. Presentations

The QI Trilogy and associated paper – *presented by Quality & Performance Improvement Senior Director Isaac Brown, MBA/MPH*

1	**Closeout Summary of FY 2025-2026 QI Work Plan – *Motion to approve: Robert Quon, MD / Second: Steven Gwiazdowski, MD – Motion carries unanimously*** In 2025-2026, QI had 72 goals, each with numerous deliverables: 59 of these goals were completed; nine were terminated, and four were delayed or left incomplete.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

- A change of vendor allowed us to complete our annual Healthcare Effectiveness Data Information Set (HEDIS®) work earlier than usual, eliminating the need to build out a monthly dashboard.
- Goals associated with the Dual-Eligible Special Needs (D-SNP) program were either postponed or terminated when our Medicare program implementation was delated to a Jan. 1, 2028 go-live date.
- Goals associated with the Health Rules Payor (HRP) replacement of our core claims system AMISYS were terminated or delayed as kinks continued to be worked out.
- The HEDIS® team significantly expanded their use of clinical data acquired through use of a National Committee for Quality Assurance (NCQA) Data Aggregator (DataLink) for MY2025 HEDIS measure rate generation, increasing participating practices from six to more than 30. Partnership will continue to scale up these activities in the 2026-2027 fiscal year (July 1, 2026 - June 30, 2027).
- Our Site Review Inspections team created a comprehensive directory of Medi-Cal dental providers, something DHCS had not been able to provide to the Managed Care Plans (MCPs). The directory captures provider type, staffing demographics, and estimated monthly patient volume with a desktop created to ensure that the information remains complete and accurate. This supports Partnership's Care Coordination department in identifying dental providers for our members. (Many thanks to Rose Aarons for spearheading this work.)
- Partnership teams spent some time working on validation frameworks for the PCP and other QIPs. We want to ensure all data providers provide to us is accounted for so we may incentivize providers as much as possible.
- The Quality Measure Score Improvement (QMSI) initiative successfully engaged for measure-specific workgroups: Behavioral Health, Chronic Disease, Women's Health and Perinatal, and Pediatrics. Follow-up within seven days for mental illness after an emergency department visit and educating providers on colorectal cancer screening modalities to serve their unique populations were just two of the many efforts that improved rates and member outcomes.
- QI Program and Project Management piloted a QI Project Toolkit & Training Program with 26 participants representing 13 organizations, launching it into a full-scale program in early CY 2026 to a first cohort of 61 participants from more than 30 provider and community-based organizations (CBOs), enabling participants to improve their project management skills. The Tool Kit is available on Partnership's public-facing webpage.

2

The QI Trilogy Documents – Q/UAC voters posed no questions. ***Motion to approve: John Murphy, MD / Second: Robert Quon, MD – Motion carries unanimously***

Annually, the Quality and Performance Improvement Team updates three documents that reflect past, present, and future work related to quality improvement at Partnership HealthPlan of California (Partnership):
1. Quality Improvement Program Description
2. Quality Improvement Program Evaluation
3. Quality Improvement Work Plan

Each document is a regulatory and NCQA Accreditation requirement. The Quality Improvement Project Management team, in partnership with the Senior Director of Quality and Performance Improvement and Director of Quality Management, serves as the QI Trilogy Document Team. The team leads the preparation of the documents for review by Partnership's quality committees. These documents will be presented during the quality committees in August and final approval will be sought from the Board of Commissioners on Oct. 28. Along with this review cycle, each document accounts for activities on a fiscal year cycle. These documents will be submitted to the State after Board approval and shared with Partnership members via the website and upon request.

The QI Program Description is a summary of the QI program with content including the structure, processes, and intra and interdepartmental work that supports quality improvement efforts at Partnership. The program description contains the following components per the NCQA accreditation standards (QI 1A):

- The QI program structure.
- The behavioral healthcare aspects of the program.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

- Involvement of a designated physician in the QI program.
- Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program.
- Oversight of QI functions of the organization by the QI Committee.

The Partnership FY 2026-2027 document reflects revisions completed through interdepartmental review and collaboration, particularly in the following areas:

1. Updated the Quality Improvement program scope and strategic direction to reflect current organizational planning, including future Medicare/D-SNP integration, quality oversight for dental services, and the planned transition of the Wellness and Recovery Program.
2. Refined governance structures by removing obsolete committees, adding D-SNP quality oversight, clarifying delegated responsibilities, and aligning committee membership and meeting cadence with current operations.
3. Strengthened leadership accountability through updated roles, including that of the Deputy Chief Medical Officer, clarified Medicare/D-SNP oversight responsibilities, and revised organizational documentation to address audit expectations.
4. Aligned health equity and accreditation language with updated NCQA terminology and clarified which activities remain discretionary versus compliance driven.
5. Updated behavioral health oversight to reflect de-delegation of member-facing functions from Carelon Behavioral Health while retaining delegated quality, network, and claims-related responsibilities.
6. Revised value-based payment program language to reflect the re-establishment, completion, or status changes of key incentive programs, including the Extended Care (EXT) QIP reconstituted in January 2026 to make sure our Skilled Nursing Facilities (SNFs) partners feel supported.
7. Expanded the Pathway to Excellence framework to emphasize continuous learning, implementation of science, leadership accountability, and sustainability of quality improvement efforts.

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

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

The Evaluation includes work directly completed by the Q & PI department and other departmental partners within Partnership. In preparing the 2025-2026 Evaluation, the following items were given greater consideration:

1. Continued analysis of the QI program structure and how the roles defined within the QI department and senior leadership/physician roles fulfill it.
2. Enhanced trend analysis and implementation of interventions for measurements related to clinical quality, member safety, and member experience outcomes, reflecting the most recent 12-month period compared to the prior year.
3. Continued assessment of barriers in quality improvement with corresponding health plan adaptations to member and provider engagement strategies and tactics.
4. Member Experience priorities, including the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), access, transportation, and benefit understanding.
5. Health equity and disparity reduction by maintaining both Health Plan Accreditation (HPA) and Health Outcomes Accreditation (HOA) readiness and compliance through NCQA and DHCS priorities.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

6. Assessment of resources and organization of quality and performance improvement activities to accommodate the growing scope and complexity of quality measurement and reporting under both DHCS and NCQA accreditation. In FY 2025-2026, of particular focus was the preparation for the implementation of Partnership's D-SNP program and HRP, evaluation of achieving at least a 3.5 STAR health plan rating as an NCQA accredited health plan, and achievement of NCQA HOA requirements.

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

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

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

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

Annually, the process for completing the trilogy documents is assessed for improvement. In developing the 2026-2027 Work Plan, QI leadership worked to proactively identify new and adapted projects and programs based on the closeout of the 2025-2026 Work Plan. This led to greater dialog among sponsors, business owners and contributors on lessons learned, which correlates to the accomplishments and challenges cited in the 2025-2026 QI Evaluation. Ultimately, this refined approach aided the work plan change process and led to sound goal setting and deliverable identification in the 2026-2027 Work Plan.

VI. Adjournment to 7:30 – 9:00 a.m. Sept. 16, 2026

Dr. Netherda adjourned the meeting at 8:26 a.m.

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

Signature of Approval: _____ Date: Sept. 6, 2026

Mark Netherda, MD, Medical Director for Quality

PARTNERSHIP HEALTHPLAN of CALIFORNIA

QI DEPARTMENT UPDATE
AUGUST 2026
PREPARED BY ISAAC BROWN
SENIOR DIRECTOR, QUALITY AND PERFORMANCE IMPROVEMENT

QUALITY INCENTIVE PROGRAMS (QIPS)

PROGRAM	UPDATE
PRIMARY CARE PROVIDER QUALITY INCENTIVE PROGRAM (PCP QIP)	**Program Overview** Pay for performance program incentivizing improved performance on Clinical, Non-Clinical, and Unit of Service (UOS) measures in the Primary Care setting. **Program Update** • Proposed measure set changes for Measurement Year (MY) 2027 will be presented at the Physician Advisory Committee (PAC) this month. • An evaluation of the 2025 eReports upload audit will be shared at August's internal technical workgroup.
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** • Payment processing for the 2026 Measure Period I (January 1 – June 30) has begun. Requests have gone out to palliative providers participating in the Palliative QIP for their reporting templates for POLST and Patient Symptom Assessment data.
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** • 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** • CY2027 measurement set proposal is scheduled for presentation at the Physicians Advisory Committee (PAC) meeting this month. There are no proposed changes.
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. Partnership has developed a simple and meaningful measurement set which includes measures in the following domains: Clinical, Functional Status, Resource Use, and Operations / Satisfaction. **Program Update** • The CY2027 measurement set proposal will be presented at the Physicians Advisory Committee (PAC) next month.

QUALITY DATA TOOLS

TOOL	UPDATE
PARTNERSHIP QUALITY DASHBOARD (PQD)	**Program Overview** The Partnership Quality Dashboard (PQD) is a Tableau designed to inform, prioritize, and evaluate quality improvement efforts. Dashboards and performance metrics built into the PQD provide the ability to track and trend QIP data. **Program Update** • No updates
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 updates

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** • BH PI: Working on the 2nd remeasurement submission due on August 6th

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:** No Update • **Women's Health & Perinatal:** We have been working with Regional Quality Leadership on setting regional priorities for PPC Pre, BCS, and CCS. • **Chronic Disease:** We have begun working on resource-based materials for improvement advisors to use around measures such as Colorectal Cancer Screening, Hypertension and Diabetes Good control. The first toolkits to take shape in this new restructured form of QMSI will be a step-by-step process around Cologuard bulk ordering with Exact Sciences. In addition, a hypertension back to the basics and remote patient monitoring is also in the works as we now meet on a weekly basis with our Chronic Disease co-leads. Our back-to-basics HEART method hypertension toolkit is currently being reviewed with our communications team. • **Behavioral Health:** Measure best practices have been finalized and are awaiting publication on the external website.
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** A new training framework will be introduced to the provider network for Improvement Academy offerings. Structured as a sequential quality improvement pathway, the framework enables participants to progress from foundational concepts to advanced application across three distinct phases: foundational (ABCs of Quality Improvement); intermediate (Performance Improvement in Action); and advanced (QI Project Training Program). **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

- Currently in the planning phases for three in-person sessions:
  - 02/11/2027 – Fairfield
  - 02/25/2027 – Chico
  - 03/11/2027 – Eureka

Performance Improvement in Action
Program Overview
The Performance Improvement in Action training helps participants move from identifying problems to testing real solutions, guiding participants through the full quality improvement process using a real challenge from their site. Participants learn how to define a strong problem statement, understand the current state of the issue through observation, and analyze contributing factors using tools such as Pareto charts, and the Five Whys. The series then focuses on developing practical change ideas and testing them through a Plan-Do-Study-Act cycle.

Program Update

- The initial pilot will launch on 09/08/2026 spanning six structured sessions. During this phase, targeted participant feedback will be gathered to evaluate and refine the program curriculum prior to the official cohort launch in 2027.

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

- Fall 2026 cohort kicks off 09/01/2027. There are currently 123 individuals enrolled.

Microlearning
Program Overview
These short, focused modules deliver key concepts in easily digestible formats.

Program Update

- No new update.

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** • Began scheduling meetings for 2027
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 –** No Update • **Chico and Auburn Regions –** Meetings facilitated in mid-July. Using Locum to close quality care gap toolkit was presented. Shared mid-year performance updates compared to similar time periods in the previous year. Discussed the importance of quality as a "team sport" and reviewed the various quality roles of different parts of the organization. • **Redding and Eureka Regions –** No Update o

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
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** • Milestones and Deliverable Payments o PHLC sent the deliverable submission report for the May 2026 deliverables. EPT practices have one (1) more opportunity to receive payments tied to milestone achievements for November 2026 deliverables. ▪ 20 out of 22 practices completed the required and final installment of the PhmCAT. ▪ The deliverable submission report shows that both Baechtel Creek and K'ima:w Medical Center are currently part of the cohort but did not complete the required 2026 PhmCAT deliverable. o DHCS will be providing MCPs payment guides for practices who completed May 2026 deliverables. MCPs will be expected to deliver payments to practices by September 2026. • MCP EPT Reporting Requirements o The MCP EPT report deadline was extended to 08/14/2026 due to PHLC's change in the reporting period from 10/01/24 – 9/30/25 to 01/01/25 – 12/31/25. o Future changes to the EPT MCP Reporting requirements are anticipated; PHLC confirmed they will be sending updated guidance. • 1:1 Technical Assistance Optional Coaching o EPT Practices can schedule their personalized 30-minute coaching sessions from July through September. o These sessions can be leveraged to map out their current workflows, review deliverable drafts, or troubleshoot roadblocks. o PHLC encourages practices to share scheduled 1:1 coaching with their MCPs. o Coaching sessions will be provided on Behavioral Health, Health-Related Social Needs, and Value-Based Payment.
EXPANDED COUNTIES REINVESTMENT IN QUALITY (E-RIQ)	**Program Overview** The Expansion Counties Reinvestment in Quality (E-RIQ) program is a strategic $2 million investment to improve health outcomes and member experience across the ten expansion counties: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Tehama, Yuba, and Sutter. *Funding is allocated through two pathways:*

	• ***Phase I: $500,000 (****$50K allocated to each county) to strengthen community-based engagement and access across priority focus areas* • ***Phase II: $1.5 million*** *for Provider opportunities to drive measurable improvements in quality priority measures through targeted initiatives and activities.* • ***Phase III:*** Currently under exploration: Piloting a vendor-supported gap closure initiative. **Program Updates:** • ***Phase I:*** All 10 counties applied, 8 have received awards, 2 are in discussions to gather more details. • ***Phase II:*** Proposed framework has been developed and is currently in review. • ***Phase III:*** Vendor exploration is in progress.
PREVENTIVE CARE BRIDGE PROJECT (FORMERLY: LOCUM PILOT INITIATIVE)	**Program Overview** 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 explored a potential model for supporting improved measure performance, reducing withholds and sanctions associated with unmet benchmarks, and enhancing the overall member experience. **Program Updates:** Pilot findings were used to develop implementation resources for network providers, including an ROI calculator, readiness checklist, self-serve training materials and a field guide to identify risks and implementation considerations. These resources are intended to support provider decision-making, improve operational readiness, and strengthen implementation success. The model and resources were presented during quality regional meetings to support broad provider engagement. This quality improvement effort translated pilot learnings into scalable support for improving access and closing preventive care gaps.
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**

Current Event Days
07/01/2026 – 09/30/2026

Region	# of Provider Organizations	# of Provider Sites	# of Provider Event Days	# of Community Event Days
Auburn	1	1	1	0
Chico	4	6	7	1
Eureka	4	5	6	0
Fairfield	1	3	3	0
Redding	6	6	7	0
Santa Rosa	2	2	2	0
Plan Wide	**18**	**23**	**26**	**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.

- Planning for October to December 2026 in progress.

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 updates at this time.

Abbott Cancer Diagnostics: Promoting Colorectal Cancer Screenings

Offering Updates

Abbott Cancer Diagnostics, formerly known as Exact Sciences, continues to work directly with providers to support care-gap orders for Cologuard kits. These care-gap orders no longer have a 300 patient minimum.

Providers interested in placing a care-gap order should contact their Abbott Cancer Diagnostics representative. Providers who are unsure who their representative is may contact Abbott's support line at 1-844-870-8870 or complete the online contact form at https://www.cologuardhcp.com/contact-us.

Partnership's Cologuard Care-Gap Orders page continues to be available as a resource for general information.

	Since a minimum is no longer required for care-gap orders, Partnerships facilitated orders will be discontinued after our current offering (further details below). If you have any questions, please reach out to the Performance Improvement team at PIT@partnershiphp.org. **Partnership Facilitated Orders** • Partnership's last facilitated order launched on 07/20/2026 with a final submission date of 08/17/2026. Pre-shipment patient letters are expected to be mailed on 09/18/2026 with the kits shipping on 09/28/2026.

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
	• All QI Trilogy documents (FY2026/27 QI Program Description; FY2025/26 QI Work Plan; FY2025/26 QI Evaluation; and FY2026/27 QI Work Plan) have been submitted for Committee and Board approval. Scheduled review and approval dates area as follows:
	  • Internal Quality Improvement (IQI) Committee – 08/11/2026
	  • Quality Utilization Advisory Committee (Q/UAC) – 08/19/2026
	  • Physician Advisory Committee (PAC) – 09/09/2026
	  • Board of Directors – 10/28/2026

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** • K'ima:w went live with their OCHIN EPIC implementation on 07/14/2026

	• Partnership will begin coordination activities to the July – December Progress Check-In with K'ima:w by November 2026.
D-SNP MEDICARE	**D-SNP** **Program Overview** The D-SNP Quality team is responsible for 1) Development and finalization of the Model of Care document, 2) Management of Partnership's CMS Medicare Star quality program, and 3) Developing D-SNP readiness for all Quality Improvement teams. QI Department D-SNP Project plans reflect the launch postponement with vendor-related projects TBD. All QI D-SNP related project plans can be found on the Partnership Advantage Share Point Project plan site. The Medicare Stars HEDIS/Analytics vendor (Wakely) has produced and released QI's baseline data for members eligible for Partnership Advantage in our eight launch counties. The dashboard includes baseline HEDIS Quality Measure Performance for 13 active Stars measures using 2025 data. Measure performance is calculated against the latest released Medicare Cut Points (MY 2023). The Medicare QI team is working with Wakely to assess and correct data gaps. Wakely will perform 5 subsequent data runs this year to assess if data gaps are reducing and to continue to assess performance estimates throughout measurement year 2026.
ACTIVITY	**UPDATE**
QUALITY ASSURANCE AND PATIENT SAFETY	
ACTIVITY	**UPDATE**
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: 6/25/2026 TO 7/30/2026	**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** • 46 referrals were received with 39 from Grievance and Appeals, 1 from Utilization Management, 1 from Care Coordination, 1 from QI Member Safety and 4 from a Regional Associate Director • 46 cases were processed and closed • 108 cases are currently open • There was no PRC meeting in July, as there were no cases to present. We are currently awaiting four cases for PRC review. • 1 case was sent to a Subject Matter Expert for review

FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR)	**Program Overview** Site Review and Medical Record Review performed for monitoring of providers. **Program Update** • No new updates

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE
Annual HEDIS® Projects	**Program Overview** HEDIS is used to evaluate clinical quality in a standardized way. This program shares performance measurement rates with the intent of improving the quality of care delivered to members. **Program Update** • HEDIS MY2025 final rates have been approved for both Health Plan Accreditation (HPA) for NCQA and Managed Care Accountability Set (MCAS) for DHCS. • The formal, detailed MY2025 Annual Summary of Performance Reports will be posted on Partnership's external website in mid-October. • We received the Final Audit Reports (FAR) from both auditors, happy to report there were no findings. • Plans are underway to prepare for the launch of MY2026. In October, the team will begin completing the ROADMAP audit deliverables for both regulatory audits with testing planned to begin in November.
HEDIS® Program Overall	**Program Updates** • The HEDIS team conducted a Provider Webinar in June to focus on the upcoming Prospective Medical Record Project and the review of the timeline for the launching of the HEDIS MY2026 Annual Project. We had good attendance and great questions. Thank you to those who participated! • Plans are underway to launch the Prospective Medical Record Project in October 2026. • Beginning in late August, the HEDIS team will be conducting another round of testing to support our core claims system transition to Health Rules Payer (HRP).

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** • No Update
NCQA Health Outcome Accreditation (HOA)	**Program Overview** The State of California requires all Managed Care Plans (MCPs) to be both Health Plan (HP) and Health Outcome (HO) Accredited. The process involves completing a Renewal Survey every three (3) years. Partnership's next HOA Renewal Survey is tentatively scheduled for 05/16/2028. **Program Update** • No Update

Partnership Policy & Procedure Updates

September 2026

Policy Number	Policy/Procedures/Guidelines
	*The following documents were reviewed by the Quality / Utilization Advisory Committee (Q/UAC) in **August 2026.*** *Highlighted policies have significant changes, new attachments, or were amended during the Q/UAC meeting. Redline versions contain attachments.* *Please review the redline drafts and the detailed **Synopsis of Changes** in the packet.* *The current policies shown in the online Provider Manual are hyperlinked.*
Care Coordination	
MPCP2007	Complex Case Management
Health Equity	
MCED6001	Health Equity and Community Reinvestment Strategy and Program Description
Member Services	
MP301	Assisting Providers with Missed Appointments *(New Title)*
Population Health Management	
MPND9001	Population Health Management Strategy & Program Description
MCNP9004	Regulatory Required Notices *(Updated Attachments A – D)*
Quality Improvement	
MPQD1001	Quality Improvement Program Description
MPQP1048	Reporting Communicable Diseases
Utilization Management	
MCUP3012	Discharge Planning (Non-capitated Members)
MCUP3050	Medication Abortion in the First Trimester
MCUP3052	Medical Nutrition Therapy (MNT) Services *(New Title)*
MCUP3119	Sterilization Consent Protocol
MPUP3035	Preoperative Day Review

Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the Aug. 19, 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: Health Equity – *Mohamed Jalloh, Pharm.D, Director of Health Equity (Health Equity Officer)*			
MCED6001 – Health Equity and Community Reinvestment Strategy and Program Description **NEW TITLE –** *CLEAN copy begins on p. 169*	127 – 200	• **Name Change on Page 1:** The Program Description name is changed from the "Quality Improvement and Health Equity Transformation (QIHEPT) Program Description" to the "Health Equity and Community Reinvestment Strategy and Program Description" to increase ease of communication to internal team members. • Health Equity Accreditation Name Change on Page 10: The National Committee for Quality Assurance's HEA (Health Equity Accreditation) is changed to HOA (Health Outcomes Accreditation) to reflect new NCQA terminology, effective Jan. 15, 2026. • Quality Improvement Priorities on Page 11, 13: Update includes the top Quality Improvement Priorities and how Partnership clarified its health disparity priorities. • Health Disparity Measures on Page 14: Update reflects which annual QIHETP administrative measures will be measured per department (e.g. Quality Improvement, Population Health, Human Resources, etc.). • Community Reinvestment Updates on Page 17: Update reflects changes in community reinvestment management. Specifically, Public Health Directors and Behavioral Health Directors will lead their county's selection efforts versus Partnership providing a specified list from which the counties could pick. • Reference to the Population Needs Assessment Committee (PNA defunct Spring 2026) has been deleted. • The Deputy Chief Medical Officer's role has been added. • Statement re conflict of interest policy added. • The Non-Discrimination Statement has been updated.	Health Services (Health Equity)
Policy Owner: Utilization Management – *Tony Hightower, CPhT, Associate Director, UM Regulations*			
MCUP3012 – Discharge Planning (Non-capitated Members)	201 – 204	**VI.B.2.:** Clarified that "Nurse Coordinator" refers to Partnership staff. **VI.B.3.a.:** Listed additional types of "Alternate Medical Services" including subacute, LTAC, and acute rehab. **VI.B.3.a.5):** Added policy MCUG3024 Inpatient Utilization Management to the list of policies with more information regarding authorization of alternate medical services. **VI.B.4.a.:** Deleted duplicative language regarding notification process when the service provider notifies Partnership's Nurse Coordinator to obtain precertification for any services included in the patient's discharge plan.	Claims Provider Relations Member Services

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, *i.e.*, NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	External Documentation (Notice required outside of originating department)
		VI.B.4.a.: Added language from APL 26-011 to say "Approval for pediatric subacute care services ceases once the Member turns 21 years of age. Authorization requests for pediatric Members should not exceed the Member's 21st birthday; therefore, discharge planning to an appropriate adult level of care must be completed at least two months prior to the Member's 21st birthday." **VII.C.:** Added a Reference for APL 26-011, Subacute Care Facilities – Long-Term Care Benefit Under Managed Care	

The department policy owner/designee must ensure the approved changes are appropriately followed up (check all that apply for <u>each</u> discussion policy): [1]

☐ Important Provider Notice (IPN)	☒ **Provider Education/Training**	☐ Provider Fax Blast *(specify provider type(s):*
☐ Member Notice *(specify education/training, external webpage, mailing, member meeting, Member Newsletter, Member Handbook/Evidence of Coverage, etc.):*		
☐ Call Center Script Change	☐ Update of TAR Requirements (MCUP041-A)	☒ Other *(specify below):* **PR/Claims special decision payments: back date to first denials (October 2025); Claims/Config update volume/limits; Provider Education to PCPs, MNTs, MTMs: note new policy with change in visit limits**
☒ **Configuration of HRP and/or Claims Editor System (CES)**	☐ Configuration of Essette/Jiva	

Policy Owner: Utilization Management – *Colleen Townsend, MD, Regional Medical Director, Southeast*			
MCUP3052 – Medical Nutrition Therapy (MNT) Services – **NEW TITLE –** *CLEAN copy begins on p. 219*	205 – 223	This policy, last approved in February 2026, is under review again to resolve conflicts that have arisen between new DHCS criteria and Partnership's existing policy criteria for Medical Nutrition Therapy services. **Title:** Title of this policy was updated to include the word "Therapy" and the acronym (MNT) as follows: Medical Nutrition Therapy (MNT) Services. **I.E. and F:** Two Related Policies are added as follows: E. MCUP3041 - Treatment Authorization Request (TAR) Review Process F. MPAP7003 - CalAIM Community Supports (CS) **IV.B.:** Attachment B was Archived and the Adult Criteria information from that document was combined with Attachment A's Child/Adolescent Criteria. Attachment C then became Attachment B. **V. Purpose:** Information regarding the Affordable Care Act requirements to cover USPSTF Class A or B recommendations was removed from the Purpose statement and added to the main policy at section VI.B. instead. Additionally, this statement was added to the Purpose section: "This policy uses evidence-based guidelines and currently recognized national	Claims Configuration Provider Relations Provider Contracting Member Services **<u>Next Steps</u>:** • PR/Claims special decision payments claim payment back dated to first denials (Oct 2025) • Claims/ Config update volume/limits • Provider Education (PCPs, MNTs, MTM) to note that our policy has

[1] This information will be captured in the meeting minutes.

		standards of care to ensure access to MNT in the treatment and prevention of chronic diseases." **VI.B.1. and 2.:** Language regarding the Affordable Care Act requirements to cover USPSTF Class A or B recommendations was added here. Specific recommendations were removed, as was a statement that previously said MNT was covered as an enhanced benefit for children. A new statement was added to say "Children, adolescents, and adults are covered under this policy." **VI.C.1.:** Section C.1. was added to define requirements for Authorization and Billing of MNT Services. Specifically, no RAF is required, and no TAR is required unless visits exceed recommendations listed in VI.C.2. **VI.C.2.:** Section C.2. was updated throughout to specify billing units and recommended frequencies for types of visits according to CPT codes. Some of these changes to recommended frequencies will require amendments to previous BREW decisions, specifically for codes 98970- 98972, G01018, G0109, and Z codes for perinatal services. **VII. Refences:** New References were added at VII.B. – K. as guidance for the recommended criteria and frequencies updated in this policy. **Attachments A and B:** Attachment B was Archived and the information was combined into one document, Attachment A. Attachment A now lists and defines ICD-10 codes that are considered to be criteria for MNT visits for children, adolescents and/or adults. Recommended frequencies were removed from this document because they have been detailed in the main policy at VI.C.2. **Attachments B and C:** Previous Attachment C is now Attachment B.	been revised with a change in visit limits

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPCP2007 (previously MCCP2007, MPCP2007)</td><td colspan="3">Lead Department: Health Services
Business Unit: Care Coordination</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Complex Case Management</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 06/20/2012</td><td colspan="4">Next Review Date: ~~09/10/2026~~09/09/2027
Last Review Date: ~~09/10/2025~~09/09/2026</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>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~09/10/2025~~09/09/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MPCD2013 – Care Coordination Program Description
B. MP~~C~~CP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services
C. MPCP2014 – Continuity of Care
D. MCCP2024 – Whole Child Model for California Children's Services (CCS)
E. MCAP7002 – CalAIM~~:~~ Enhanced Care Management (ECM)
F. MP~~C~~ND9001 – Population Health Management Strategy & Program Description
G. MPCP2006 – Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities
H. MPQP1038 - Physician Orders for Life-Sustaining Treatment (POLST)
I. MPQP1047 - Advance Directives
J. MPCP2034 - Transitional Care Services (TCS)
~~J.~~K. CGA024 - Medi-Cal Member Grievance System

II. IMPACTED DEPTS:

A. Health Services
B. Claims
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. 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.
C. 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.
D. HIPAA: The Health Insurance Portability and Accountability Act
E. Individualized Care Plan (ICP): A Member-focused care plan designed to optimize the Member's health, function, and well-being.
F. Medical Home: The provider identified as the M~~m~~ember's medical home or primary care provider (PCP) is responsible for managing the M~~m~~ember's primary care needs.
G. 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~~Members~~ will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook. Coverage criteria apply on implementation of D-SNP, effective January 1, 2028 and subject to CMS and DHCS approval.

H. Partnership CC: Partnership HealthPlan of California's Care Coordination department
I. Seniors and Persons with Disabilities (SPD): A group of Medi-Cal beneficiaries who are most vulnerable to adverse health outcomes.
J. 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 process by which Partnership HealthPlan of California's (Partnership's) Members are reviewed for the Complex Case Management (CCM) program. CCM is a voluntary program that provides interventions aimed at both improving the Member's self-management of their health and also increasing appropriate usage of health and medical resources while reducing the inappropriate utilization of healthcare resources. Members may decline or withdraw at any time without impact to their benefits. ~~These~~ CCM goals are achieved by working with the Member/caregiver and Member's interdisciplinary care team to do the following:

A. Educate the Member about their benefits with managed care and how to use available resources
B. Identify and help the Member understand their medical condition(s)
C. Support and encourage self-management skills to promote and optimize the Member's personal health goals and well-being
D. Coordinate necessary health care services, and
E. Refer to appropriate medical or social community resources, when applicable

VI. POLICY / PROCEDURE:

A. Identification of Participants
    1. Operating within HIPAA regulations, Partnership proactively identifies Members eligible for CCM services from many data sources that may include:
        a. New Member assessments such as the Health Information Form (HIF), Health Risk Assessment (HRA), or Pediatric Health Risk Assessment (PHRA)
        b. Internal Reports such as:
            1) Weekly Hospital Discharge Report
            2) Monthly Utilization Report
            3) Monthly Pediatric Case Finding Report
        c. Referrals from other Care Coordination interventions when a Member meets the criteria for inclusion in CCM. Examples of services that may provide a source of referral include:
            1) Access to Care
            2) Transitional Care Services (TCS)
            3) Growing Together Program (GTP)
        d. Member/Caregiver self-referral: via telephone, or through Partnership's Member Portal

e. Provider referral: via telephone or Provider website referral form
f. External Reports such as:
   1) County CCS enrollment
   2) Members served by Targeted Case Management Services

2. Additional Sources of R~~r~~eferrals
   a. Partnership performs outreach activities, such as meetings and education notices to primary care providers (PCPs) within Partnership's network to discuss the CCM program and to identify Members who may benefit from the program. Partnership outreach activities extend beyond PCPs; education regarding the CCM program, participant eligibility, and referral process is also shared.
   b. Referral sources for Members and practitioners ~~may also~~ include, but are not ~~not~~ limited to: ~~:~~
      1) Internal Department Referrals: Claims, Utilization Management, Pharmacy, etc.
      2) Vendor/Delegated Entity Reports including~~:~~ Advice Nurse Report, etc.
      3) Specialists
      4) Hospital Discharge Planners
      5) Ancillary Providers
      6) Behavioral Health Specialists
      7) Community Partners (e.g., Case Managers, County Public Health Departments, etc.)
      8) Regional Centers
      9) California Children's Services (CCS)
      10) Enhanced Care Management (ECM) Providers
   c. Members or their caregiver/representative are provided information on the CCM program through Member newsletters, the Partnership Member Portal, from their providers, and through direct outreach by Partnership's Care Coordination team, and may request CCM assistance at any time.

B. Eligibility

To be eligible for CCM services, Members must have Partnership Medi-Cal as their primary health plan, be a Partnership Advantage ~~Member, or~~Member or have an eligible condition for which Partnership may be responsible (e.g., Partnership is secondary). Partnership Members ~~cannot be~~ enrolled in ECM will not receive duplicative CCM services, and Partnership shall coordinate to avoid duplication. ~~and the ECM benefit simultaneously.~~ For more information on the ECM benefit, see Partnership policy MCAP7002 CalAIM Enhanced Care Management (ECM). Partnership will identify Members who meet at least one of the following criteria as potential candidates for CCM services:

1. Members who have barriers to managing their care without the support of CCM, (e.g., poor support systems, fragmented care, health literacy barriers), or
2. Seniors and Persons with Disability identified as needing CCM to reduce risk of adverse effects, according to the parameters outlined in policy MP~~C~~CP2019 Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services, or
3. Pediatric Members identified as needing CCM to reduce risk factors according to the parameters outlined in policy MCCP2024 Whole Child Model for California Children's Services or
4. One (1) or more California Children's Services (CCS)–eligible conditions and requiring the support of an individualized care plan; or
5. Two (2) or more chronic medical conditions (e.g., Chronic Kidney Disease [CKD], Chronic Obstructive Pulmonary Disease [COPD], Congestive Heart Failure [CHF], Diabetes Mellitus [DM], Hypertension [HTN], hyperlipidemia), and requiring the support of an individualized care plan.

C. Initial Assessment

1. Members identified as candidates for the CCM program will be contacted within 30 days of identification and offered the opportunity to enroll in CCM. If the Member agrees to enrollment, the assigned Partnership Care Coordination (CC) Staff will initiate a detailed assessment of the Member, which will be completed within 60 days of identification. Partnership CC Staff will make two (2)

attempts to reach the referred Member by phone, followed by a mailed letter inviting the Member to participate in the CCM program. These three attempts will be completed within 14 calendar days. If the Member does not respond to outreach efforts, the case will be closed. The case may be re-opened at any time should the Member opt in to participation in the program.

2. When a Member agrees to participate in the CCM program, Partnership CC Staff performs a Complex Case Management Assessment to address and document the Member's self-reported health status. This assessment gathers information about the Member, including the Member's medical history (e.g., major procedures and surgeries and the dates these interventions occurred, when known), current medical conditions (e.g., the presence or absence of comorbidities), ability to manage condition-specific issues, caregiver ability and willingness to participate in care, current and past medications (including schedules and doses), mental and behavioral health status, ability to perform self-care, and their engagement in enjoyable activities.
    a. In select cases, the initial assessment may be performed in person.
3. Assessments will be tailored to the needs of the individual Member. Branching logic will be utilized to prevent Members from being asked questions that may not apply (e.g., if a Member says they are completely independent in daily activities, we will not ask if they get help when they need it). In addition to the Adult Complex Case Management Assessment, there is a Perinatal Complex Case Management Assessment for pregnant Members. Pediatric cases will be assessed using a Pediatric Complex Case Management Assessment (through an interview with the Member's parent or caregiver) along with an Age-Specific Questionnaire that will be updated each year to capture developmental and psychosocial changes. In cases where cognition, literacy, or other issues limit a Member's ability to accurately complete the assessment, the staff member will be prompted to seek other means of gathering the appropriate and necessary information to evaluate the Member's needs.
4. Members are informed of their right to file a grievance or appeal regarding CCM services.
    a. Please refer to Grievance & Appeals policy CGA024 Medi-Cal Member Grievance System for more information.
5. All efforts and methods to contact the Member to complete the assessment will be documented in the case management system. Partnership begins the initial assessment within 30 calendar days of identifying a Member for CCM *(Within NCQA Regulations, one Factor will be completed within 30 calendar days)* and completes the assessment within 60 calendar days of identifying the Member.
~~4.~~6. In certain events beyond Partnership's control, the CCM assessment may not be ~~completed~~ started within 30 days of enrollment in the CCM program. In these instances, the case status will be updated to show the reason for delay/incompletion of the assessment; these circumstances include the following:
    a. Member is hospitalized during the initial assessment period
    b. Member cannot be contacted or reached through telephone, letter, e-mail, or fax after at least three attempts over two or more weeks
    c. Natural disaster
    d. Member is deceased
    e. Member is no longer eligible for Partnership managed care services
~~5.~~7. Through the initial assessment process, Partnership CC Staff will collect, document and review the information below. The information collected during the assessment process will be analyzed by the Partnership CC Staff to develop the Individualized Care Plan (ICP) for the Member. A summary statement of this analysis is captured at either the end of each question or at the end of the Complex Case Management assessment. For any area of the assessment where the information below is considered inappropriate or not applicable to the Member, Partnership CC Staff will indicate an 'N/A' on the assessment next to that question followed by a clear reason or explanation why the assessment was marked N/A. If a Member is unable to recall information on the assessment or refuses to answer a particular question on the assessment, Partnership CC Staff will notate

applicable areas.

a. The referral source and condition that led to the Member's eligibility for CCM.
b. A comprehensive clinical history of medical conditions based on available medical records from the 30 days prior to referral to the CCM program, and retrieved from provider offices for diagnostic and treatment information, plan of care and medications. Other resources of treatment history may be obtained by Treatment Authorization Requests (TARs), Service Authorization Requests (SARs), and Medical/Pharmacy Claims.
c. Member's ability to function with or without assistance to perform activities of daily living (e.g., grooming, dressing, bathing, toileting, continence, eating, transferring, walking), caregiver availability and involvement, as well as Member's ability/motivation for self-management.
d. Age specific questions, including developmental milestones, school-related concerns, family interactions, etc.
e. History of alcohol or other substance use disorders along with any treatment(s) for these conditions, as well as the use of tobacco products and willingness to quit.
f. Evaluation of mental health status, memory/retention, and cognition. The Patient Health Questionnaire-2 (PHQ-2) is administered to assess for depression, and how often the Member feels lonely. Questions included in the assessment ask if the Member has trouble getting thoughts out, remembering things, or understanding directions, and Partnership CC staff are prompted to evaluate the Member's understanding and retention throughout the assessment process.
g. Potential social barriers to health that may include Member's education, economic stability, or access to safe housing, transportation, food, social support and the healthcare system.
h. Whether Member has family, caregivers, friends and/or care providers who may help make decisions about Member's health. Partnership CC Staff will explain and offer Advanced Care Directive and Physician's Orders for Life-Sustaining Treatment (POLST) forms to the Member if they do not currently have these forms completed and available for use. See Partnership policies MPQP1047 Advance Directives and MPQP1038 Physician Orders for Life-Sustaining Treatment for more details.
i. Evaluation of language preference, cultural or religious beliefs, health literacy, mental health, cognition, memory and understanding, as well as communication needs that include possible visual and hearing accommodations.
j. Information about available benefits and resources within Partnership and the community. This includes, but is not limited to, information regarding copays or pharmacy benefits, dental benefits, enhanced benefits, the authorization process, and community resources on mental health, wellness, nutrition, transportation, In Home Support Services (IHSS) and palliative care programs. The assessment will also evaluate the Member's awareness of their available benefits and determine whether the benefits and resources available to the Member are adequate to fulfill the treatment plan.
k. The Member's readiness to change existing behaviors to improve their health and which behavior(s)/health condition(s) are the Member's priorities. Included in this assessment is an evaluation of the caregiver's involvement in and decision-making about the care plan, and how adequate that support is for the Member's needs.
l. Provider(s)' treatment plan and objectives.

D. All Partnership CC activities are documented in an electronic case management system that automatically documents the ID of the staff member who completed the activity as well as the date and time completed. Screening and assessment questions and interventions are built on evidenced-based protocols such as the PHQ-2 for depression screening, the Alcohol Use Disorders Identification Test (AUDIT-C) for substance use, etc. Automated prompts direct staff to schedule further assessments and interventions to support the goals of the care plan. The staff user manual includes detailed instructions and workflows for how to perform and document case management activity by program.

E. Upon completion of the assessment, Partnership CC Staff and the Member/caregiver collaborate to develop the person-centered Individualized Care Plan (ICP), comprised of the following:

1. Identified and prioritized goals (high, medium, low) that address personal, clinical, and psychosocial needs identified during the assessment process. The prioritization of which goals are addressed during the CCM program will be a collaborative decision between Partnership CC staff and the Member/caregiver. Each prioritized goal will be specific, measurable, and have a targeted completion date.
2. Barriers to achieving each goal are identified by Partnership CC staff or the Member.
3. Identification of evidence-based interventions to overcome barriers and advance the plan of care. Reminders to follow up on the interventions can be scheduled for future dates through the case management system and are tracked through system reports.
4. Identification, referral and coordination for community resources beyond the benefits available through Partnership when/where applicable (e.g., Energy Assistance Programs, ~~In-Home Support Services,~~IHSS, Meals on Wheels, health education classes, wellness programs, local food banks, parenting/caregiving support programs, etc.).
5. A schedule for when follow-up calls will occur.
   a. Partnership CC staff will attempt to contact Members enrolled in CCM at a minimum of every 30 days. Follow-up calls may be scheduled after:
      1) planned ~~physician~~ clinician visits
      2) transitions across care settings
      3) therapy visits
      4) other scheduled activities
      5) as agreed for follow-up and support
   b. Partnership CC staff will also follow up on referrals to community resources, wellness programs, and other means by which Members may demonstrate increasing self-management and engagement in their care.
6. As the Member's care plan is developed, Partnership CC Staff will educate/reinforce self-management activities that the Member can adopt. The Member/caregiver will select up to three behaviors to target as their self-management plan, to be incorporated into the ICP.
7. Partnership CC Staff sends a confirmation letter to the Member advising of their enrollment into CCM, providing contact information for the CCM team, and giving the Member the option to withdraw from the program at any time. Partnership CC Staff also sends a letter and a copy of the ICP to the Member (if desired) and to the Member's PCP and/or specialist(s) to advise them of their enrollment into CCM and to promote communication between the interdisciplinary care team. Partnership shall share the ICP with the Member and care team as appropriate and consistent with HIPAA.
8. A timeline for meeting the overall goals of the ICP. The ICP will be reviewed at scheduled intervals to assess overall progress toward the goals of the care plan. The initial re-evaluation will take place 60 days after enrollment. The case may be closed at this point or remain open for on-going case management for as long as the Member remains with Partnership and has an appropriate medical need.
9. A strategy to ensure communication of care needs across transitions of care, (e.g., hospitalizations, transitioning to a new provider(s), or transitioning from pediatric providers to adult providers).

10. Discussion of health plan benefits, Member's eligibility for these benefits, and any concerns the Member may have with limitations to the benefits.

F. Ongoing Case Management
1. Partnership CC Staff collaborate with the Member and/or the Member's caregiver to help the Member reach the goals outlined in the ICP through the use of Member engagement, motivational interviewing techniques, continual review of the ICP goals, barriers, and overall progress of the case.
2. As the case progresses, goals and barriers and the Member's self-management plan will be reviewed and updated. New goals and behaviors may be identified through the collaboration between the Member/caregiver and Partnership staff. Should a Member be admitted to a facility and have a length of stay longer than 30 days, the Member will be re-assessed after discharge and upon resumption of case management activities.
3. Over the course of the ICP, the Member/caregiver has the opportunity to participate in discussions or decisions about any treatments or services offered. The Member/caregiver may request the involvement of additional family/friends or professionals of their choosing in the case management process. Partnership CC Staff will coordinate family/provider conferences when requested by the Member/caregiver or when the case will benefit from a collaborative multi-disciplinary discussion.
4. Partnership Clinical Supervisors perform case ~~-~~reviews on the caseloads of their assigned Partnership CC Staff. Cases are reviewed to ensure adherence to CCM policy, that the Member's ICP is followed, and that barriers to care are addressed in a timely manner. If there are concerns about the trajectory or needs of a specific case, the Clinical Supervisor may escalate the concern to CC Leadership and/or to a Partnership Medical Director.
5. Partnership CC staff maintain frequent communication with the Member/caregiver, PCP, and other members of the Member's care team and support system throughout the duration of the CCM program.
6. In instances where the Member has multiple care coordination services, Partnership will collaborate with other care providers to ensure there is no duplication in services.

G. Case Closure

Partnership CCM services are voluntary and based on active participation from the Member. Members who do not demonstrate active participation, are uncooperative, whose behavior or environment poses a safety risk that cannot be reasonably addressed~~is unsafe for staff~~, or those who would be better managed in another care program, will be reviewed for disenrollment from CCM services. Partnership Staff may recommend the Member be transitioned to another case management program or that the Member be disenrolled from Partnership's case management. ~~-~~Examples of when Partnership may discontinue CCM services include:

1. ~~The Member elects to participate in CCM services, but after 45 days of enrollment the Member is non-responsive to Partnership's outreach attempts.~~The Member elects to participate in CCM services; however, prior to case maturity or within 60 calendar days, the Member is non-responsive to ~~-~~Partnership's outreach attempts.
2. Agreement by Partnership CC Staff and Partnership Clinical Leadership that the Member is uncooperative as evidenced by not demonstrating consistent adherence to the ICP.
3. Goals and self-management behaviors identified on the ICP have been reached per agreement between Partnership CC Staff and the Member, and the Member has demonstrated readiness to be transitioned from CCM services.
4. Member has been established with their Medical Home as evidenced by one or more visits with Primary Care/Medical Home with additional visit(s) scheduled, and Member/caregiver agrees that their care needs are met in that environment.
5. The Member has been enrolled in Partnership's Enhanced Care Management (ECM) benefit.
6. Members found to have either Severe Mental Illness (SMI) or a Substance Use Disorder (SUD) upon initial assessment will be referred to alternative case management programs according to their

county of residence, and CCM interventions will focus on coordination of care between Partnership-contracted providers and the Member's other service providers.

7. Members who have been closed to case management may be considered for re-enrollment if there is a change in their condition or desire to engage in CCM.

H. CCM Services Outcome Measurement

1. Outcomes associated with Partnership's CCM services are reviewed and analyzed no less than annually by Partnership. Tools utilized to analyze CCM program outcomes include:
   a. Aggregate outcomes for member satisfaction surveys received by Partnership
   b. A series of measures that evaluate member utilization data as specified below, and how that data has trended with the intervention of CCM:
      1) Number of ED Visits
      2) Number of Hospital Stays
      3) Total Number of Hospital Days
      4) Number of Outpatient Visits
2. The data will compare three (3) data collection points: the six (6) months prior to CCM program enrollment, six (6) months from the start of CCM services and, when available, the six (6) months after the case has been closed to CCM.
3. Partnership CC Staff will obtain reports from Grievance and Appeals department on M~~m~~ember concerns regarding the services they received in the CCM program. Information is to be collected and analyzed in order to help Partnership identify opportunities to better identify candidates for the CCM program, to improve CCM services, and to make timely adjustments to CCM services to better meet the needs of our Members, providers and communities.

VII. REFERENCES:

A. National Committee for Quality Assurance (NCQA) Health Plan Standards 2026~~5~~. Population Health Management 5 Complex Case Management

~~A.~~B. 2026 HP Accreditation PHM Standards

~~B.~~C. Partnership Complex Case Management Assessment

~~C. The Playbook (2024). Institute for Healthcare Improvement. Retrieved from https://www.bettercareplaybook.org/~~

D. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-032 Enhanced Care Management Requirements (12/22/2023 *supersedes* APL 21-012)

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)
09/10/25; 09/09/26~~N/A~~

Medi-Cal
05/21/14; 01/20/16; 04/19/17; *02/14/18; 04/10/19; 11/13/19; 04/08/20; 06/10/20; 06/09/21; 03/09/22; 03/08/23; 02/14/24; 09/11/24; 09/10/25; 09/09/26

*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.

Policy/Procedure Number: MPCP2007 (previously MCCP2007, MPCP2007)			**Lead Department: Health Services** Business Unit: Care Coordination
Policy/Procedure Title: Complex Case Management			☒ **External Policy** ☐ **Internal Policy**
Original Date: 06/20/2012			**Next Review Date: 09/09/2027~~10/2026~~** **Last Review Date: 09/09/2026~~10/2025~~**
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

PREVIOUSLY APPLIED TO:
Partnership Advantage:
PACP2007, MPCP2007 - 04/16/2008 to 01/01/2013

****

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

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

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

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

~~QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM (QIHETP)~~ Health Equity and Community Reinvestment Strategy and PROGRAM DESCRIPTION

MCED6001

September 2026~~5~~

Origination Date: 11/08/2023 Effective Date: 03/03/2024
Physician Advisory Committee (PAC) Approved: 11/12/24; 09/10/25; 09/09/26

TABLE OF CONTENTS

Program Purpose and Goals 1
Program Objectives 2
Authority and Responsibility 3
Program Staff 3
Committees 5
Quality and Performance Improvement Collaboration 9
NCQA Accreditation Program Management 10
Data Sources 11
Culturally & Linguistically Appropriate Services (CLAS) 18
Quality Improvement and Health Equity Annual Work Plan 19
Annual Program Evaluation 20
Non-Discrimination Statement 22
References 24

PROGRAM PURPOSE AND GOALS

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

The mission of Partnership HealthPlan of California is "To help our Members, and the Communities we serve, be healthy." Our vision is to be "the most highly regarded health plan in California." Partnership believes in fostering strong partnerships with members, providers, and community leaders to collectively improve health outcomes; focusing on continuous quality improvement in every aspect of the organization and in collaboration with our partners; and promoting diversity by accepting, respecting, and valuing individual differences and capitalizing on the diverse backgrounds and experiences of our members, community partners, and staff.

Partnership's defining focus is ensuring the highest quality of care, positive health outcomes, and timely access to care for all diverse members (i.e., Quality, Access, and Equity). Therefore, Partnership has developed program descriptions and policies to describe the structures needed to promote health equity. Specifically, Partnership has implemented the Partnership Quality Improvement and Health Equity Transformation Program (QIHETP~~) .~~).

The QIHETP is designed to develop, implement, monitor, and maintain a health equity transformation system to address improvements in the quality of care delivered by all of its providers in any setting, and take appropriate action to improve upon the health equity and health care delivered to members. The Partnership QIHETP serves to accomplish the following:

- Ensure that members receive the appropriate quality and quantity of healthcare services
- Ensure that healthcare service is delivered at the appropriate time and in an equitable manner

The Partnership QIHETP provides a reliable and credible mechanism to review, monitor, evaluate, recommend, and implement actions that acknowledge health equity.

The Partnership QIHETP serves as an organized framework to:

- Review and develop equity-focused interventions intended to address disparities in the utilization and outcomes of physical and behavioral health care services by engaging with a member and family-centric approach
- Review activities and identify opportunities to improve health equity throughout Partnership with oversight and participation of the governing Board of Commissioners and the Quality Improvement and Health Equity Committee (QIHEC)
- Promote participation from a broad range of network providers, including but not limited to hospitals, clinics, county partners, physicians, community health workers, and other non-clinical providers for QIHETP development and performance reviews
- Review health equity-related training activities and validate that the trainings review the impact of structural and institutional racism and health inequities on members, staff, network providers, subcontractors, and downstream subcontractors per Department of Health Care Services (DHCS) published All Plan Letters (APLs) regarding diversity, equity and inclusion (DEI) training.

PROGRAM OBJECTIVES

The Partnership QIHETP serves to ensure that appropriate, high quality cost-effective utilization of health care resources is available to all members while being cognizant of health care disparities and inequities. This is accomplished through the systematic and consistent application of management processes based on current health equity review literature and expert opinion when needed. The scope of the QIHETP includes the quality of clinical care and services for all members receiving Medi-Cal healthcare services from Partnership. The monitoring and evaluation of clinical issues reflects the population served by Partnership without regard to social drivers of health (SDOH), age group, disease category, or risk status. In alignment with other Partnership departments, the QIHETP encompasses all aspects of medical and behavioral healthcare including:

- Identifying and addressing racial/ethnic and other disparities in health care delivery or outcomes
- Identifying overuse, misuse, and underuse of health care services and prescription medications
- Evaluating clinical quality of physical health care
- Evaluating clinical quality of behavioral health care focusing on prevention, recovery, resiliency, and rehabilitation
- Identifying and addressing equitable access or quality issues related to behavioral health services through delegated contracts
- Ensuring access to primary and specialty health care providers and services
- Ensuring availability and regular engagement with primary care providers (PCPs)
- Evaluating continuity and care coordination across settings and at all levels of care, including transitions in care, with the goal of establishing consistent provider-patient relationships
- Evaluating member experience with respect to clinical quality, access, and availability and culturally and linguistically competent health care and services, and continuity and care coordination
- Promoting cultural and linguistic competence of Partnership staff and network practice sites and providers

The QIHETP program accomplishes these goals by:

- Systematically monitoring and evaluating services and care provided by conducting quantitative and qualitative data collection. Using this data and various statistical analyses, Partnership will make data-driven decisions
- Identifying, evaluating, and reducing health disparities utilizing internal reports, reflecting utilization management, quality improvement, member satisfaction (Consumer Assessment of Healthcare Providers and Systems [CAHPS®]), care coordination, grievance and appeals, and population health activities to ensure services are provided equitably.
- Actively conducting systematic searches for tertiary and primary medical literature to ensure decisions are based upon up-to-date evidence in the health equity discipline
- Actively pursuing opportunities for improvement in areas that are relevant and important to Partnership members' health
- Implementing strong and sustainable interventions when opportunities for improvement are identified for addressing a health disparity

AUTHORITY AND RESPONSIBILITY

Board of Commissioners
The Board of Commissioners on Medical Care (the Commission) promotes, supports, and has ultimate accountability, authority, and responsibility for a comprehensive and integrated Quality Improvement and Performance Improvement (QI/PI) programs. The Commission is ultimately accountable for the quality of care and services provided to members. The Commission has delegated direct supervision, coordination, and oversight of the QI/PI program to the Physician Advisory Committee (PAC), which serves as the main Quality Improvement committee. PAC is supported by two other quality committees – the Quality and Utilization Advisory Committee (Q/UAC) and the Internal Quality Improvement Committee (IQI), which are described in more detail below. The county Boards of Supervisors for each geographic area appoints members of the Commission, which include representation from the community: consumers, businesses, physicians, providers, hospitals, community clinics, HMOs, local government, and County Health departments. The Commission meets six times per year.

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

Key Roles
The following leadership roles carry authority and responsibility to ensure the QIHETP Program is fully implemented and maintained. The qualifications of staff presently fulfilling these roles are detailed in Appendix D (included with QI Trilogy submission) which includes documented evidence corresponding to that collected annually on behalf of DHCS. Given the personal details included, this appendix is not posted publicly.

PROGRAM STAFF

Chief Medical Officer
The Chief Medical Officer (CMO), with the assistance of the members of PAC, Q/UAC, and IQI, as well as the other medical directors of Partnership, is responsible for providing professional judgment regarding matters of quality of care, peer review, clinical, and medical procedures. The CMO is the chair of IQI and Q/UAC and has significant involvement in all QI/PI, Pharmacy, and Health Services activities as well as providing oversight to these programs on a day-to-day basis. The CMO is a Medical Doctor (MD) or Doctor of Osteopathy (DO) with an unrestricted license in the State of California.

Deputy Chief Medical Officer
Assists the Chief Medical Officer (CMO) in oversight of the appropriateness and quality of care. Serves as the interim CMO when the CMO is absent, unavailable or as requested, which includes representing the CMO in state policy and regulatory activities. The Deputy CMO is a Medical Doctor (MD) or Doctor of Osteopathy (DO) with an unrestricted license in the State of California.

Chief Health Services Officer
The Chief Health Services Officer (CHSO) works closely with leaders in Utilization Management to provide accountability for delegates to meet necessary National committee for Quality Assurance (NCQA) accreditation requirements and provide strategic leadership and guidance in the review and

revision of provider contracts to ensure QI reporting requirements and value-based program contingencies are met. The CHSO also has purview over the Care Coordination, Utilization Management, Enhanced Health Services, Behavioral Health and Health Equity departments and ensures that these departments incorporate and prioritize quality improvement work and processes in coordination with standing work. The CHSO's level of involvement fulfills the need for executive

support and accountability for improvements with data quality, and coordination of activities between QI and these departments. Collaborates with the Chief Medical Officer and members of PAC, Q/UAC, and IQI in matters involving quality of care, clinical, and medical procedures.

Director of Health Equity (Health Equity Officer)
The Director of Health Equity serves as the Health Equity Officer (HEO) for Partnership. In collaboration with Partnership leaders, the Director of Health Equity leads the development and implementation of strategies that advance health equity across our network diversity, equity, and inclusion across the organization. This role drives systemic change to enhance representation and cultivates programs that foster a culture of belonging. This role provides oversight, strategic direction, and support for improving quality measure performance and member experience in specified cultural, linguistic, economic, educational, etc. groups in our community and workforce. In collaboration with the CMO, oversees the Quality Improvement and Health Equity Transformation Program (QIHETP) program operations and assists in the development and coordination of QIHETP policies and procedures. This role also leads the development and management of the diversity, equity, and inclusion and gender-affirming care training programs.

Medical Director for Quality
Assists CMO by providing physician support for varying activities within the QI/PI department, including Performance Improvement, Member Safety, Peer Review, and the Quality Incentive Programs, as well as assists with utilization management review activities. This role also serves as management oversight for the Member Safety teams within the QI/PI department.

Senior Director of Quality and Performance Improvement
This role works collaboratively with the CMO to define strategy, develop programs and services, and to evaluate the effectiveness of the QI/PI Program. Together with the QI management team, including the Medical Director for Quality, provides oversight of Facility Site Reviews, investigation of potential quality issues, compliance with NCQA standards, Healthcare Effectiveness and Data Information Set (HEDIS®) and other performance measure data collection and performance reporting, value-based payment programs (QIPs), performance improvement initiatives and programs, external and internal QI training, provider education on the QIPs and HEDIS®, grant application and grant management. This role works to foster greater cross collaboration of QI staff and strategic involvement of other departments to support the execution of tactics defined and maintained under Partnership's 5-Star Quality Strategy.

Director of Population Health Management
The Director of Population Health Management works collaboratively with leaders across the organization, to execute the organization's Population Health Management strategy. This role provides oversight, strategic direction, and support for related initiatives, including those essential to improving quality measure performance and member experience. This role offers guidance and ensures alignment with health care policies, financing, accreditation requirements, and regulations to drive optimal health outcomes for members.

Behavioral Health Clinical Director
The Behavioral Health Clinical Director holds an MD/DO, PhD or PsyD credential. With the assistance of the Behavioral Health team, this individual is responsible for providing professional judgment regarding matters of quality of care, peer review, and clinical policies and procedures through oversight

of Partnership activities in the areas of mental health and substance use disorder services as provided by Partnership's delegated behavioral health providers.

Administrative Assistant
Under the direction of the Health Equity Officer (HEO) or other designated leadership, provides administrative support to the Health Equity Officer Director and/or other QIHETP Leadership. Responsible for maintaining and updating online policy and procedure manuals and managing appointment calendars. Coordinates setup and executes minutes for designated meetings.

- Tracks project deliverables and resources using appropriate internal tools to ensure deadlines are met
- Coordinates the QIHEC meetings

Project Coordinator II

Oversees timelines and deliverables for department projects. Provides routine and ad hoc reporting for key Population Health activities and initiatives. Works closely with designated department staff and leadership to gather, compile, and distribute reports, and facilitates structured file and record management. Supports ongoing audit readiness activities by maintaining structures around audit deliverables, meeting minutes, and the file retrieval system.
Uploads and maintains policy documents in PowerDMS

COMMITTEES

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

Quality/Utilization Advisory Committee (Q/UAC)
The Q/UAC is responsible to assure that quality, comprehensive health care and services are provided to Partnership members through an ongoing systematic evaluation and monitoring process that facilitates continuous quality improvement. Q/UAC voting membership includes consumer representative(s) and external providers who are contracted primary care providers (PCPs) and board certified specialists in the areas of internal medicine, family medicine, pediatrics, OB/GYN, neonatology, behavioral health, and representatives from other high volume specialties. The Partnership Chief Medical Officer (CMO) (chair of the committee), Clinical Director of Behavioral Health, Health Equity Officer, Medical Director for Quality, Associate and Regional Medical Directors and leadership from the Quality and Performance Improvement, Provider Relations, Utilization Management, Care Coordination, Population

Health, Health Equity, Pharmacy, and Grievance departments attend the Q/UAC meetings regularly. Other Partnership staff attend on an ad hoc basis to provide expertise on specific agenda items. The

committee meets monthly at least ten (10) times per year, with the option to add additional meetings if needed. Q/UAC activities and recommendations are reported to the PAC and at least quarterly to the Commission. The Q/UAC provides guidance and direction to the QIHEC by functioning as the expert reviewing panel as follows:

- Annually r~~R~~eviewing, making recommendations to, and approving this~~e *QIHETP*~~ Program Description ~~annually~~
- Analyzing summary data and making recommendations for action
- Reviewing action plans for quality improvements of QIHETP activities and providing ongoing monitoring and evaluation

Quality Improvement and Health Equity Committee (QIHEC)

Partnership's QIHEC is overseen by the Quality/Utilization Advisory Committee (Q/UAC) and the Physicians Advisory Committee (PAC), which subsequently reports to our governing Board of Commissioners. The QIHEC analyzes and evaluates the results of Health Equity-related Quality Improvement activities. Specifically, QIHEC will conduct an annual review of the results of key health equity-related data to provide plan-wide recommendations (e.g.,, generate policy recommendations) to address health-equity performance deficiencies. The QIHEC ensures appropriate assessment of interventions, measurement, and follow-up of identified performance deficiencies. The QIHEC responsibilities include the following:

- Analyze and evaluate the results of clinical quality performance measures related to Health Plan Ratings (HPR), as specified by NCQA Health Equity Accreditation (HEA) standards, as mandated by DHCS, or due to poor performance trending on the DHCS Managed Care Accountability Set (MCAS) (with stratification by race/ethnicity and language):
  - Assigned Health Effectiveness Data & Information Set (HEDIS®) Measures
  - Consumer Assessment of Healthcare Providers and Systems [CAHPS®]
- Analyze utilization data (types of services, denials, deferrals, modifications) with stratification by race/ethnicity and language
- Analyze utilization data of language services and experience with language services with stratification by language.
- Analyze and evaluate the results of member satisfaction surveys, Grievance and Appeal surveys, and care coordination-based surveys with stratification by race/ethnicity and language
- Analyze and evaluate the strategy and work plans presented by internal committees to ensure that clinical quality performance measures (with stratification by race/ethnicity and language) and member satisfaction are evaluated and attended to in prospective work plans
- Analyze and evaluate feedback from member representative committees (e.g., Community Advisory Committee, Family Advisory Committee)
- Recommend Managed Care Plan (MCP)-related interventions (e.g., education, programs, etc.) for various departments to address key clinical quality performance deficiencies (e.g., HEDIS, CAHPS, etc.) per the scope of work of managed care plans.

Partnership's QIHEC membership will consist of the following key members, who subsequently will report directly to Q/UAC:

- Chief Medical Officer or CMO Designee (e.g., Medical Director)
- Health Equity Officer
- Chief Operating Officer
- Internal Leadership from following departments: Health Analytics, QI/PI, Provider Relations, Utilization Management, Member Services, Care Coordination, and Population Health

In addition, the Partnership's QIHEC membership will be composed of representatives from our Providers, health plan subcontractors, and health plan downstream subcontractors, who provide health care services to members affected by health disparities, members who are considered to have Limited English Proficiency (LEP), members with children with special health care needs (CSHCN), members who are considered to be Seniors and Persons with Disabilities (SPDs), and persons with chronic conditions. Example entities from which representatives will be drawn include, but are not limited to, hospitals, clinics, county partners, physicians, subcontractors, downstream subcontractors, network

providers, and Partnership members. The QIHEC meeting minutes, findings and recommendations will be reported directly to the Quality/Utilization Advisory Committee (Q/UAC), Physician Advisory Committee (PAC), and Partnership's Board of Commissioners. Also the QIHEC will report findings to our various other internal committees (e.g., CAC, FAC, etc). Partnership's Conflict of Interest Policy for QI Activities (MPQP1008) and Confidentiality Policy (CMP-10) provides guidance to ensure avoidance of conflict of interest among committee members and ensure that member confidentiality is maintained throughout QIHEC-related meetings.

~~**Population Health Needs Assessment (PNA) Committee**~~

~~The Population Health Needs Assessment Committee (PNA) is an internal committee and serves as a multi-departmental body whose goal is to support the advancement, growth, and execution of population health and health equity interventions at Partnership. The committee consists of Partnership staff representing member, community, regional, and provider-facing departments; it also incorporates representatives from Human Resources, Regulatory Affairs, IT, and Health Analytics. The committee meets every other month to align interdepartmental efforts promoting health equity through member and systemic interventions outlined in the relevant Needs Assessment (PNA) Action Plans. The PNA Committee activities and recommendations will be shared with the, Internal Quality Committee (IQI), Quality/Utilization Advisory Committee (Q/UAC), QIHEC, Physician Advisory Committee (PAC) and Partnership's Board of Commissioners..~~

Family Advisory Committee (FAC)

The Family Advisory Committee (FAC) is a member advisory group to the CEO and staff of Partnership. The FAC provides a forum for parents, guardians and caregivers of children with California Children Services (CCS) conditions to discuss common issues of interest and importance, to create a supportive and informative networking environment and to advocate for members by ensuring that Partnership is responsive to the diversity of health care needs for all members. Minutes from FAC meetings are reviewed by the Pediatric Quality Committee (PQC). The FAC membership is comprised of representatives from throughout Partnership's geographic service areas who advocate for CCS-eligible children of diverse cultures, ethnicities, genders, ages and disabilities. Meetings are held at least four (4) times per year with the option for additional meetings as needed

Community Advisory Committee (CAC)

The Community Advisory Committee (CAC) is composed of Partnership health care consumers who represent the diversity and geographic areas of Partnership's membership including hard-to-reach populations. The CAC is a liaison group between members and Partnership, advocating for members by ensuring that the health plan is responsive to the health care and information needs of all members. The CAC meets quarterly, reviews and makes recommendations regarding Member Services' quality improvement activities, provides feedback on quality and health equity initiatives, and serves in the capacity of a focus group. A CAC member(s) serve(s) on the Partnership Board to provide member input and report back to the CAC.

QUALITY AND PERFORMANCE IMPROVEMENT COLLABORATION

The Health Equity department works collaboratively with the Quality and Performance Improvement (QI/PI) department to enhance the care provided to our members through venues such as the Internal Quality Improvement Committee (IQI), the Quality/ Utilization Advisory Committee (Q/UAC) and daily QIHETP activities.

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

- Reviewing, making recommendations to, and approving the *QIHETP Program Description* annually
- Analyzing summary data and making recommendations for action
- Reviewing the recommendations of QI's Performance Improvement Teams to develop QIHETP improvement action plans specific to clinical quality measure performance with on-going monitoring and evaluation. The QI/PI department is often the lead for many improvement efforts, particularly those that are mandated or due to poor performance on the Managed Care Accountability Set (MCAS), which is the set of measures that DHCS selects for annual reporting by Medi-Cal managed care health plans. This can include mandated improvement efforts to meet disparity reduction targets for specific populations and/or measures as identified by DHCS. The QI/PI department also takes the lead on mandated Performance Improvement Projects (PIPs) that are assigned by DHCS. PIPs are led by the QI/PI program based on criteria defined by DHCS and overseen by the California External Quality Review Organization (EQRO), and include at least annual status reports to DHCS
    - Recommending improvements to enhance health equity language in Partnership policies and protocol according to QIHETP standards

For improvement efforts focused on reducing health disparities, the QIHEC ensures appropriate follow-ups on equity-focused interventions and related activities Partnership commits itself to in addressing quality measure performance deficiencies. Additionally, the Health Equity department supports ongoing quality improvement efforts in the identification of potential quality or equity of care issues, improvement of HEDIS quality measures in context with social drivers of health. For member-facing improvement efforts, CAC and other member focus groups are often consulted.

NCQA Accreditation Program Management

Partnership strives to improve the health status of members and their care experience to become one of the highest quality health plans in California. NCQA Health Plan Accreditation supports Partnership's vision, mission, and strategic goals by providing a rigorous and comprehensive framework for essential quality improvement, operational excellence, and measurement of clinical performance (HEDIS) and member experience (CAHPS).

Per the 2024 DHCS contract, all managed care plans (MCPs), including Partnership, are mandated to achieve both NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation (HEA) by Jan. 1, 2026. Partnership successfully achieved HPA reaccreditation on Dec. 18, 2023.~~.~~ In order to maintain NCQA Health Plan Accreditation, Partnership was required to report annual results starting in June 2022.

As of May of 2025, Partnership Health plan of California has acquired Health Equity Accreditation status (Now Known as Health Outcomes Accreditation) and the next review date is of 05/16/2028. During the 2025 NCQA HEA audit, no actions or improvements were recommended. Also, there were no corrective action plans. NCQA made changes to its Health Equity Accreditation program naming. Effective January 15, 2026, Health Equity Accreditation was to be renamed Health Outcomes Accreditation and Health Equity Accreditation Plus was to be renamed Community-Focused Care Accreditation.

- Source: https://reportcards.ncqa.org/health-plan/Hp_2_1_001G000001uwsI9IAI_3219

~~Partnership earned a Health Plan Rating (HPR) of 3.5 stars in June 2023 based on HEDIS/CAHPS performance from MY 2022/RY 2023. NCQA released Partnership's current HPR of 3.5 stars in September 2024.~~

~~Partnership's defining focus is ensuring the highest quality of care, positive health outcomes, and timely access to care for all diverse members (i.e., Quality, Access, and Equity). NCQA Health Equity Accreditation (HEA) complements Partnership's overall mission by encouraging managed care organizations to establish a foundation of health equity work. Specifically, the HEA encourages the focus on building an internal culture that complements external health equity work with our population health management department; collecting relevant data that provides insight on how to ensure appropriate representation in language services and providers; identifying and categorizing inequities to guide future population health-based interventions~~

~~Partnership will be submitting first survey documentation, to obtain the NCQA Health Equity Accreditation (HEA), by June 2025.~~

DATA SOURCES

DHCS Bold Goals

To have a context of Health Equity and align internal quality and health equity efforts with DHCS, Partnership will review the DHCS's Health Disparities Report and Bold Goals of 2025. Currently, The Bold Goals of 2025 are as follows:

- Close racial/ethnic disparities in well child visits by 50%
- Close racial/ethnic disparities in immunizations by 50%
- Close maternity care disparity for Black and Native American persons by 50%
- Improve maternal and adolescent depression screening by 50%
- Improve follow up for mental health and substance use disorder by 50%

Partnership Health Plan Quality Improvement Priorities

To have a context of Health Equity and align internal quality and health equity efforts with Partnership, Currently, the measures priorities are as follows:

- CAHPS (Consumer Assessment of Healthcare Providers and Systems) Scores
- Child-Adolescent Well-Care Visits (WCV)
- Controlling High Blood Pressure (CBP)
- Glycemic Status Assessment for People with Diabetes (GSD)
- Adolescent Immunizations (IMA-2)
- Timely Prenatal Care (PPC-Pre)

Partnership uses several methods to identify and prioritize the health disparities of focus ~~evaluate member needs, and strategize how to address such needs by reducing health disparities.~~

- Calculate numeric size of disparity when compared to minimum performance level (e.g % of CBP of Asian vs % MPL)
- Calculate numeric size of disparity of pay for performance submitted data when compared to white population (e.g % of CBP of Asian vs % white)

MCAS Sample Evaluation

Step 1: Sample Selection to Evaluate Disparities

Partnership initially utilized Measurement Year 2023 (MY 2023) MCAS final sample measures (n=186 to 167,450 members) to evaluate each of the clinical measures of focus. The rates for each measure are comprised of the members included in each measure's audit for Partnership's Health Plan Accreditation Plan-wide summary of performance report. The random member sample that was generated for each hybrid measure and full member denominator along with member race/ethnicity demographic information, was provided by Partnership's HEDIS vendor, Inovalon. Inovalon has been classified as a direct data source.

Step 2: Statistical Analysis to Identify Key Disparities

After receiving the data from Inovalon, members from Partnership's Health Analytics team conducted various statistical analyses. The Chi-Square and Fisher's Exact statistical tests were utilized, based upon sample size, to determine if there were significant differences for the various categorical measure outcomes.

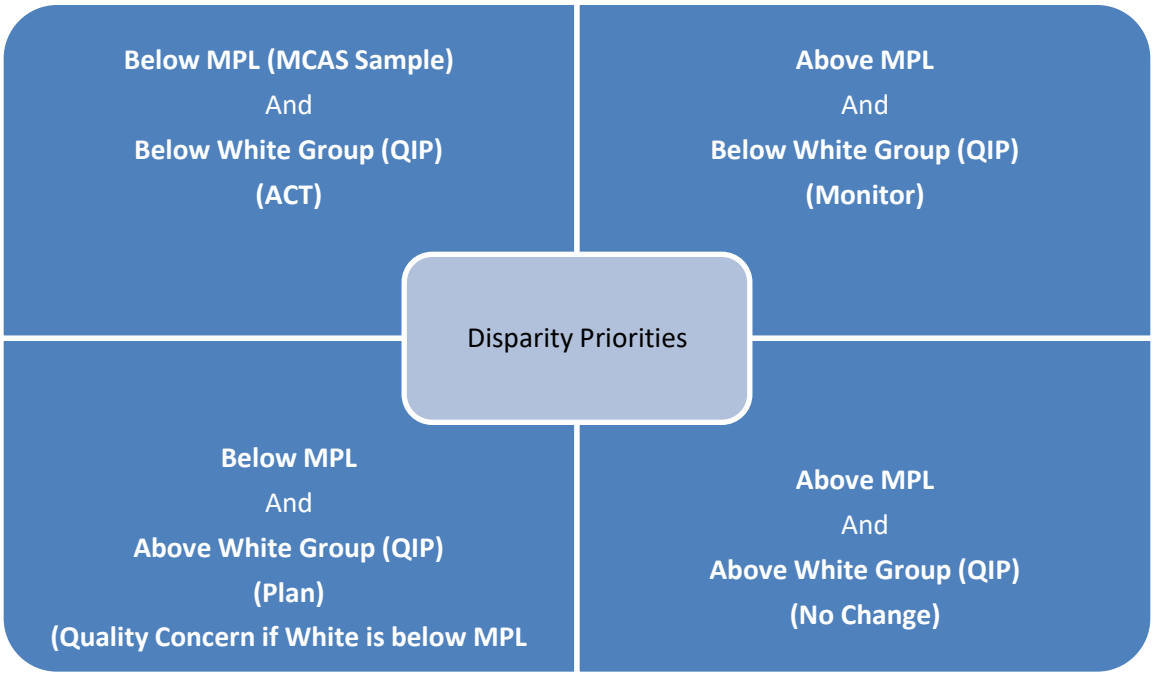
When analyzing disparities based upon race/ethnicity, Partnership conducted various statistical analyses using the White group as the key comparator group. When analyzing disparities based upon language, Partnership conducted various statistical analyses using the English language group as the key comparator group. Finally, when analyzing disparities based upon gender, Partnership conducted various statistical analyses using the Male gender identity group as the key comparator group. A statistically significant difference was classified as a p value less than 0.05 when comparing the categorical outcomes of one group versus the key comparator group, respectively (i.e., White, English-speaking, Male). These comparators were identified based upon various literature suggesting that such groups, respectively, have had significantly more political, economic, and/or social advantages within the United States (Malat et al., 2018). Data, that were excluded from the evaluation, were findings from patients who reported "Unknown" in race, language, and gender identity.

Step 3: Analysis of Measures

Partnership also reviewed the performance of each race/gender identity/linguistic group in comparison to the MCAS benchmarks to assess not only how each group performed statistically in comparison to the White/Male/English speaking group, but also in comparison to the national Medicaid benchmarks. In MY 2023, DHCS is holding managed care plans (MCPs) accountable and imposing sanctions on selected Hybrid and Administrative measures performing below the minimum performance level (MPL) (50th national Medicaid percentile) by reporting region, and as a result, Partnership thought it valuable to assess how each group is performing in comparison to that benchmark to assess whether group performance could also have an impact on accountable measures.

Step 4: Prioritization of Disparities

The HEO, CMO, and members of the QI/PI team reviewed the information supplied about health disparities and draft a preliminary report of disparity metrics to prioritize based upon clinical measure stratification, statistical or clinical findings, size of the disparity, strength of evidence, feasibility, and return of investment. An established baseline will be developed for each group to follow for the next 3 to 5 years to evaluate long-term impact. The team will identify the key disparity priorities per region and per population of key racial/ethnic, gender, or linguistic groups.



Step 5: Distribution of Disparity Data for Community Feedback

The preliminary report will be shared with relevant internal committees (e.g., CAC, FAC etc), corresponding providers, health plan subcontractors, and health plan downstream subcontractors, via their corresponding QIHEC representative or newsletter. The goal will be to solicit feedback to ensure we have identified disparities that may not have been captured during our internal data analysis and identify strategies to address the disparities in respective communities. The Health Equity department will review internally submitted community needs assessment information to increase the likelihood of receiving credible information from community leaders and CAC/FAC/QIHEC members. Also, the Health Equity department will review feedback from members, parents, and/or caregivers to ensure that the community is given an opportunity to engage in the development of quality improvement and health equity activities and suggest interventions that will likely work in their respective communities. The advisory feedback will be transcribed and shared with the Health Equity department.

The Health Equity department will review the solicited findings from QIHEC, CAC, FAC, providers, health plan subcontractors, and health plan downstream subcontractors and share the results to the QIHEC for final approval of the key Partnership health equity priorities to share with the overall organization to serve as guidance for various departments and activities (e.g. PNA, QIP, etc.).

Step 6: Distribution of Disparity Data into Department Activities

Quality Improvement

~~For internal QI/PI related activities, the Health Equity department, in collaboration with the QI/PI team, will ensure that HEDIS/CAHPS- associated disparities (e.g. racial, ethnic, linguistic, disability, SOGI, etc.) are specifically being addressed in QI/PI programs (e.g., value-based payment programs, provider improvement plans, Corrective Action Plans (CAPS) etc.). Specifically, the QIHETP and QI/PI teams will review the internal value based payment programs (e.g., primary care provider quality improvement program (PCP QIP), hospital quality improvement program, (HQIP) etc.) and performance improvement projects to assess whether adjustments need to be made to ensure the projects can address HEDIS/~~

~~CAHPS –associated disparities. For improvement efforts focused on reducing health disparities, the QIHEC ensures appropriate follow-ups on equity-focused interventions and related activities Partnership commits itself to in addressing quality measure performance deficiencies. Additionally, the Health Equity department supports ongoing QI/PI efforts in the identification of potential quality or equity of care issues, improvement of HEDIS quality measures in context with social determinants of health. The QIHETP and QI/PI teams will collaborate to develop QIHETP improvement action plans specific to clinical quality measure performance with on-going monitoring and evaluation. Finally, the QIHETP and QI/PI teams will share data with NCQA team members to validate that disparity reduction goals/targets are compliant with NCQA HEA standards.~~

Department	Description of Activities	Annual QIHETP Key Administrative Measures
Quality Improvement	For internal QI/PI related activities, the Health Equity department, in collaboration with the QI/PI team, will ensure that HEDIS/CAHPS–associated disparities (e.g. racial, ethnic, linguistic, disability, SOGI, etc.) are specifically being addressed in QI/PI programs (e.g., value-based payment programs, provider improvement plans, Corrective Action Plans (CAPS) etc.). Specifically, the QIHETP and QI/PI teams will review the internal value based payment programs (e.g., primary care provider quality improvement program (PCP QIP), hospital quality improvement program, (HQIP) etc.) and performance improvement projects to assess whether adjustments need to be made to ensure the projects can address HEDIS/ CAHPS –associated disparities. For improvement efforts focused on reducing health disparities, the QIHEC ensures appropriate follow-ups on equity-focused interventions and related activities Partnership commits itself to in addressing quality measure performance deficiencies. Additionally, the Health Equity department supports ongoing QI/PI efforts in the identification of potential quality or equity of care issues, improvement of HEDIS quality measures in context with social determinants of health. The QIHETP and QI/PI teams will collaborate to develop QIHETP improvement action plans specific to clinical quality measure performance with on-going monitoring and evaluation. Finally, the QIHETP and QI/PI teams will share data with NCQA team members to validate that disparity reduction goals/targets are compliant with NCQA HEA standards. The QIHEC will review, among other reports, the	• MCAS measures of health disparities • Amount of QIP Health Equity funds awarded to Parent Organizations • Number of Quality Improvement Projects executed to address specific • Impact Analysis of each quality improvement project to address health disparities

	updated QI/PI Program Evaluation to ensure that one or more HEDIS/CAHPS-associated racial disparity, HEDIS/CAHPS-associated linguistic disparity, or a mandated disparity reduction target for specific populations and/or measures as identified by DHCS has been addressed in response to findings from Partnership's annual QI Work Plan.	
Population Health Management	For internal population-health specific activities, the ~~QIHETP~~Health equity department and Population Health teams will collaborate to generate a finalized report to help refine the various population health reports and analyses. (The PHM Strategy provides a high-level overview of Partnership's approach to improving the health and wellbeing of the population served in the program. Specifically, teams will review tertiary and primary medical literature and health indices, review findings from other managed care organizations, collaborate with community key opinion leaders or subject matter experts, and survey members of the CAC and FAC to find credible interventions that can be executed by a managed care organization based upon the synthesized findings of the preliminary report. The ~~QIHETP and~~ Population Health and Health Equity teams will review and assess corresponding social drivers of health metrics. t. Social determinants or drivers of health have been classified as conditions in various environments that affect health and overall quality-of-life outcomes The QIHEC will review, among other reports, relevant Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) information, Population Health and Cultural and Linguistics (C&L)-associated work plans to ensure that one or more HEDIS-associated racial/ethnic disparity(ies), and one or more HEDIS-associated disparity(ies) related to one additional category of stratification (e.g., disability, geographical representation, etc.) is addressed based on the findings from the assessed reports. The QIHEC will also review reports regarding the utilization of language services, individual experience with language services, staff experience with language services, and member experience with language services during health care encounters to ensure that one or more interventions is identified and incorporated into work plan(s) to address one or more culturally and linguistically appropriate services (CLAS) disparity or HEDIS-associated	• Assessment of Health Disparities from PNA • Analysis of each PHM Campaign to address health disparities • Analysis of community events or activities (e.g. photoshoot) to address health disparities

	linguistic disparity. The QIHEC will review these elements to ensure they correlate appropriately with Partnership's annual QI Work Plan.	
Enhanced Care Management	The Health equity department and Enhanced Care Management teams will collaborate to increase the number of Community Health Workers (CHWs) and Doulas in non-traditional community settings (e.g. Barbershops, Beauty Salons, etc). Also, HE department and EHS team will review the annual CHW/Doula training to validate that it meets all the criteria to be considered appropriate per any related APL set forth by DHCS.	• Number of Community Health Workers per County • Number of Doulas per county • Annual Analysis of claims data
Grievances and Appeals	In collaboration with the Grievances and Appeals team, the HE department will review and provide input on discrimination grievances. For grievance and appeals-related activities, the Health Equity department, in collaboration with leadership from the Population Health and Grievance and Appeals departments, will review for any patterns of disparities in reported grievances. The QIHEC will review, among other reports, the updated PNA, Cultural and Linguistics (C&L) Program Description and Work Plan, and/or Grievance and Appeals-associated Work Plans to ensure that one or more CAHPS-associated racial disparity(ies) or CAHPS-associated linguistic disparity(ies) is addressed with a Work Plan action item . The HE department will review all discrimination grievances and provide a written opinion regarding the likelihood of discrimination. For clinicians who are deemed "likely," they are referred to complete the CARES training. In accordance with APL 24-016, the Partnership CARES (formerly known as DEI) training provides staff with specific, structured instruction to address health inequities across DHCS programs. Training content is designed to increase awareness, sensitivity, and practical application of diversity, equity, inclusion and cultural responsiveness principles. Training is tailored to member demographics to ensure relevance and effectiveness.	• Analysis of discrimination grievances • Annual Analysis of completion of CARES training • Survey Analysis of CARES training
Human Resources	For internal Human Resources (HR) related activities, the Health Equity department, in collaboration with the	

	HR department, will review submitted data for annual CARES-related training for employees, network providers, etc. to ensure review of completion. Specifically, the QIHETP and HR team will review the annual training on culturally and linguistically appropriate practices to ensure they are teaching principles to reduce bias and promote inclusion. Also, HE department and HR team will review the annual training to validate that it meets all the criteria to be considered appropriate per any related APL set forth by DHCS. The HE department and HR team will also review internal recruiting and hiring processes to ensure they support diversity in staff leadership, committees, and governance bodies. Also, the Health Equity department will conduct an annual survey of the DEI satisfaction from staff, leadership,	
Subcontractors	~~*Miscellaneous Contributors*~~ For any subcontractors' and downstream subcontractors' QI and Health Equity activities, QIHEC will review report findings and actions on a quarterly basis during each QIHEC meeting. A summation of the results will be evaluated in the annual program evaluation.	

Community Reinvestment Management

The Health Equity department will work with the Finances, Population Health, Behavioral Health, Project Management Operations departments to ensure the health plan reinvests a minimum level of our net income into our local communities. Community reinvestment planning will start in calendar year 2025, with community reinvestment activities starting in 2026 and follow a 3 year cycle to align with other DHCS-related initiatives (Community Health Assessment, Behavioral Health Transformation, etc.)

Partnership's Health Equity Officer and Health Equity team, will lead the management of the community reinvestment planning process to ensure all community reinvestment plans align with overall health equity needs and priorities. Also, the health equity team will ensure that the health plan and qualifying subcontractors' activities are based upon engagement with the community and community-identified priorities, with investments in health quality improvement and equity outcomes.

Data

Every 3 years, Partnership will review the following to make a preliminary assessment of community reinvestment landscape in our counties:

- PNA
- CHA/CHIP for each corresponding county
- Behavioral Health Transformation assessment for each county
- Health Equity Grand Analysis per QIHETP workplan

Funding Requirements

Partnership and qualifying subcontractors will define the base Community Reinvestment as the minimum level of net income that, if with positive net income, is required to invest into initiatives that serve the communities in which the Partnership operates, starting with net income based on Calendar year (CY) 2024 Contract Revenues for Community Reinvestment activities initiated in CY 2026.

- Partnership, since in multiple counties, will calculate the Base Community Reinvestment funding obligations with the following allocation methodology:
  - 5% of Base Community Reinvestment Funds equally across counties in which Partnership operates + 95% of Base Community reinvestment Funds in Proportion to Medi-Cal membership by county
- Partnership will allocate the base community reinvestment funds = (5% of the Partnership's or Qualifying Subcontractors annual net income that is less than or equal to 7.5% of Medi-Cal Contract Revenues/Subcontractor agreement for the year**)** + (7.5% of the Partnership's or Qualifying Subcontractor's annual net income that is greater than 7.5% of Medi-Cal Contract Revenues/subcontractor agreement for the year)
- The approved net income from Partnership will invest into initiatives in counties that do not meet minimum quality measure performance thresholds for the applicable year
- Partnership receives an Enforcement Tier 2 or Tier 3 assignment for the applicable calendar year for any county, it will reinvest at minimum an additional 7.5% of their annual net income into Community Reinvestment initiatives
  - ** For any county in which the Partnership is assigned to Enforcement Tier 2 or Tier 3, it will allocate 100% of our Quality Achievement Community Reinvestment funds toward investments in the "Cultivating Improved Health" category per the discretion of the corresponding public health and behavioral health officers
- Partnership will notify our Qualifying Subcontractors of their minimum Community Reinvestment funding obligations, and any corrections to such obligations, within 7 calendar days of notice from DHCS?
- Partnership and its Qualifying Subcontractors as applicable, will initiate investments in Community Reinvestment activities by no later than the close of the CY in which DHCS approves the initial Community Reinvestment Plan for the applicable investment period, and that Community Reinvestment funding obligations for each three-year investment period will be spent on specific activities included in the initial Community Reinvestment Plan by the end of the three-year period

Community Reinvestment Spending Categories (Inclusion/Exclusion Criteria)

Partnership's investments will be targeted toward reducing existing health disparities and/or promoting health outcomes for Medi-Cal populations through investments primarily focused on upstream causes of poor health such as housing instability, food insecurity, poverty, barriers to access to health and social services, and environments that negatively impact health.

Reinvestment spending may fall into at least one of the following categories but will be specific to each county's needs

- Cultivating Neighborhoods and Built Environment.
- Cultivating a Health Care Workforce.
- Cultivating Well-Being for Priority Populations.
- Cultivating Local Communities
- Cultivating Improved Health

Reinvestment spending may NOT fall into any of the following categories, regardless of the needs of the counties:

- Partnership Contract or Services carved out of the contract but covered under Medi-Cal (e.g. Pharmacy Benefit)
- Health care services inclusive of activities that improve health care quality or within the scope of Medi-Cal benefits or state-funded services
- Administrative activities of Partnership Health Plan (e.g. Employment, Meeting Scheduling, etc.)
- Administrative activities related to community reinvestment planning, implementation
- Member incentives or Grants
- Contract Activities

Local Health Jurisdiction (LHJ) and Behavioral Health Transformation Engagement

Partnership will engage with the community to ensure alignment with community reinvestment principles. Specifically, Partnership will engage at least quarterly meetings with corresponding public health and behavioral health officers in collaboration with the Population Health team to ensure alignment with community health assessment activities. Also, this will be implemented to ensure that local health jurisdiction and county behavioral health are included in community reinvestment planning and decision-making processes. Each reinvestment plan will solicit attestation from public health and county health directors to confirm that the investment strategy is generally agreeable to the LHJ and County Behavioral Health Department and aligns with community needs identified in the CHA / CHIP.

Community Engagement

Partnership will engage with the community to ensure alignment with community reinvestment principles. Specifically, Partnership will annually consult with our Community Advisory Committees (CACs), Quality/Utilization Advisory Committee (Q/UAC), and Quality Improvement and Health Equity Committee (QIHEC) to solicit Community Reinvestment recommendations. Also, Partnership may intermittently solicit feedback and insight from Members, community residents, community-based organizations, tribal organizations, providers, and other external stakeholders to ensure that Community Reinvestment decisions are rooted in the needs of the community.

Health Plan Engagement

Partnership will engage and coordinate with Kaiser Permanente to align investment planning processes and maximize the collective impact of our corresponding funds.

Community Reinvestment Management

Step 1: Community Reinvestment Team Engagement with Community

- Community Reinvestment Team (CRT) engage with Community Advisory Committees (CACs), Local Health Directors, and Behavioral Health Directors/Officers for reinvestment information
    - CRT will collect a description of all investments recommended by the CAC and identify those recommendations that materially influenced or informed decisions reflected in the plan by sharing with Local Health Directors and Behavioral Health Directors/Officers and/Partnership Executive Team
    - CRT will provide guidance for counties to help select reinvestments for their respective counties

Step 2: County Leaders will Complete Partnership Community Reinvestment Grant Program Application

- County leaders will review their allocated amount of funds and clarify what reinvestment activities they are suggesting for their county. Partnership will provide suggestions on what each county should elect to use their funds for. Partnership will share suggestions from various internal committees (e.g. CAC, QIHEC, etc)

Step 3: Community Reinvestment Team Review

- CRT will review application submissions to accuracy and assess feasibility of investment item.
    - One Community Health Needs Liaison and/or Community Reinvestment Liaison will review each county submission for accuracy.

Step 4: DHCS Submission

County Submission of Application via online platform every August 1st to meet September 1st deadline

Step 5: CAC and Board Review

- CAC and Board Review of annual review of outcomes and approval of DHCS submission every December

Initial Community Reinvestment Plan

Every three-year investment period, Partnership will detail the composite set of proposed community reinvestment activities including (but not limited to):

- A detailed description of the anticipated Community Reinvestment activities and their related use category or categories.
- A description of how activities are directly informed by community need identified through the LHJ CHA process.
- If applicable, identification of the LHJ CHIP activity that each Community Reinvestment activity matches.
- If applicable, a description of community needs identified through the Behavioral Health Transformation community planning process that the Community Reinvestment activity addresses.

- Anticipated benefits of Community Reinvestment activities (in alignment with criteria described in the "Guiding Principles" and "Community Reinvestment Categories" sections above).
- A description of the approach taken to engage the CAC in the Community Reinvestment planning process, including a summary of the CAC recommendations.
- A description of the approach taken to engage other interested stakeholders in the Community Reinvestment planning process, if any, and identification of those stakeholders.
- A description of any investments recommended by CACs not included in the Community Reinvestment Plan.
- A summary of input provided by Chief Health Equity Officers, and the QIHEC if applicable.
- The expected dollar amount allocated for each Community Reinvestment activity, based on the overall funding obligation for the applicable CY.
- The expected populations that will benefit from or participate in each Community Reinvestment activity.
- A description of how the impact of Community Reinvestment activities will be measured and evaluated.
- A signed attestation from local Public Health and County Behavioral Health Directors.

Subsequent Community Reinvestment Plan Submissions

Each subsequent community reinvestment plan within the investment period will indicate the allocation of additional investments for each activity documented in the initial community reinvestment plan for funding obligations resulting from positive net income for the applicable year. Every future three-year investment period, Partnership will detail the composite set of proposed community reinvestment activities including (but not limited to):

- The expected dollar amount allocated for each Community Reinvestment activity in the initial Community Reinvestment Plan approved by DHCS based on funding obligations for the applicable CY.
- A signed attestation from local Public Health and County Behavioral Health Directors.

Communication

The DHCS-approved Community Reinvestment Plan will be posted on the websites and use DHCS-recommended use templates. Also, Partnership will post a Community Reinvestment Report on our website, using templates included in APL 24-016 in Q2 CY 2030 and every three years thereafter.

CULTURALLY & LINGUISTICALLY APPROPRIATE SERVICES (CLAS)

Partnership is committed to delivering Culturally and Linguistically Appropriate Services (CLAS) to all eligible beneficiaries. Partnership's Health Education team regularly assesses and documents member cultural and linguistic needs in the C&L Program Description to determine whether covered services are available and accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability. The Health Education team also ensures that all culturally and linguistics services are provided in an appropriate manner through the C&L Program Description.

The Population Health department is responsible for the operation and implementation of the C&L Program Description and associated work plan. Additionally, key internal committees with community members (e.g., CAC, QIHEC, FAC) provide feedback on the development and implementation of culturally and linguistically accessible services.

Partnership monitors and evaluates the effectiveness of cultural and linguistic services by reviewing and responding to: CAHPS, member grievances and appeals, reports of utilization of interpreter services by language, provider assessments, and facility site reviews.

to the MCAS benchmarks to assess not only how each group performed statistically in comparison to the White/Male/English speaking group, but also in comparison to the national Medicaid benchmarks. In MY 2023, DHCS is holding managed care plans (MCPs) accountable and imposing sanctions on selected Hybrid and Administrative measures performing below the minimum performance level (MPL) (50th national Medicaid percentile) by reporting region, and as a result, Partnership thought it valuable to assess how each group is performing in comparison to that benchmark to assess whether group performance could also have an impact on accountable measures.

Step 4: Prioritization of Disparities

The HEO, CMO, and members of the QI/PI team reviewed the information supplied about health disparities and draft a preliminary report of disparity metrics to prioritize based upon clinical measure stratification, statistical or clinical findings, size of the disparity, strength of evidence, feasibility, and return of investment. An established baseline will be developed for each group to follow for the next 3 to 5 years to evaluate long-term impact. The team will identify the key disparity priorities per region and per population of key racial/ethnic, gender, or linguistic groups.

Step 5: Distribution of Disparity Data for Community Feedback

The preliminary report will be shared with relevant internal committees (e.g., CAC, FAC etc), corresponding providers, health plan subcontractors, and health plan downstream subcontractors, via their corresponding QIHEC representative or newsletter. The goal will be to solicit feedback to ensure we have identified disparities that may not have been captured during our internal data analysis and identify strategies to address the disparities in respective communities. The Health Equity department will review internally submitted community needs assessment information to increase the likelihood of receiving credible information from community leaders and CAC/FAC/QIHEC members. Also, the Health Equity department will review feedback from members, parents, and/or caregivers to ensure that the community is given an opportunity to engage in the development of quality improvement and health equity activities and suggest interventions that will likely work in their respective communities. The advisory feedback will be transcribed and shared with the Health Equity department.

The Health Equity department will review the solicited findings from QIHEC, CAC, FAC, providers, health plan subcontractors, and health plan downstream subcontractors and share the results to the QIHEC for final approval of the key Partnership health equity priorities to share with the overall organization to serve as guidance for various departments and activities (e.g. PNA, QIP, etc.).

Step 6: Distribution of Disparity Data into Department Activities

Quality Improvement

For internal QI/PI related activities, the Health Equity department, in collaboration with the QI/PI team, will ensure that HEDIS/CAHPS–associated disparities (e.g. racial, ethnic, linguistic, disability, SOGI, etc.) are specifically being addressed in QI/PI programs (e.g., value-based payment programs, provider improvement plans, Corrective Action Plans (CAPS) etc.). Specifically, the QIHETP and QI/PI teams will review the internal value based payment programs (e.g., primary care provider quality improvement program (PCP QIP), hospital quality improvement program, (HQIP) etc.) and performance improvement projects to assess whether adjustments need to be made to ensure the projects can address HEDIS/CAHPS –associated disparities. For improvement efforts focused on reducing health disparities, the QIHEC ensures appropriate follow-ups on equity-focused interventions and related activities Partnership commits itself to in addressing quality measure performance deficiencies. Additionally, the Health Equity department supports ongoing QI/PI efforts in the identification of potential quality or equity of

~~care issues, improvement of HEDIS quality measures in context with social determinants of health. The QIHETP and QI/PI teams will collaborate to develop QIHETP improvement action plans specific to clinical quality measure performance with on-going monitoring and evaluation. Finally, the QIHETP and QI/PI teams will share data with NCQA team members to validate that disparity reduction goals/targets are compliant with NCQA HEA standards.~~

~~The QIHEC will review, among other reports, the updated QI/PI Program Evaluation to ensure that one or more HEDIS/CAHPS-associated racial disparity, HEDIS/CAHPS-associated linguistic disparity, or a mandated disparity reduction target for specific populations and/or measures as identified by DHCS has been addressed in response to findings from Partnership's annual QI Work Plan.~~

Population Health

~~For internal population health specific activities, the QIHETP and Population Health teams will collaborate to generate a finalized report to help refine the various population health reports and analyses. (The PHM Strategy provides a high-level overview of Partnership's approach to improving the health and wellbeing of the population served in the program. Specifically, teams will review tertiary and primary medical literature and health indices, review findings from other managed care organizations, collaborate with community key opinion leaders or subject matter experts, and survey members of the CAC and FAC to find credible interventions that can be executed by a managed care organization based upon the synthesized findings of the preliminary report. The QIHETP and Population Health and Health Equity teams will review and assess corresponding social drivers of health metrics. t. Social determinants or drivers of health have been classified as conditions in various environments that affect health and overall quality-of-life outcomes~~

~~The QIHEC will review, among other reports, relevant Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) information, Population Health and Cultural and Linguistics (C&L)-associated work plans to ensure that one or more HEDIS-associated racial/ethnic disparity(ies), and one or more HEDIS-associated disparity(ies) related to one additional category of stratification (e.g., disability, geographical representation, etc.) is addressed based on the findings from the assessed reports. The QIHEC will also review reports regarding the utilization of language services, individual experience with language services, staff experience with language services, and member experience with language services during health care encounters to ensure that one or more interventions is identified and incorporated into work plan(s) to address one or more culturally and linguistically appropriate services (CLAS) disparity or HEDIS-associated linguistic disparity. The QIHEC will review these elements to ensure they correlate appropriately with Partnership's annual QI Work Plan.~~

~~*Human Resources*~~

~~For internal Human Resources (HR) related activities, the Health Equity department, in collaboration with the HR department, will review submitted data for annual DEI-related training for employees, network providers, etc. to ensure review of completion. Specifically, the QIHETP and HR team will review the annual training on culturally and linguistically appropriate practices to ensure they are teaching principles to reduce bias and promote inclusion. Also, QIHETP and HR team will review the annual training to validate that it meets all the criteria to be considered appropriate per any related APL set forth by DHCS. The QIHETP and HR team will also review internal recruiting and hiring processes to ensure they support diversity in staff leadership, committees, and governance bodies. Also, the Health Equity department will conduct an annual survey of the DEI satisfaction from staff, leadership,~~

governance bodies, and committees and solicit recommendations to improve the DEI or cultural humility of each.

The QIHEC will review, among other reports, the annual results of such DEI surveys to ensure that Partnership has acted on at least one opportunity identified to improve DEI for at least one group (staff, leadership, committees, or governance bodies). Also, the QIHEC will review annual employee demographic data to ensure that our internal recruiting and hiring process continues to support diversity in staff leadership, committees, and governance bodies.

For grievance and appeals-related activities, the Health Equity department, in collaboration with leadership from the Population Health and Grievance and Appeals departments, will review for any patterns of disparities in reported grievances. The QIHEC will review, among other reports, the updated PNA, Cultural and Linguistics (C&L) Program Description and Work Plan, and/or Grievance and Appeals-associated Work Plans to ensure that one or more CAHPS-associated racial disparity(ies) or CAHPS-associated linguistic disparity(ies) is addressed with a Work Plan action item.

Miscellaneous Contributors

For any subcontractors' and downstream subcontractors' QI and Health Equity activities, QIHEC will review report findings and actions on a quarterly basis during each QIHEC meeting. A summation of the results will be evaluated in the annual program evaluation.

Community Reinvestment Management

The Health Equity department will work with the Finances, Population Health, Behavioral Health, Project Management Operations departments to ensure the health plan reinvests a minimum level of our net income into our local communities. Community reinvestment planning will start in calendar year 2025, with community reinvestment activities starting in 2026 and follow a 3 year cycle to align with other DHCS-related initiatives (Community Health Assessment, Behavioral Health Transformation, etc.)

Partnership's Health Equity Officer and Health Equity team, will lead the management of the community reinvestment planning process to ensure all community reinvestment plans align with overall health equity needs and priorities. Also, the health equity team will ensure that the health plan and qualifying subcontractors' activities are based upon engagement with the community and community-identified priorities, with investments in health quality improvement and equity outcomes.

Data

Every 3 years, Partnership will review the following to make a preliminary assessment of community reinvestment landscape in our counties:

- PNA
- CHA/CHIP for each corresponding county
- Behavioral Health Transformation assessment for each county
- Health Equity Grand Analysis per QIHETP workplan

Funding Requirements

Partnership and qualifying subcontractors will define the base Community Reinvestment as the minimum level of net income that, if with positive net income, is required to invest into initiatives that serve the communities in which the Partnership operates, starting with net income based on Calendar year (CY) 2024 Contract Revenues for Community Reinvestment activities initiated in CY 2026.

- Partnership, since in multiple counties, will calculate the Base Community Reinvestment funding obligations with the following allocation methodology:
  - 5% of Base Community Reinvestment Funds equally across counties in which Partnership operates + 95% of Base Community reinvestment Funds in Proportion to Medi-Cal membership by county
- Partnership will allocate the base community reinvestment funds = (5% of the Partnership's or Qualifying Subcontractors annual net income that is less than or equal to 7.5% of Medi-Cal Contract Revenues/Subcontractor agreement for the year) + (7.5% of the Partnership's or Qualifying Subcontractor's annual net income that is greater than 7.5% of Medi-Cal Contract Revenues/subcontractor agreement for the year)
- The approved net income from Partnership will invest into initiatives in counties that do not meet minimum quality measure performance thresholds for the applicable year
- Partnership receives an Enforcement Tier 2 or Tier 3 assignment for the applicable calendar year for any county, it will reinvest at minimum an additional 7.5% of their annual net income into Community Reinvestment initiatives
  - ** For any county in which the Partnership is assigned to Enforcement Tier 2 or Tier 3, it will allocate 100% of our Quality Achievement Community Reinvestment funds toward investments in the "Cultivating Improved Health" category per the discretion of the corresponding public health and behavioral health officers
- Partnership will notify our Qualifying Subcontractors of their minimum Community Reinvestment funding obligations, and any corrections to such obligations, within 7 calendar days of notice from DHCS?
- Partnership and its Qualifying Subcontractors as applicable, will initiate investments in Community Reinvestment activities by no later than the close of the CY in which DHCS approves the initial Community Reinvestment Plan for the applicable investment period, and that Community Reinvestment funding obligations for each three-year investment period will be spent on specific activities included in the initial Community Reinvestment Plan by the end of the three-year period

Community Reinvestment Spending Categories (Inclusion/Exclusion Criteria)

Partnership's investments will be targeted toward reducing existing health disparities and/or promoting health outcomes for Medi-Cal populations through investments primarily focused on upstream causes of poor health such as housing instability, food insecurity, poverty, barriers to access to health and social services, and environments that negatively impact health.

Reinvestment spending may fall into at least one of the following categories but will be specific to each county's needs

- Cultivating Neighborhoods and Built Environment.
- Cultivating a Health Care Workforce.
- Cultivating Well-Being for Priority Populations.
- Cultivating Local Communities
- Cultivating Improved Health

Reinvestment spending may NOT fall into any of the following categories, regardless of the needs of the counties:

- Partnership Contract or Services carved out of the contract but covered under Medi-Cal (e.g. Pharmacy Benefit)
- Health care services inclusive of activities that improve health care quality or within the scope of Medi-Cal benefits or state-funded services
- Administrative activities of Partnership Health Plan (e.g. Employment, Meeting Scheduling, etc.)
- Administrative activities related to community reinvestment planning, implementation
- Member incentives or Grants
- Contract Activities

Local Health Jurisdiction (LHJ) and Behavioral Health Transformation Engagement

Partnership will engage with the community to ensure alignment with community reinvestment principles. Specifically, Partnership will engage at least quarterly meetings with corresponding public health and behavioral health officers in collaboration with the Population Health team to ensure alignment with community health assessment activities. Also, this will be implemented to ensure that local health jurisdiction and county behavioral health are included in community reinvestment planning and decision-making processes. Each reinvestment plan will solicit attestation from public health and county health directors to confirm that the investment strategy is generally agreeable to the LHJ and County Behavioral Health Department and aligns with community needs identified in the CHA / CHIP.

Community Engagement

Partnership will engage with the community to ensure alignment with community reinvestment principles. Specifically, Partnership will annually consult with our Community Advisory Committees (CACs), Quality/Utilization Advisory Committee (Q/UAC), and Quality Improvement and Health Equity Committee (QIHEC) to solicit Community Reinvestment recommendations. Also, Partnership may intermittently solicit feedback and insight from Members, community residents, community-based organizations, tribal organizations, providers, and other external stakeholders to ensure that Community Reinvestment decisions are rooted in the needs of the community.

Health Plan Engagement

Partnership will engage and coordinate with Kaiser Permanente to align investment planning processes and maximize the collective impact of our corresponding funds.

Initial Community Reinvestment Plan

Every three-year investment period, Partnership will detail the composite set of proposed community reinvestment activities including (but not limited to):

- A detailed description of the anticipated Community Reinvestment activities and their related use category or categories.
- A description of how activities are directly informed by community need identified through the LHJ CHA process.
- If applicable, identification of the LHJ CHIP activity that each Community Reinvestment activity matches.
- If applicable, a description of community needs identified through the Behavioral Health Transformation community planning process that the Community Reinvestment activity addresses.

- Anticipated benefits of Community Reinvestment activities (in alignment with criteria described in the "Guiding Principles" and "Community Reinvestment Categories" sections above).
- A description of the approach taken to engage the CAC in the Community Reinvestment planning process, including a summary of the CAC recommendations.
- A description of the approach taken to engage other interested stakeholders in the Community Reinvestment planning process, if any, and identification of those stakeholders.
- A description of any investments recommended by CACs not included in the Community Reinvestment Plan.
- A summary of input provided by Chief Health Equity Officers, and the QIHEC if applicable.
- The expected dollar amount allocated for each Community Reinvestment activity, based on the overall funding obligation for the applicable CY.
- The expected populations that will benefit from or participate in each Community Reinvestment activity.
- A description of how the impact of Community Reinvestment activities will be measured and evaluated.
- A signed attestation from local Public Health and County Behavioral Health Directors.

Subsequent Community Reinvestment Plan Submissions

Each subsequent community reinvestment plan within the investment period will indicate the allocation of additional investments for each activity documented in the initial community reinvestment plan for funding obligations resulting from positive net income for the applicable year. Every future three-year investment period, Partnership will detail the composite set of proposed community reinvestment activities including (but not limited to):

- The expected dollar amount allocated for each Community Reinvestment activity in the initial Community Reinvestment Plan approved by DHCS based on funding obligations for the applicable CY.
- A signed attestation from local Public Health and County Behavioral Health Directors.

Communication

The DHCS-approved Community Reinvestment Plan will be posted on the websites and use DHCS-recommended use templates. Also, Partnership will post a Community Reinvestment Report on our website, using templates included in APL 24-016 in Q2 CY 2030 and every three years thereafter.

~~Culturally & Linguistically Appropriate Services (CLAS)~~

~~Partnership is committed to delivering Culturally and Linguistically Appropriate Services (CLAS) to all eligible beneficiaries. Partnership's Health Education team regularly assesses and documents member cultural and linguistic needs in the C&L Program Description to determine whether covered services are available and accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability. The Health Education team also ensures that all culturally and linguistics services are provided in an appropriate manner through the C&L Program Description.~~

~~The Population Health department is responsible for the operation and implementation of the C&L Program Description and associated work plan. Additionally, key internal committees with community members (e.g., CAC, QIHEC, FAC) provide feedback on the development and implementation of culturally and linguistically accessible services.~~

~~Partnership monitors and evaluates the effectiveness of cultural and linguistic services by reviewing and responding to: CAHPS, member grievances and appeals, reports of utilization of interpreter services by language, provider assessments, and facility site reviews.~~

QUALITY IMPROVEMENT AND HEALTH EQUITY ANNUAL WORK PLAN

The QI and Health Equity Annual Work Plan will be used to strategize, prioritize, and track progress on equity-related initiatives throughout the year. Specifically, the QI and Health Equity Annual Work Plan will provide a comprehensive assessment of the QI and Health Equity activities, undertaken by Partnership, to evaluate effectiveness of Health Equity-related QI interventions.

The QI and Health Equity Annual Work Plan describes population-based Health Equity measured objectives, timelines, and accountable Partnership employees for each activity. It includes progress updates on planned activities and objectives for achieving internal measures of equity in context of clinical care, safety of clinical care, quality of service, and member experience. Forms for providing status updates are sent to staff one month in advance of the semi-annual and annual update deadlines to be completed by work plan contributors. Finally, the Work Plan will be reviewed annually by Q/UAC and approved by PAC and the Board of Commissioners.

The QI and Health Equity Annual Work Plan will also evaluate delegated subcontractors' and downstream fully delegated subcontractors' performance measure results and evaluate actions to mitigate any identified deficiencies.

ANNUAL PROGRAM EVALUATION

The overall effectiveness of the Quality Improvement and Health Equity Transformation Program is annually evaluated and approved at Q/UAC, PAC, and the Commission. The annual QIHETP Program Evaluation includes:

- Clinical Quality of Physical and Behavioral Health
  - Annual assessment of key HEDIS MCAS measures with stratification to race/ethnicity, primary language, gender identify, and/or age
- Member Experience
  - Annual assessment of key CAHPS measures with stratification to race/ethnicity and primary language
  - Analysis of CAC findings and strategy to increase member listening session-like activities
- Access and Engagement of Providers, Community – Access – Respect – Engagement – Service (CARES) Training provided by Partnership, which includes core trainings that cover diversity, equity and inclusion (DEI) and transgender, gender diverse, intersex (TGI) competency.
  - Review submitted data of annual CARES training (sensitivity, diversity, communication skills, and cultural competency training) for staff via internal human resources department
  - Review submitted data of transgender, gender diverse, intersex (TGI) cultural competency training program completion for staff via internal human resources department
  - Review submitted data of CARES training (sensitivity, diversity, communication skills, and cultural competency training) for network providers from the provider relations department per APL 24-016. Per internal Credential and Re-credential decision making process policy, a negative response on a provider attestation regarding completion of training, on credentialing criteria for practitioners, will trigger a file review
- Continuity and Coordination Across Settings and all levels of care
  - Analysis and evaluation of interventions to address both over- and under-utilizations of services and interventions
- Health Equity Promotion in Quality Improvement and Population Health
  - Analysis and evaluation of equity-related programs, initiatives and QI-related work as well as the overall effectiveness of the QI/PI program and of its progress toward influencing network-wide safe clinical practices
  - Analysis of county and region specific population needs assessment data
  - Analysis of community partnerships with local health departments, community based organizations, nonprofit organizations, etc.
- Community Reinvestment Plan
  - Community Reinvestment Plan for each investment period
    - DHCS calculated minimum community reinvestment funding obligations required
    - Composite set of proposed community reinvestment activities by county served and expected dollar amount allocated for each community reinvestment activity
    - Description of approach taken to engage with CAC and QIHEC
    - Measurement, analysis and evaluation of community reinvestment programs initiatives (e.g. qualitative description of benefits to Members)
  - Community Reinvestment Analysis
    - The actual dollar amount spent on each Community Reinvestment activity by county.
    - Description of each Community Reinvestment activity by category and county.

        - Description of how each Community Reinvestment activity aligns with DHCS' Guiding Principles.
        - Description of how each Community Reinvestment activity aligns with designated Reinvestment categories
        - Outcomes from Community Reinvestment activities, including any preliminary data and qualitative description of benefits to Members and the communities in which they reside
        - Signed letters from the CAC with descriptions of the degree to which Partnership engaged with CAC members in planning efforts and clarification on how their feedback was integrated with reinvestment activities.
- Regional Quality and Health Equity Team Compositions
    - Names and Roles of Partnership Team Members per region for quality and health equity
    - Identity of key network providers, county behavioral health plans, local health departments, community-based organizations, local government agencies, First 5 programs, etc. per disparity priority
- Administrative
    - The annual QI and Health Equity Work Plan goals and associated deliverables are informed by the QIHEC. If there are opportunities for improvement identified in the evaluation of prior year initiatives and work conducted to support the goals of the quality improvement program, these opportunities are translated into goals with actionable deliverables for the next year's work plan. The results in the annual QI and Health Equity Program Evaluation, particularly those tied to the need to revisit allocated resources, for committees, standing programs and other related activity are assessed and if changes are deemed necessary, they are reflected in the program in the subsequent year.
    - Strategy of sharing annual program evaluation with various subcontractors, downstream subcontractors, and network providers
    - Analysis of actions taken to address any recommendations in the annual external quality review technical report
    - Analysis of annual reports of any subcontractors' and downstream subcontractors' performance of delegated health equity activities. Each subcontractor's health equity officer/liaison will be required to submit an annual performance report to Partnership
    - NCQA Health Equity Accreditation Status
    - Annual Summary of QIHEC activities

The following are separate evaluations and not included in the QI and Health Equity Annual Work Plan Evaluation:

- Evaluation of cultural and linguistic competency work plan activities
- Evaluation of Utilization Management and Care Coordination activities
- Evaluation of Member grievance and appeals

Preparation for the Annual Program Evaluation involves participation by all QIHETP leadership including but not limited to:

- Chief Medical Officer
- Chief Health Services Officer
- Health Equity Officer
- Senior Director of Quality and Performance Improvement

The QI and Health Equity Plan will be made available on the Partnership website on an annual basis

NON-DISCRIMINATION STATEMENT

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

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

Partnership provides access to staff for members and practitioners seeking information about the UM process and the authorization of care. For more information, refer to the Communication Services Section of Partnership Policy MPUD3001 Utilization Management Program Description. ~~in the following ways:~~

- ~~Calls from members are triaged through Member Services staff who are accessible to practitioners and members to discuss UM issues during normal working hours when the health plan is in operation (Monday - Friday 8 a.m. - 5 p.m.).~~
- ~~After normal business hours, Members and Providers may contact the Partnership voice mail service to leave a message which is communicated to the appropriate person on the next business day. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.~~
- ~~After normal business hours, members may contact the advice nurse line at (866) 778-8873 for assistance with clinical concerns.~~
- ~~Practitioners, both in-network and out-of-network, may contact UM staff directly either through secure email or voicemail. Each voice mailbox is confidential and will accept messages after normal business hours. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.~~
  - ~~Partnership has a dedicated after-hours phone number local (707) 430-4808 or toll free (855) 798-8759 to receive calls from physicians and hospital staff for addressing post-stabilization care and inter-facility transfer needs 24 hours per day, 7 days per week. Calls are returned within 30 minutes of the time the call was received. Partnership's Chief Medical Director or physician designee is on call 24 hours per day 7 days per week to authorize medically necessary post-stabilization care services and to respond to hospital inquiries within 30 minutes. Partnership clinical staff are available 24 hours per day 7 days per week to coordinate the transfer of a member whose emergency medical condition is stabilized.~~
- ~~Partnership UM staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.~~
- ~~Partnership maintains a toll free number (800) 863-4155 that is available to both members and practitioners.~~
- ~~Members can view information about Partnership's language assistance services and disability services in the Member Handbook which is made available to members upon enrollment and is always~~

~~viewable online at~~ ~~http://www.partnershiphp.org/Members/Medi-Cal/Documents/MCMemberHandbook.pdf~~

Additionally, Partnership provides annual written notice to Members about our language assistance services and disability services (e.g., TTY for hearing impaired) in our Member Newsletter.

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

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

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

- Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact
- Information written in other languages
- Use of California Relay Services for hearing impaired~~Linguistic services are provided by Partnership to monolingual, non-English speaking or limited English proficiency (LEP) Medi-Cal beneficiaries as well as eligible members with sensory impairment for population groups as determined by contract. These services include the following:~~

No Cost Linguistic Services

- Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries
- Written information and materials (to include notice of action, grievance acknowledgement and resolution letters) are fully translated by qualified translators into threshold languages for Partnership Members according to regulatory timeframes, and into other languages or alternative formats upon request. Alternative material formats include audio, large print and electronically for members with hearing and/or visual disabilities. Braille versions are available for members with visual disabilities. Auxiliary aids are also available upon request. Please refer to MP~~C~~ND9002 Cultural and Linguistic Program Description for more information. The organization may continue to provide translated materials in other languages represented by the population at the discretion of Partnership, such as when the materials were previously translated or when translation may address Health Equity concerns.
- Use of California Relay Services for hearing impaired [TTY/TDD: (800) 735-2929 or 711]

Partnership regularly assesses and documents member cultural and linguistic needs to determine and evaluate the cultural and linguistic appropriateness of its services. Assessments cover language preferences, reported ethnicity, use of interpreters, traditional health beliefs and beliefs about health and health care utilization. (See policy MP~~C~~ND9002 *Cultural and Linguistic Program Description*)

REFERENCES

1. Department of Health Care Services (DHCS) standards

	08/19/26

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

	09/09/26

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

	10/28/26

~~*Kim Tangermann*~~ *Dean Germano* *Date Approved*
Board of Commissioners Chairperson

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MP301			**Lead Department: Member Services**	
Policy/Procedure Title: Assisting Providers with Missed Appointments			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 01/22/1999		**Next Review Date: 09/09/2027~~09/10/2026~~** **Last Review Date: 09/09/2026~~09/10/2025~~**		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: Robert Moore, MD, MPH, MBA			**Approval Date:** **09/09/2026~~09/10/2025~~**	

I. RELATED POLICES:

A. MP316 – Provider Request to Discharge Member & Assistance with Inappropriate Member Behavior

II. IMPACTED DEPTS:

A. Provider Relations

III. DEFINITIONS:

A. Primary Care Provider (PCP): The provider responsible for coordinating a Member's primary health care services.

~~A.~~

IV. ATTACHMENTS:

A. Missed Appointments~~s~~ Notification Form #29

V. PURPOSE:

To preserve and strengthen the provider-member relationship by educating members on the importance of attending and maintaining their scheduled appointments, thereby promoting continuity of care, timely access to services, and positive health outcomes.

~~To provide guidelines on how Partnership partners with preserve the provider/patient relationship, assist providers to address missed appointments to preserve the provider/member relationship and reinforce the importance of member adherence to keeping with patient compliance and educate the Mmember about the importance of keeping scheduled appointments.~~

VI. POLICY / PROCEDURE:

Members who miss two (2) or more consecutive appointments within the previous three (3) month period may be ~~are~~ contacted by Partnership staff at the ~~, upon~~ request of the M~~m~~ember's provider. If the request originates from ~~is initiated by~~ a specialist, the specialist is responsible ~~expected~~for ~~to~~ notify~~ing~~ the M~~m~~ember's Primary Care Provider (PCP) of the missed appointments.

~~A.~~ Provider~~s~~ r~~R~~equesting Partnership's ~~intervention~~assistance shall~~,~~

~~B. Providers complete and~~ submit~~fax~~ the Missed Appointment Notification Form (~~Attachment A~~Form #29, Attachment A) to ~~the~~ Partnership's Member Services (MS) D~~d~~epartment.

A.

~~C. Processing the Missed Appointment Notification Form~~

Member Services contacts the member by letter or by phone to advise the member of the: ~~1. Designated MS staff informs the Mmember of the importance of keeping scheduled appointments and possible disenrollmentscharge from the practice as outlined below:~~

Policy/Procedure Number: MP301			Lead Department: Member Services
Policy/Procedure Title: Assisting Providers with Missed Appointments			☒External Policy ☐Internal Policy
Original Date: 01/22/1999		**Next Review Date:** 09/09/2027~~09/10/2026~~ **Last Review Date:** 09/09/2026~~09/10/2025~~	
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

B.

~~MS staff attempts to contact the Mmember by phone and/or sends the Missed Appointment letter (#66A) , maintained by Member Services) to determine if the Mmember has had any barriers to care, is currentlyf they are in treatment, or have hasany scheduled tests.~~

~~When a member is identified as having barriers that may impact their ability to attend appointments, they should be referred to appropriate Partnership services and resources to support their needs. This may include Care Coordination (CC) as well as other available programs designed to address barriers such as transportation.~~

1. ~~The Mmember is advised of Ithe i~~mportance of keeping their appointments and promoting continuity of care, timely access to services etc.

~~1. and , iCf they continued to~~ Repeated missed appointments, ~~the provider can request~~may result in the provider requesting transfer of the Member's care or termination ~~disenrollment from~~of the ~~the~~ provider-member relationship in accordance with Partnership policy and procedure MP-316 Provider Request to Discharge Member & Assistance with Inappropriate Member Behavior ~~'s practice~~. ~~to discharge the Mmember from their practice.~~

2. ~~b. When a member is identified as having barriers that may impact their ability to attend appointments, they should be referred to appropriate Partnership services and resources to support their needs. This may include Care Coordination (CC) as well as other available programs designed to address barriers such as transportation.When a medical condition(s) is identified, the case is referred to the Partnership's Care Coordination (CC) department.~~

3. ~~c. Designated The MS staff completes the "Partnership Use Only" section of the Missed Appointment Notification Form (Attachment AForm #29, Attachment A) and faxes it back to the provider's office.~~ Partnership may ~~be able to~~ assist ~~with~~in identifying and addressing ~~any~~ barriers to care through member education, referrals to the appropriate department, care coordination, transportation assistance, or other available Partnership resources.~~, by educating members of Partnership resources and/or completing referrals to the appropriate department, e.g. Care Coordination, Population Health etc~~.

~~3. d. All actions are noted in the Mmember's record and completed within five (5) business days.~~

VII. REFERENCES:

N/A

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:

Senior Director of Member Services & Grievance~~.~~

X. REVISION DATES:

Medi-Cal
01/22/99; 01/10/01; 01/16/03; 07/22/03; 08/10/04; 08/10/05; 06/16/06; 12/09/08; 02/01/10; 04/21/10; 03/12/13; 01/30/15; 04/12/16; 03/15/17; *05/09/18; 08/14/19; 08/12/20; 08/11/21; 09/14/22; 09/13/23; 09/11/24; 09/11/25; 09/09/26

Policy/Procedure Number: MP301			Lead Department: Member Services
Policy/Procedure Title: Assisting Providers with Missed Appointments			☒**External Policy** ☐**Internal Policy**
Original Date: 01/22/1999		**Next Review Date:** 09/09/2027~~09/10/2026~~ **Last Review Date:** 09/09/2026~~09/10/2025~~	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

*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:
Healthy Kids
(11/01/2005 to 12/31/2016)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Missed Appointment Notification Form

Providers fax this form to Partnership's Member Services Department (707) 863-4415 attention: Enrollment Unit

Patient Name:	Date of Birth (MM/DD/YYYY):
Parent/Guardian Name (if applicable):	Phone Number:
Primary Diagnosis:	Partnership ID# (on the Partnership ID Card):
Dates of missed appointments within the last 3 months:	Dates of the last kept appointments:
If your request is from a specialist, has the PCP's office has been notified of missed appointments ☐ Yes ☐ No	
Was the patient notified or reminded of the appointment date(s) and time of the missed appointments listed above: ☐ Yes ☐ No When was the patient notified or reminded of the last scheduled appointment? _____ (date) How was the patient notified/reminded of the last scheduled appointment? ☐ at the physician's office ☐ over the phone ☐ by mail ☐ by email	
Were~~List~~ interventions attempted following the~~after any of~~ missed appointments~~the~~ above ~~missed appointments~~?~~done when member missed appointments:~~ ☐ Yes ☐ No If so, what were the interventions?	
What was the ~~member's~~ patient's response to your interventions?	
Name of Provider:	
Person completing form Name: Date form was completed:	Phone: Fax:

Partnership USE ONLY
Member was contacted by phone on (date):
Letter was sent to member on (date):
Reasons for missing appointments:
Comments:

Form #29

Care Coordination Referral: _____
CC: Provider Relations: _____

Population Health Management Strategy & Program Description

MPND9001
(previously MCND9001, MCCD2027)

June 2026~~5~~

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

Table of Contents

Program Purpose 47
Introduction 47
Data Analysis and Strategy 58
Quality Improvement and Health Equity Committee (QIHEC) 811
Population Needs and Local Planning Requirements (CHA/CHIP) Community Needs Assessments 811
Population Needs Assessment (PNA) Committee 1013
Social Drivers of Health and Community Needs 1215
Population Risk Stratification & Segmentation 1316
Partnership's Risk Stratification Process 1417
Future Risk Stratification, Segmentation, and Risk Tiering 1922
Programs and Services 2023
Basic Population Health Management 2023
Wellness, Prevention, and Chronic Disease Management Programs 2225
Organizational Support for PHM 2326
Health Education 3235
Material Development 3336
Member Incentives 3538
Point of Service Education 3639
Practitioner Education and Training 3740
Health Education Interventions 3740
Other Activities – Interventions that Indirectly Affect Members 3841
Informing Members About Available PHM Programs 3942
Community Engagement and Coordination of PHM Programs 4043
Informing Members on Interactive Content 4346
Program Evaluation 4447
Identifying Opportunities for Improvement 4548
Delivery-System Supports for Population Health Management 4548
Value-Based Payment Programs 4548

Incentivizing Patient-Centered Medical Home (PCMH) Recognition 4649
Sharing Data 4649
eReports 4750
Partnership Quality Dashboard (PQD) 4750
Transformation Technical Assistance 4851
Population Health and Health Education Delegation Oversight and Monitoring 4952
Population Health Department Structure 4952
Team Roles and Responsibilities 5053
References 5558
Population Health Management Strategy & Program Description Approval 5760
Appendix A 5861
Appendix B 5962

Program Purpose

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

Introduction

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

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

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

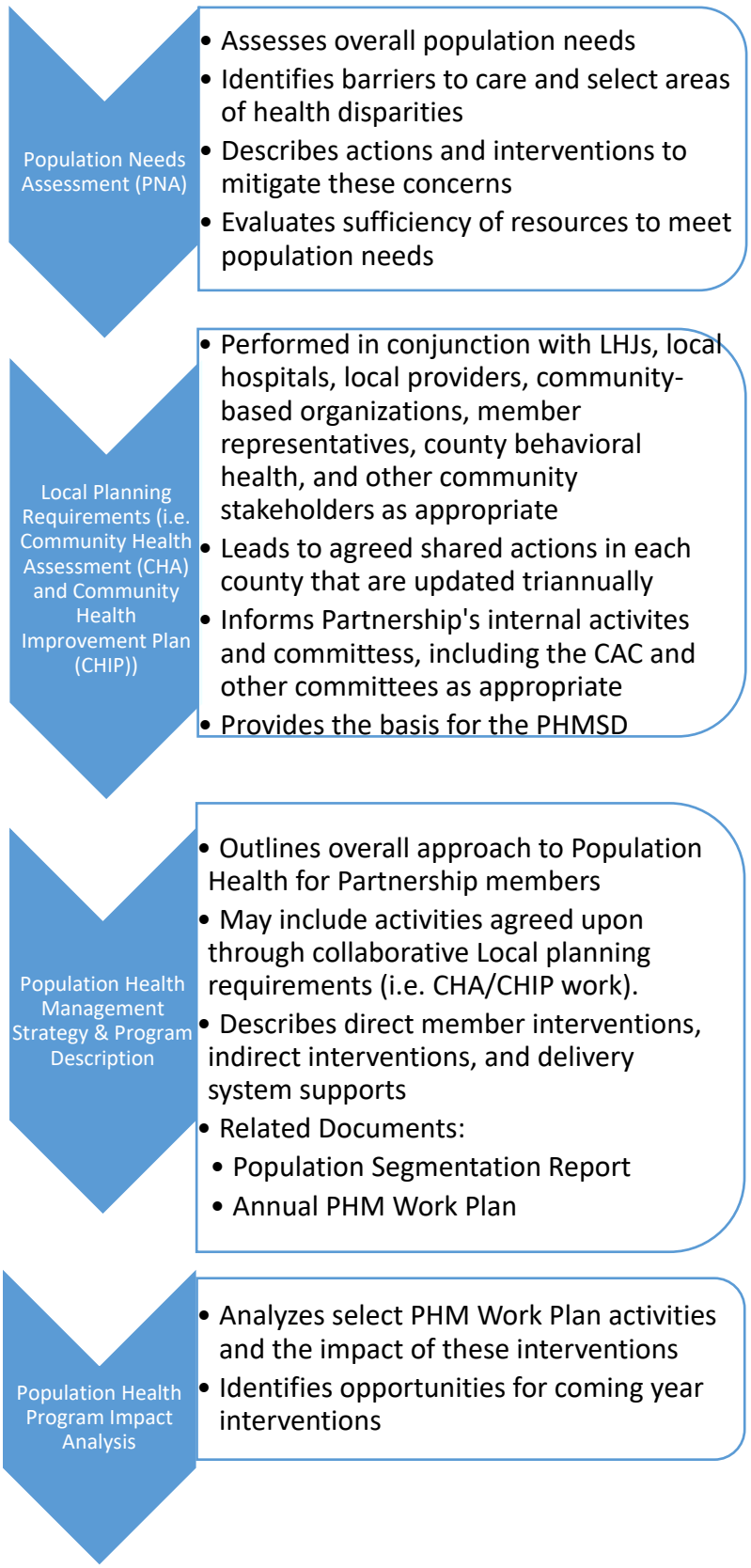
Health Improvement Plans (CHIPs), documenting the shared work in accordance with each of the LHJ reporting cadences in all Partnership's counties of operation.

Data Analysis and Strategy

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

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

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


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

Quality Improvement and Health Equity Committee (QIHEC)

The proceedings and recommendations from the written PNA, and/or updates from the CHA/CHIP efforts, are presented to Partnership's QIHEC for review. The QIHEC consists of a broad range of network providers, including but not limited to, hospitals, clinics, county partners, physicians, subcontractors, and/or downstream subcontractors, as well as Partnership members. The committee identifies, reviews, and recommends actions and/or activities designed to promote health equity for Partnership members in their communities. It also reviews the PNA, ~~regular~~ CHA/CHIP updates as needed, and other reports and data that represent Partnership's activity to promote the quality and equity of program offerings. For more information, see Policy MCEP6002 Quality Improvement and Health Equity Committee (QIHEC).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

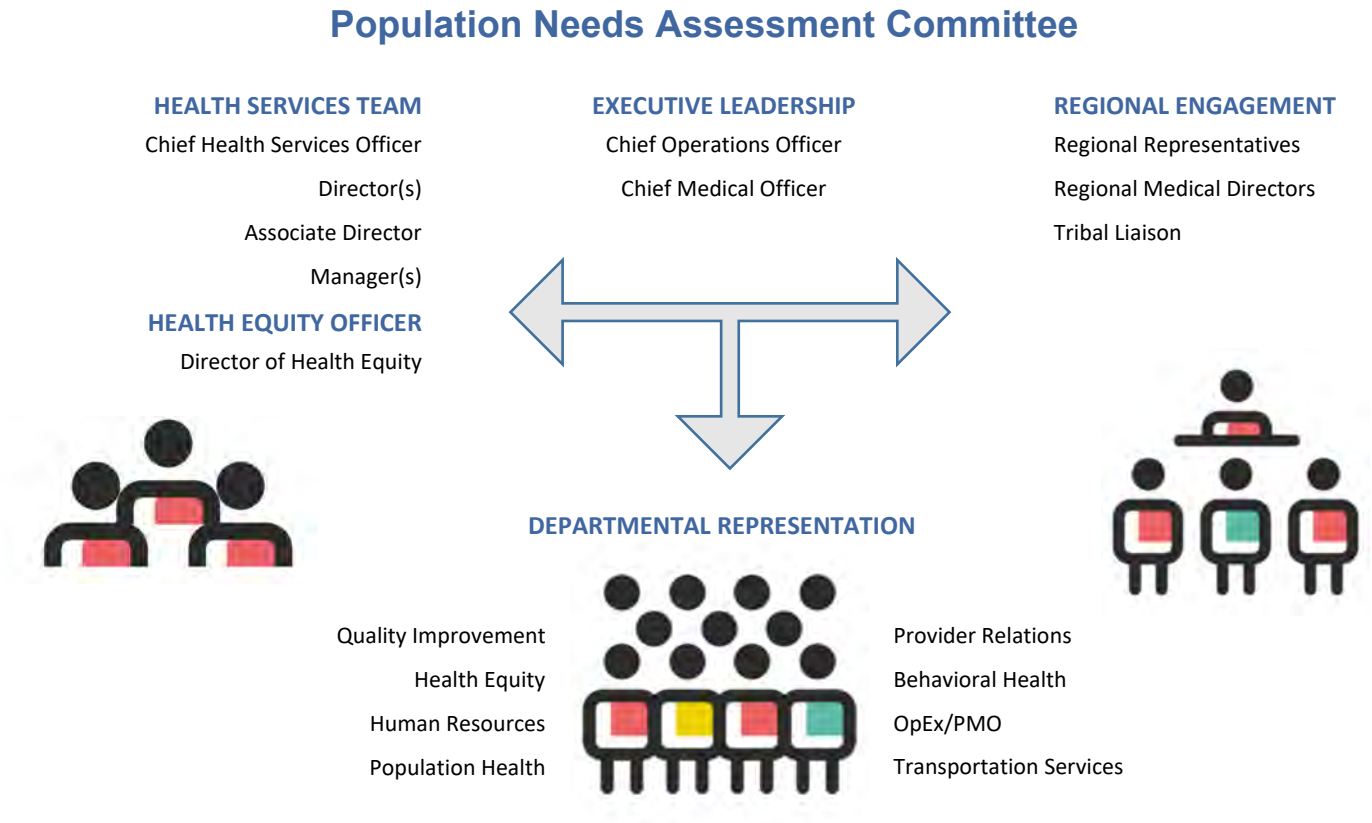
Lastly, Partnership also publishes the CHAs/CHIPs of all LHJ's in its Service Area on Partnership's website, along with a description of how Partnership ~~'s~~ collaborated~~ion~~ on the report(s).

Population Needs Assessment (PNA) Committee

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

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

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



Social Drivers of Health and Community Needs

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

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

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

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

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

In July 202~~0, 0,~~ Partnership began administer~~ing ing~~ the Drug Medi-Cal Organized Delivery System (DMC ODS) substance use treatment services on behalf of participating counties. Partnership works together with our providers and partners in seven Partnership counties (Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano) to provide integrated physical health and SUD services for the Medi-Cal population. By 2026 yearend, Partnership plans to transition the administration of this benefit back to these counties. The following counties have their own county-managed programs: Lake, Marin, Napa, Nevada, Placer, Sonoma and Yolo over which Partnership has no regulatory oversight.

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

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

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

Population Risk Stratification & Segmentation

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

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

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

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

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

Partnership's Risk Stratification Process

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

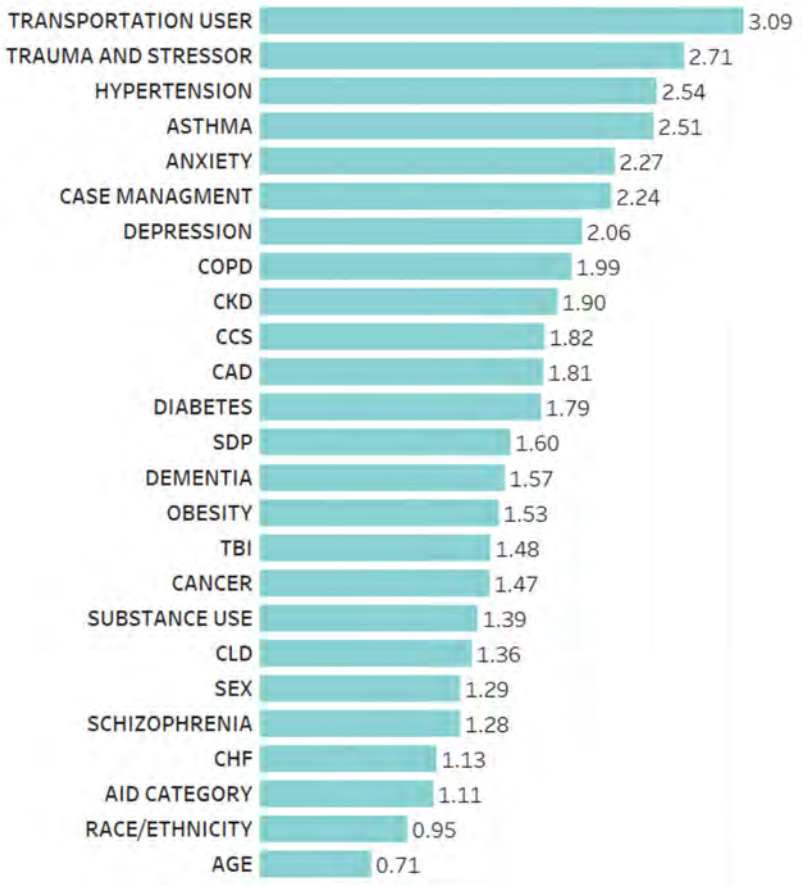
1. ~~(a)~~ Ffive or more ED visits,
2. ~~(b)~~ Oone or more acute hospital admission,
3. ~~(c)~~ Ffifteen or more distinct drug prescriptions, or
4. ~~(d)~~ Ttotal paid claims of more than $50,000 for medical costs (hospital and pharmacy)

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

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

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

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



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

Accordingly, the risk tiers are assigned as follows:

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

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

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

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

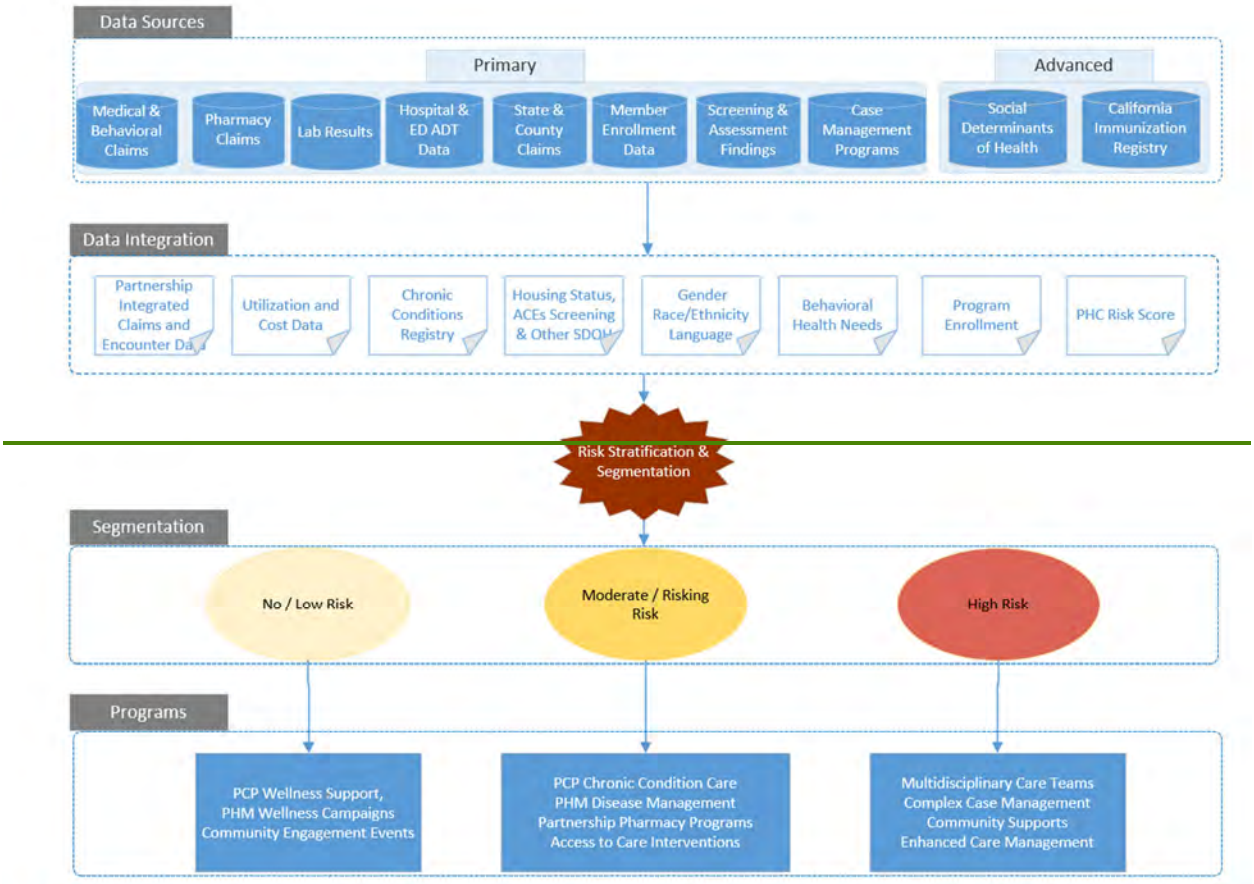
HEDIS measures provide insight into~~on~~ members ~~having~~ experiencing gaps in care, and this information is shared with providers to help members obtain preventive and chronic care. ~~-~~Partnership's Population Health team has various member-facing campaigns that are designed to positively impact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

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

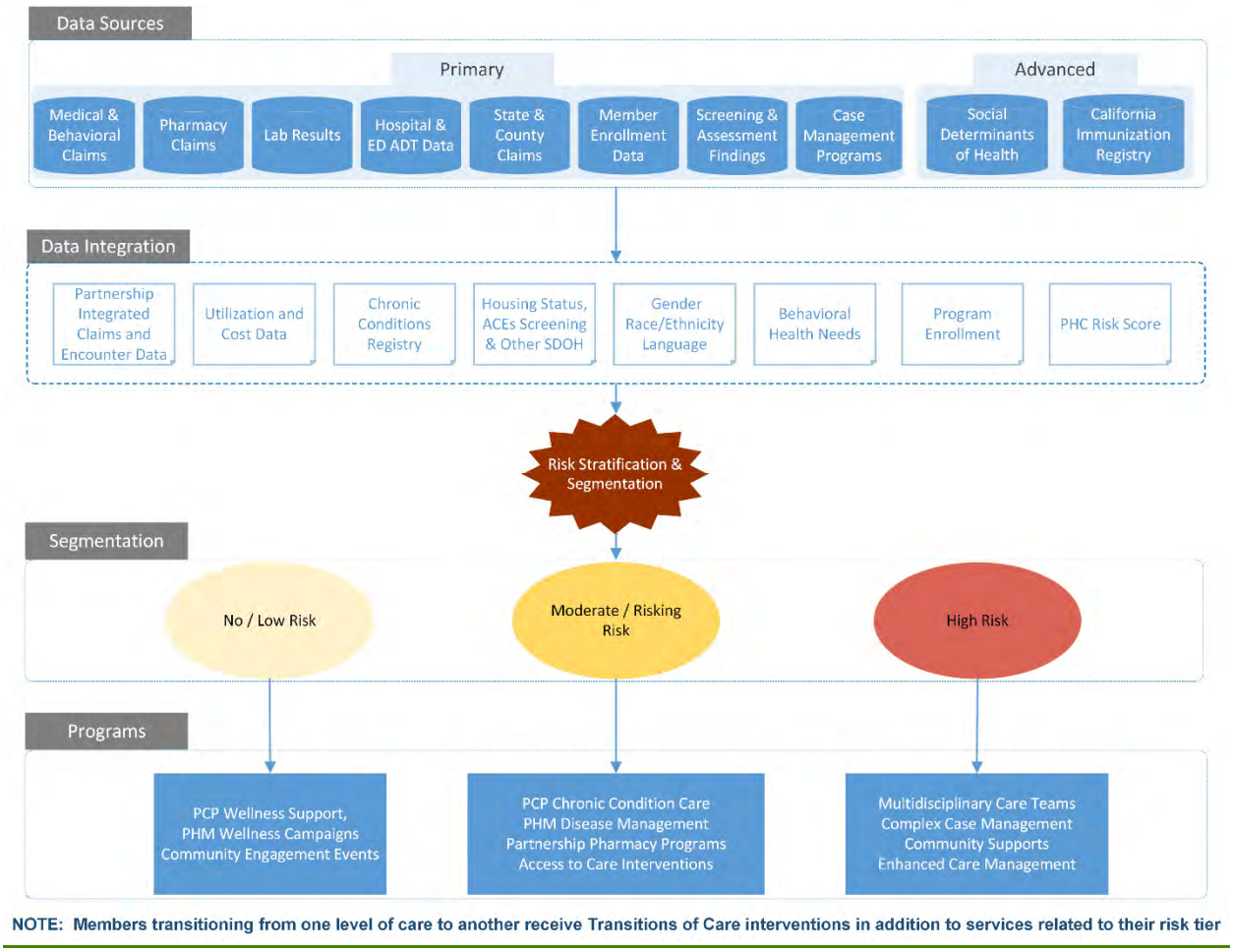
low-risk scores, insufficient data to assign a risk score, or members who may benefit from intervention regardless of risk score. Partnership recognizes that cost and utilization data is insufficient to identify the needs of all racial, language, and gender groups. Therefore, Partnership mitigates the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

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

Partnership's Risk Stratification and Segmentation Process



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



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

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

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

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

Programs and Services

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

Basic Population Health Management

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

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

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

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

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

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

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

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

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

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

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

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

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

- Diabetes

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

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

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

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

Organizational Support for PHM

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

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

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

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

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

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

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

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

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

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

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

Health Education

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

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

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

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

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

- Evidence-based Healthy Lifestyle, Self-Care, and Management of Health Conditions: Partnership provides or connects members to health educational interventions that can help members learn about and follow self-care management for existing chronic diseases or health conditions like, pregnancy, depression, asthma, diabetes, and hypertension.

This collection of health education strategies forms the health education system. The health education system is maintained and monitored to ensure equal access to all Partnership programs for all members, including accessibility for Limited English Proficient (LEP) members; to ensure appropriate allocation of health education resources; and to conduct appropriate levels of program evaluation. All programs and materials are available to members at no charge. Programs will not discriminate against Partnership members for any reason.

The Senior Health Educator participates in Partnership's internal committees, addressing quality and compliance with Partnership's programs. The Senior Health Educator ensures that all health education programs and materials are appropriate for members of varying demographics, including but not limited to: language, age, race, ethnicity, national origin, disability, sex and gender per Section 1557 of the Patient Protection and Affordable Care Act (ACA 1557).[5]

Material Development

In collaboration with Population Health, Care Coordination, Communications, Pharmacy, Quality Improvement, and other internal departments, the Health Education team develops targeted health education materials to help members modify health behaviors, achieve healthy lifestyles, and promote health equity (See Appendix A). Data from the PNA, CHA/CHIP collaboratives, other resources, and regulatory requirements also guide decisions regarding the availability and creation of health educational materials and resources for specific member populations. Furthermore, the health education team may assess~~es~~ member health care needs and barriers to care by consulting ~~regularly~~ with the Community Advisory Committee (CAC), the Family

[5] Section 1557, HHS, 2020

Advisory Committee (FAC), community organizations, Partnership's Chief Medical Officer, and also through community outreach such as through CHA CHIP efforts, ~~use of Healthy Living Tools,~~ and analysis of Partnership's data. Materials are available to members through direct mail, their network provider's office, community events, on the Partnership website and Member Portal, and via email ~~by~~ request.

In alignment with APL 18-016,[6] the Senior Health Educator assesses written, member-facing materials for readability and suitability according to state and national guidelines, which ensures that member facing materials are written at the 6th~~sixth~~ grade reading level using a readability formula that is most appropriate and reliable for the type of materials and target audience. The Senior Health Educator also ensures that health education materials are culturally and linguistically appropriate for the intended audience with special attention to concept, density, tone, key messages, including format, page design and graphics, and that documents are up to date. Member facing materials (which includes health education materials) are made available in Partnership's threshold languages, large font, in any of California's top 18 non-English languages upon the request of the member, and in specific languages as requested; alternative formats such as braille, large font, or audio are also available upon request (see MNCD9002 Cultural and Linguistic Program Description for more information on this). Partnership's qualified Health Educator(s) can approve written member health education materials as long as the following conditions are met:

- Materials purchased to distribute for member health education are from a DHCS approved company. The Health Education team will maintain a list of approved companies as these are updated by DHCS throughout each year.
- Materials are field-tested to ensure written health education materials are understood by the target audience. A~~The~~ qualified ~~Senior~~ Health Educator will provide oversight of the ~~field-testing~~field testing of all materials. ~~Field-testing~~Field testing is designed to garner feedback from the targeted audience for the materials and may include community focus groups, key informant interviews, simple review and surveys by community members, and/or review during Community Advisory Committee and Family Advisory Committee meetings. The H~~h~~ealth E~~e~~ducation team will review the results and adapt materials as needed and as appropriate.
- Health Education materials are assessed using the Readability and Suitability Checklist (per DHCS requirements). They are approved when:
    - A majority of the Readability and Suitability Checklist provisions are met.

[6] APL 18-016

  - When some of the Readability and Suitability Checklist provisions are somewhat met and/or not met, so long as the qualified Health Educator provides justification, and keeps the justification on file with the Suitability Checklist.
  - The signed/approved Readability and Suitability Checklist, along with the approved health education material, must be kept (electronic file or hard copy) by the health plan and made available to DHCS for auditing/monitoring purpose upon request.
- The assessment and approval process must be conducted by a qualified Hhealth Eeducator/Hhealth Eeducation Sspecialist with the equivalent training and background required by DHCS per APL 18-016.

Health education staff who do not meet the definition of a "qualified Hhealth Eeducator" as listed above will not approve health education materials for Partnership. If Partnership does not have a qualified health educator on staff to assess and approve health education materials, Partnership will submit health education materials to the Managed Care Quality and Monitoring Division (MCQMD) of DHCS for review and prior approval, along with a completed Readability and Suitability Checklist.

Member Incentives

In alignment with APL 16-005,[7] ~~Non-monetary~~non-monetary member incentives (MI) may be used in conjunction with, or as a component of, Partnership education programs and Basic Population Health Management programs to motivate members to adopt heathy behaviors, enhance health education activities, including participation in focus groups, or to gain feedback on member experiences. Member incentives must meet DHCS guidelines and follow Partnership's approval process for Member, Survey and Focus Groups (see Appendix B). MI program components include, but are not limited to:

- Increasing member participation, learning, and motivation to effectively use health care services including preventive and primary care services.
- Appropriate health care utilization includes, but is not limited to:
  - Timely prenatal and post-partum care
  - Timely immunizations
  - Timely well child visits
  - Timely screenings (i.e., mammograms, colorectal screening)
  - Regular monitoring tests for chronic diseases
  - Other as appropriate

[7] APL 16-005 Requirements for Use of Non-Monetary Member Incentives for Incentive Programs, Focus Groups, And Member Surveys

- Non-monetary member incentives may range in value depending on the components and complexity of the health education program.
- A Member Incentive Request, Focus Group Request, or Survey Request form (per APL 16-005) that includes:
    - Completion of the MI request form by a qualified Health Educator
    - Review by Partnership's Regulatory Affairs and Compliance Coordinator
    - Submission to DHCS Health Education Consultants for final review and approval at least 2~~two~~ weeks prior to implementing new MI programs or focus groups.

- Annual Member Incentive, Focus Group, and Survey Incentive Evaluation forms are required to be submitted to the DHCS Health Education Consultant thirteen (13) months after the planned program start date, covering the prior 12 months. If the program has ended, a Member Incentive Evaluation form must be submitted to the DHCS Health Education Consultant within 45 days from the date the program ended. Focus group and survey incentive program evaluation forms are due 60 days after the due date for completed surveys.

For more information on incentives, please refer to APL 16-005.

Point of Service Education

Partnership ensures that network providers will complete an Initial Health Appointment (IHA) for new members within 120 days of a member's enrollment in Partnership HealthPlan of California (Partnership) or within 90 days of a member's assignment to a PCP (whichever is most recent). Partnership abides by DHCS guidance for member screening and assessment, and monitors assessments through the Site Review process. The IHA must include the member's physical and behavioral health history, past medical history, social history, Review of Systems, identification of risks, an assessment of any needs for preventive screens or services, referrals to health education where appropriate, a member risk assessment, and if applicable, the diagnosis and treatment plan for any diseases.

Primary Care Providers (PCPs) are responsible for the screening and identification of members with specific health educational needs. PCPs are also responsible for providing appropriate health education information or referring the member and/or the caregiver to Partnership's Population Health department for assessment of appropriate health education activities or materials, and for following up on referrals (including providing anticipatory guidance). For more information on IHA, please refer to MCQP1021 Initial Health Appointment policy.

Members can also identify their own needs for health education. Partnership makes educational materials, benefits and resource information, and other tools (such as the Healthy Living Tools) available to members and network providers. Select health education materials are available on Partnership's website or upon request.

Partnership health education materials and resource topics are also available on Partnership's Member Portal and include, but are not limited to, topics such as:

- Age-Specific Anticipatory Guidance (adult and child routine checkups)
- Alcohol and drug use
- Asthma
- COPD
- Chronic Disease Management
- Diabetes Management
- Family Planning (contraception)
- Heart Disease & Prevention
- HIV/STD Prevention
- Immunizations (vaccines)
- Injury Prevention
- Living Well with a Disability
- Medication Management
- Nutrition (healthy eating)
- Parenting
- Perinatal/Breastfeeding
- Physical Activity
- Preventive Screening (health screenings)
- Senior Services
- Stress Management
- Tobacco Prevention & Cessation
- Weight Management & Exercise

Practitioner Education and Training

~~Starting in 2025,~~ Partnership provides Diversity, Equity, and Inclusion (including sensitivity, communication skills, cultural competency/humility training, health equity, and related trainings) for practitioners of our network providers, Partnership staff, and subcontractors and downstream subcontractors. This training is referred to as the CARES training. Partnership staff will receive the staff-specific DEI training on an annual basis. For more information on these ~~trainings~~training courses, please see MPND9002 Cultural and Linguistic Program Description and the forthcoming policy MCEP6004 DEI/Cultural Connection Training Policy ~~on~~ which describes requirements for the Diversity, Equity, and Inclusion Training Program ~~Requirements~~ for External Practitioners.

Health Education Interventions

The CHA/CHIP efforts, PNA, ~~and~~ community needs, and other regulatory requirements serve as the basis of setting the Health Education Program goals and activities. The written PNA findings and conclusions drawn from CHA/CHIP efforts ~~are~~ may be used to evaluate and make recommendations for appropriate allocation of health education resources, provider trainings, Partnership staff trainings, and intervention evaluation

efforts. The departments responsible for monitoring outcomes for specific interventions to ensure program objectives are being met. Performance improvement plans are implemented as necessary to improve Partnership and provider performance in delivering programs and services to our members.

Other Activities – Interventions that Indirectly Affect Members

There are many opportunities to collaborate through joint action with providers, county initiatives, and local care management programs to meet the needs of individual members. The following table describes the strategies used to promote population wellness through partnerships with community resources and organizations.

Initiative Type	Definition
Partnership Provider Population Reports	An automated list of members with missing services supplied to providers that are specific to low-performing HEDIS measures and immunization status updates. s. Supports providers in conducting direct outreach to close gaps in preventive care. County Health Officer Forums are held to disperse annual data and encourage collaboration and alignment.
Outreach/ Scheduling Calls	Based on the list of care gaps provided by Partnership, provider offices call members to remind them about scheduling needed services.
Scheduling Block	Clinic days at provider sites or health centers where blocks of appointment time are scheduled for Partnership members to receive missing services. Incentives are may be provided to add operational days / hours to expand access to members.
Poster Campaign, School Engagement	Educational events where students create art projects that amplify a health topic (e.g., immunizations, tobacco and vaping prevention); engagements with screening sessions at school clinics.Peer-to-peer, school-based projects where students receive information and resources on a health topic (e.g. tobacco and vaping prevention, mental health) to engage their peers in incentivized educational activities.
Provider Newsletters	Monthly Medical Director Newsletter to Primary Clinician Leaders, as well as a quarterly publication by the Provider Relations Department (Provider Newsletter) with dedicated

Initiative Type	Definition
	space for Quality Improvement and Member Engagement articles for providers to consider applying to their patients.
Provider Education	Coaching, consultation, measure review, and in-depth guidance for providers on HEDIS/Quality Improvement Program (QIP) measures as part of the Partnership value-based payment program, improving communication between providers, and promoting appropriate specialty referrals. Regular training on health equity. -Webinars provide reminders on standards and best practices, including reminders about external policies, APLs and other regulatory/contractual guidance.
Provider Email & Fax Blast ~~(email or fax)~~	Communication to all network providers for important updates (e.g., a fax blast on new standards for using combined long-acting beta agonist/corticosteroid combinations in treating asthma).
Partnership Website	Changing banners to communicate health information to providers, community-based organizations, as well as to members.
Point of Service Interaction	I The Provider Relations Education team will collaborate with the Pharmacy and QI departments to ensure educational notices are created and sent to providers when there are changes or updates that impact them.
Media Campaign	Social media campaigns and county-level websites focused on improving member education and influencing member decision-making in preventive services/screenings. Websites include public service announcements from local providers and community members.

Informing Members About Available PHM Programs

Partnership shares information on programs and services available to the communities it serves in multiple ways, including Partnership's website (PartnershipHP.org), the Partnership Member Portal, member newsletters, program introductory letters, event attendance, and its provider network as appropriate, as well as~~and~~ telephonically

through Partnership's Care Coordination, Population Health, ~~and~~ Member Services departments. ~~.~~ Partnership also has the ability to inform providers of various programs through Partnership's website, various provider newsletters, in-person meetings, fax blasts, email, and flyer distribution. When a member requires a referral to a Population Health or Care Coordination program, the member is directed to the appropriate staff for assistance with enrollment to the program best matching the member's level of need, and providers are informed as appropriate to support referrals and coordination of member care.

Community Engagement and Coordination of PHM Programs

Partnership has committed to being an active partner in each of the communities it serves, through local presence, local knowledge, and consciously building productive and strong working relationships. The emphasis on Population Health is an exciting opportunity to expand community engagement activities and build on the strong partnerships developed over many years, and in some cases, decades.

Partnership is divided into six distinct geographic areas, with regional offices strategically located in each area. Regional offices and the regional staff are responsible for working closely with local providers of health care to Partnership members, county health and social services departments, local health improvement coalitions and a variety of community-based organizations addressing the social, economic and health needs of Plan members. Regional staff live and work in these communities and share their knowledge of the managed care program with the community, and just as importantly, share their knowledge of the community with Partnership.

Regional staff meet regularly with county health and social service leaders to share information and collaborate on projects with aligned goals, such as childhood immunization campaigns, local disaster response management or planning, CHA/CHIP activities, and more. These staff attend a variety of community organization meetings and collaboratives, and they participate in local initiatives aimed at improving health and quality of life for Partnership members and others in the community. All communities (including Partnership) have ~~came~~come together over the years to respond to various natural disasters and outbreaks such as the devastating wildfires in Northern California and the COVID pandemic. ~~the devastating wildfires in Northern California, forming strong working relationships. Regional staff were able to build on these working relationships as the COVID pandemic emerged to share information, communicate consistently, and build cohesive strategies in each community~~Given the success~~ful~~ of these joint efforts, ~~.~~ Partnership seeks to continue this type of collaboration for years to come.

Partnership has many different member programs/initiatives concurrently planned and executed. In order to prevent duplication of efforts, any department planning or implementing programs affecting our members has the ability to log their member-facing campaign in the Population Health Campaign Tracker within Partnership's internal SharePoint sites. This campaign tracker is a central location for anyone in the organization to ensure staff are aware of current interventions. Quarterly check-in meetings include all member-facing departments and provide updates on new initiatives and outreach campaigns. Member-facing departments also have read-only or edit access to Essette, Partnership's case-management software system. A move to a new system, JIVA, is planned ~~after mid-2025~~for 2026. Campaign documentation occurs within the case management platform, and departments with read-only access have the ability to read through outreach that has already been conducted on a mutual member.

Population Health department staff communicate with providers, multidisciplinary health agencies, community resources, community-based organizations, and workgroups to share and gather information about member-facing programs. This process facilitates identification, planning, and support of healthy initiatives in the community, and identifies community programs and resources that can improve member health and wellness.

Partnership's regional liaisons and leaders in various departments actively participate in both internal and external workgroups to share information and reduce duplication of efforts. Through collaborative meetings, these staff members identify community resources that may be of benefit to Partnership's members and share these resources with the organization to promote integration into program offerings and meet member needs. Programs within the community or offered through providers may include:

- Enhanced Care Management (ECM)
- Community Health Workers
- Doulas
- Community Supports
- Regional Center participation
- Behavioral Health and Wellness & Recovery services
- Eating Disorder treatment
- Outpatient palliative care
- Other community programs such as WIC, support groups, community collaboratives, etc.
- Partnerships with Local Health Jurisdiction
- And more

Partnership members enrolled in the above programs are tracked through Partnership's internal data platforms as appropriate. , along with Tthe cloud-based Point Click Care Platform is also used to facilitate real-time data sharing between Partnership and ECM or other community providers of services (see Partnership Policy MCACP2007700220322032). This allows members of Care Coordination or other member-facing teams to collaborate with community partners and external case management leads without duplicating services. In addition, Partnership has appropriate agreements in place with each lead entity to ensure HIPAA mandates are followed and member data is not shared inappropriately.

Per DHCS's California Advancing and Innovating Medi-Cal (CalAIM) effective January 1, 2022, members with exceptional clinical and non-clinical needs have access to a community-based benefit called Enhanced Care Management (ECM). ECM provides coordination of services and comprehensive care management through an interdisciplinary, high-touch, person-centered care plan. Members who qualify for ECM services are tracked through a shared data platform to promote communication between providers and reduce duplication of effort. Certain services may differ for a Medi-Cal Member compared to a Partnership Advantage Membermembers enrolled in a Dual Eligible Special Needs Plan (D-SNP) with Medicare.

In alignment with the most recent DHCS PHM Policy Guide, Partnership also makes a good faith effort to executes Memorandums of Understanding (MOUs) with the following Third Party Entities to ensure the delivery of services to Partnership members:

- County In-Home Supportive Services to coordinate between county and managed care plan (MCP) for members who may be eligible for and/or are receiving IHSS
- Regional Centers for the coordination of services between Regional Center and MCP for Members who are or may be served by Regional Center, including Intermediate Care Facilities for Developmentally Disabled Services
- Mental Health Plans (MHPs) to coordinate between MCP and MHP for Non-specialty and specialty Mental Health Services
- Substance Use Disorder Treatment Services to coordinate covered substance abuse services between DMC-ODS and MCPs
- Local Health Jurisdictions/Local Health Departments to coordinate between LHJ/LHD and MCP for the delivery of care and services for Members who reside in LHJ's jurisdiction and may be eligible for one or more services provided, made available, or arranged for by LHJ

- County Social Services for Child Welfare to coordinate between County and MCP for the delivery of care and services for Members who are receiving County Child Welfare Services
- Women, Infant, and Children (WIC) to coordinate services between WIC Agencies and MCP to ensure provision and delivery of MCP's Covered Services and WIC Services to Members
- Local Government Agency (LGA) County-Based Targeted Case Management (TCM) Program to coordinate services between LGA TCM Programs and the MCP to ensure the delivery of care and services for eligible Members.
- County Behavioral Health Departments to coordinate services for Specialty Mental Health Services in Medi-Cal Mental Health Plans and SUD Services in Drug Medi-Cal Organized Delivery System (ODS) Counties

~~Other MOUs with the following organizations became effective January 1, 2025:~~

- LGA/California Department of Corrections and Rehabilitation, County Jails, and Youth
- First 5 Programs
- Whole Child Model
- Local Education Agencies (LEAs) (effective in 2027)

~~By mid-2025,~~ Partnership ~~will~~ also makes a good faith effort to ~~work to~~ implement DHCS guidance regarding Closed Loop Referrals to applicable services, and in certain MOUs, as needed. Furthermore, Partnership ~~also~~ works to ensure services carried out by third party entities are delivered in a culturally and linguistically appropriate manner. Finally, Partnership supports warm handoffs with third party entities as appropriate. For more information on MOU requirements, see MCCP2036 Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities.

Informing Members on Interactive Content

Many of Partnership's programs and services are designed to be interactive, allowing members to select the extent to which they wish to engage in these opportunities. In all instances of interactive services, members have the ability to opt out of the program. Should the member express this wish – in writing, in a telephonic conversation, or through a face-to-face interaction – this preference is documented for each campaign or intervention. The annual PHM Work Plan details the interactive services offered, how members qualify for programs, and how to opt out of programs.

Program Evaluation

The Population Health department analyzes the impact of PHM programs annually through clinical, utilization, and member experience measures, in accordance with the PHM efforts of the year. Partnership's Health Analytics department takes the lead in performing quantitative analyses to monitor the ~~c,~~ utilization results in aggregate and by subpopulation, and data supporting the tracking measures identified in specific initiatives. Data gathered to perform this analysis may include advanced data sets described previously, as well as member demographics, annual medical/behavioral and pharmacy claims data, immunization data from California Immunization Registry, transportation claims data, health appraisal results, HEDIS data, and data specific to internal programs such as case management, pilot programs, and/or provider performance improvement activities, as appropriate, and member feedback survey results. The QIHEC reviews reports on PHM activities for potential areas of concern, opportunities for improvement, and evaluates the impact of existing programs. This allows Partnership's leadership to review and update PHM activities to meet the needs of the members, as well as identify staffing, education, system, and infrastructure changes/requirements needed to support the delivery of those services as needed. Partnership's Quality Improvement and Performance Improvement programs use HEDIS monthly and annual reporting and analysis to monitor the impact of the programs and select opportunities for future interventions. Data from Quality Incentive Programs is also used as a proxy while HEDIS data is tabulated. The PHM Work Plan tracks the progress of interventions according to the measures identified at the beginning of the year, while the Population Health Management Impact Analysis reports on select clinical and utilization measures, as well as member experiences with the population health interventions.

In addition, Partnership hosts quarterly committees to encourage members to engage directly with Partnership. One such committee is the Community Advisory Committee (CAC), made up of member representatives from each of the regions in which Partnership operates. This committee meets to review Partnership's programs and provide feedback on how Partnership meets the needs of its members and of its communities. A separate Family Advisory Committee (FAC) is comprised of members whose children have special needs. The Pediatric Quality Committee consists of public and private sector physicians who care for Partnership members; ~~the committee provides insight into challenges members may have in getting the care they need from a provider perspective~~. The committee provides input on pediatric members that are eligible for CCS services and helps shape policies and access for these members as well as provide input on pediatric concerns.

The Grievances & Appeals department gathers and analyzes trends in member-reported complaints to identify areas for program improvement in the coming year. Partnership also has a process for identifying and intervening where there may be Potential Quality Issues (PQIs) related to a provider or provider organization. Finally, Partnership participates in two NCQA-approved Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys; one assesses factors under Health Plan influence, the other focuses on factors managed by Primary Care sites.

Identifying Opportunities for Improvement

No less than annually, the QIHEC reviews the impact of PHM's programs, identifies opportunities for improvement, and may select at least one improvement opportunity to address in the coming year as appropriate.

Delivery-System Supports for Population Health Management

~~Through PHM, Partnership acts to support providers by working intentionally and collaboratively with the provider community. The Quality Improvement department outlines strategies for the coming year in the Quality Improvement Program Description (See Policy MPQD1001) and annual Work Plan, addressing how providers will be made aware of population needs, and how they will be supported in addressing them.~~
Through PHM, Partnership supports providers by working intentionally and collaboratively with the provider community to improve population health outcomes. The Quality and Performance Improvement ~~Trilogy~~ Program Description (Policy MPQD1001) outlines how Partnership identifies population health needs using performance monitoring, disparities analyses, community health assessments, member experience data, and other required evaluations. The annual Work Plan then translates those identified needs into targeted strategies and activities, including improvement initiatives, value-based programs, reporting tools, training, and technical assistance.

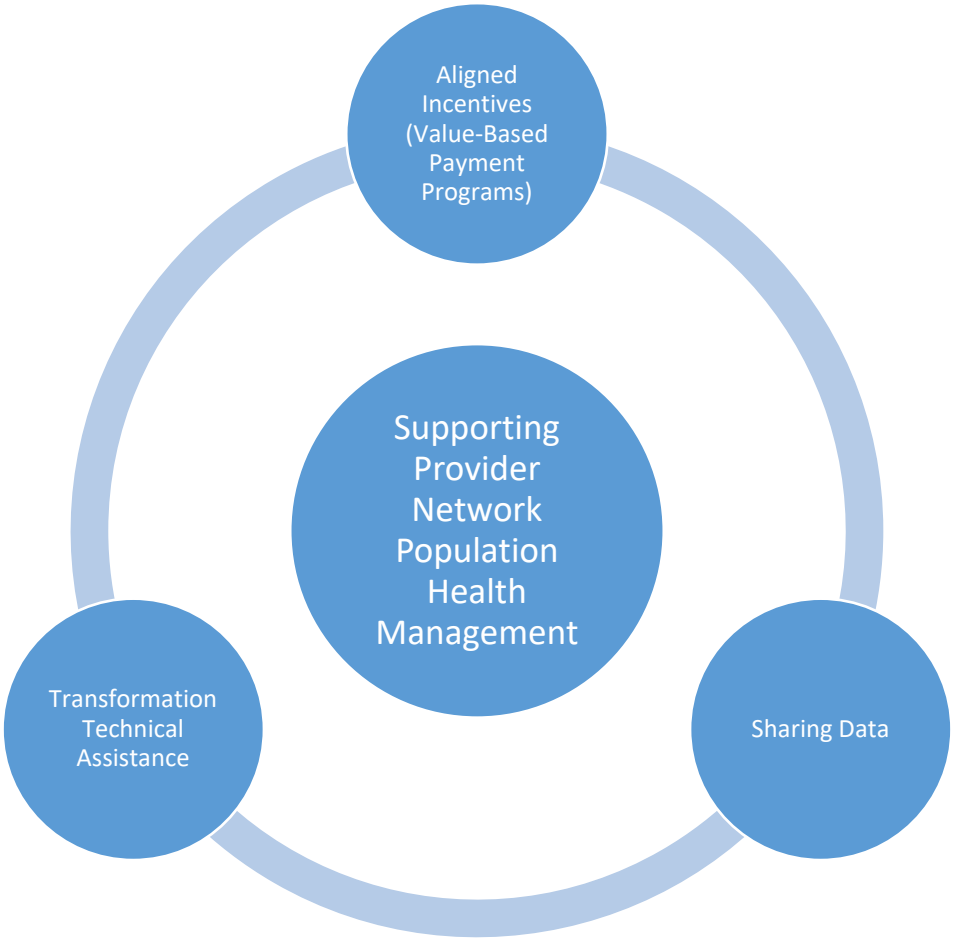
Value-Based Payment Programs

Partnership has a number of value-based payment programs through which contracted provider organizations can qualify for a financial incentives for quality-related performance. There are separate incentive programs for primary care providers, hospitals~~-~~, perinatal ~~providers, palliative~~providers, palliative care, ECM providers, extended care and ~~other~~more. Partnership's Primary Care Provider Quality Improvement Program (PCP-QIP) is Partnership's value-based payment program for

primary care providers. The PCP-QIP is largely focused on improving the quality of care members receive through a measure set reflecting Partnership's HEDIS measure score improvement priorities.

Incentivizing Patient-Centered Medical Home (PCMH) Recognition

Through our PCP-QIP, Partnership incentivizes contracted primary care practices to achieve and maintain Patient-Centered Medical Home recognition. This program is designed as an annual incentive, intended to encourage and recognize those provider practices that achieve excellent levels of service, care integration, and panel management, as recognized by established quality organizations.



Sharing Data

Partnership shares a variety of member data with our provider network in an effort to facilitate coordination of care and population health management. The two main

systems for data sharing are eReports and the Partnership Quality Dashboard (PQD). Partnership also shares a publicly available, annual data report with County Public Health Departments in alignment with DHCS's PHM requirements.[8]

eReports

eReports is a web-based platform that supports measurement and reporting for the clinical care domain of the Core Measurement set in Partnership's PCP-QIP. These preventive care and chronic disease management measures reflect DHCS's priority quality measures and are developed in-house by Partnership. The Core Measurement set is reviewed, modified, and approved annually by Partnership's Physician Advisory Committee (PAC) after considerable input from an internal technical workgroup, an external provider advisory group, and an open comment period involving all participating providers. eReports gives providers member-level data showing member eligibility and compliance for each clinical measure leveraging claims, lab, pharmacy, and immunization registry data. Providers may also upload medical record data to substantiate member compliance where representative administrative data is unavailable. eReports data ~~are~~ is refreshed twice per week, giving providers nearly real-time visibility to their measure-specific performance relative to performance targets. It also offers the ability to drill down into member lists by measure and view measure performance by site or organizational level (i.e. if multi-site provider). Once an organization is contracted with Partnership, ~~Healthplan~~ their PCP sites are loaded into the eReports platform and their Quality contact is notified via email by the QIP team with eReports registration and user access instructions.

Partnership Quality Dashboard (PQD)

This secure, online platform makes provider-site-level quality data available across quality improvement programs to help inform, prioritize, and evaluate quality improvement efforts. Specifically, PQD functionality includes:

Measure-Specific Data	PQD tracks provider performance on all Primary Care Provider Quality Improvement Program and HEDIS measures relevant to targets.
Trended Data	Providers can track their performance on the measures throughout the measurement periods (i.e. monthly rates).

[8] ~~DHCS Population Health Management Policy Guide, 2024~~DHCS Population Health Management Policy Guide, 2026

Comparative Data	PQD allows providers to compare their performance to blinded data of peer providers, including local averages and national benchmarks

Note: While the most currently available data for QIP Clinical measures is available on eReports, PQD serves as a visualization tool. PQD does not allow for any data entry. Instead, all clinical rates are calculated in eReports, and PQD takes the output of eReports, presenting the data longitudinally and comparatively. While eReports display performance at a given point in time, PQD shows performance data trending. In addition, the eReports interface compares performance against pre-defined thresholds, whereas PQD has multiple means of comparison including averages at regional, sub-regional, and county levels. PQD also includes data for non-clinical measures (e.g. 7 Day Follow-Up Visits, Avoidable ED Visits). Thisese data, which isare inclusive of measures involving follow-up visits after discharge from the emergency department, and ambulatory care sensitive admissions, are displayed in PQD allowing providers to view the number of members with admissions based on Preventive Quality Indicator diagnosis, date of admission and date of discharge. Other measures display members in a denominator based on number of acute inpatient discharge or observation visits in the measurement year and who received a follow-up visit within seven (7) days of hospital discharge. Thisese data isare all displayed at the member level and isare available for download into Excel format., readmissions, PCP Office Visits).

Transformation Technical Assistance

In addition to aligned incentives and data sharing, Partnership supports quality improvement and care delivery transformation in our network via the Partnership Improvement Academy and its component offerings. These opportunities are designed to prepare providers, including primary care providers, to optimize population health, enhance their patients' experiences of care, promote provider and care team satisfaction, and foster a culture of continuous quality improvement. The Improvement Academy offerings include the ABCs of Quality Improvement (QI) (QI basic methodology for the model for improvement)., the Improving Measure Outcome series that focuses on Partnership's Primary Care and Perinatal Quality Incentive Program (QIP) measures, offering practical strategies to close care gaps, and advance health equity; and improve clinical outcomes; and personalized services through Quality's Improvement Advisors, who work directly with provider sites to provide support, guidance, and tailored recommendations in support of practice transformation and the development of quality improvement subject matter expertise.. Tthe QI Project Training program to helps providers and community partners to plan and lead quality

improvement projects;~~, and personalized services through Quality's Improvement Advisors, who work directly with provider sites to provide support, guidance, and tailored recommendations in support of practice transformation and the development of quality improvement subject matter expertise~~.

Population Health and Health Education Delegation Oversight and Monitoring

Partnership may delegate Population Health, Health Education, and Cultural and Linguistics functions. Prior to assigning delegated responsibility, Partnership ensures the entity's capacity to perform. This is called a pre-delegation evaluation. Once confirmed, the parties enter into a formal agreement inclusive of all delegated responsibilities. Partnership conducts an audit of all delegated entities no less than annually to ensure that the delegate is performing consistent with the delegation agreement, applicable Partnership policies/procedures, and applicable regulatory obligations. Results from Oversight and Monitoring activities are presented to the Delegation Oversight Review Sub-Committee (DORS) for review and approval, as needed.

Population Health Department Structure

Population Health operations are supported by a leadership team and administrative staff. Partnership's Population Health department is responsible for developing, maintaining, and overseeing implementation of Partnership's overall PHM strategy, partnering with other departments to identify the health disparities and wellness needs of Partnership's members, implement DHCS's local planning requirements (previously known as the PNA requirement), and aligning organizational and community efforts to meet these needs in accordance with DHCS and NCQA requirements. In order to accomplish these objectives, Population Health departmental resources are leveraged to engage internal stakeholders, external stakeholders, and members aligning existing projects and efforts to promote health equity for Partnership's population. Population Health department staff are allocated to develop and share member education materials, ensure all member subpopulations have resources specific to their needs, engage with the community, educate community partners on Partnership programs and interventions, learn about resources available within communities, promote collaboration of effort, support each local LHJ's CHA/CHIP process, and reduce duplication of services.

Team Roles and Responsibilities

Chief Medical Officer:

As the principal manager of medical care, the Chief Medical Officer is responsible for the appropriateness and quality of medical care delivered through Partnership HealthPlan of California (Partnership) and for the cost-effectiveness of the utilization of services. ~~This position provides overall direction to multiple departments, including the Population Health Management Team and has the ultimate responsibility of ensuring that departmental programs and services are consistent and meet all regulatory requirements in every office location.~~ Required education includes an MD/DO degree from an accredited program, preferably in a primary care specialty required; minimum two (2) years' experience in a managed care plan preferred with duties comparable to those listed above, and experience administering medical programs. This role also requires board certification in a specialty and a minimum of seven (7) years clinical/medical practice experience.

Director of Population Health

The Director of Population Health is the key business leader who oversees the organization's Population Health Management strategy and is responsible for providing leadership, alignment, support, strategic development and implementation of associated activities and interventions. Provides clinical guidance and strategic direction for departmental activities by applying their understanding of population health management priorities, health care policy, financing, and regulations to promote optimal health outcomes for members. Works with the Chief Medical Officer, Chief Health Services Officer, Senior Director of Quality and Performance Improvement, Director of Health Equity, and other department leaders to meet organization and department goals and objectives while developing and tracking the measurable outcomes of department services. A Bachelor of Science Nursing or Doctorate in Public Health is required. At least 5 years of experience in a leadership/management role is also required. Experience in a managed care, health care provider network and/or working with Medi-Cal population is preferred.~~Provides oversight and direction of the Population Health strategy, programs and services to improve the health of Partnership members. Works with the Chief Medical Officer, Chief Health Services Officer, Senior Director of Quality and Performance Improvement, Director of Health Equity, and other department leaders to meet organization and department goals and objectives while developing and tracking the measurable outcomes of department services.~~

Associate Director of Population Health

~~Assists the Director of Population Health in the development, implementation and evaluation of Partnership's population health interventions and program oversight. The~~

~~Associate Director oversees the Managers of Population Health and the operational workings of the Population Health department. The Associate Director reviews and submits issues, updates, recommendations, and information to the HS Leadership when appropriate. Ensures ongoing audit readiness for Population Health deliverables.~~Under the leadership of the Director of Population Health, manages and provides direction to the Population Health team managers and supervisors to ensure key Basic Population Health Management activities are performed in compliance with DHCS and NCQA requirements. Participates in the development, implementation, and maintenance of Population Health programs and achievement of department goals and objectives in a fast paced, dynamic environment. This role ensures compliance with established operational criteria, NCQA, and DHCS Standards, and PHC policies and procedures. A bachelor's degree is required, but an RN license is preferred. A minimum of 5 years of relevant experience in health care operations, a minimum of 3 years of management experience with effective problem solving, or equivalent combination of education and experience is required.

Manager of Population Health

Gives day-to-day direction and has management responsibility for the implementation of member-facing outreach campaigns, member wellness coaching, CHA/CHIP activities, and other member and community-facing activities designed to keep members healthy and support them in managing their emerging health risks. The Manager provides day-to-day direction for supervisor~~ss,~~ and other key staff, manages escalated concerns, and ensures ongoing audit readiness for Population Health deliverables within the scope of their assigned unit.

Supervisor of Population Health

~~Provides supervisory oversight during daily department operations for assigned team members through sustained leadership and support. Using the best expertise and sound judgment (and in consultation with clinical leaders, providers, and staff), provides daily oversight, leadership, support, training, and direction of Population Health staff. S upports and assists the Manager and other Supervisors in developing and maintaining a cohesive team with a high level of productivity and accuracy to achieve the department's overall performance metrics.~~ Provides daily oversight, leadership, support, training, and direction of assigned Population Health staff. Supports and assists the Team Manager and other supervisors in developing and maintaining a cohesive team with a high level of productivity and accuracy to achieve the department's overall performance metrics. Bachelor's degree in business, Communication, Healthcare

Administration, or a related field, or 3-5 years of managed care experience, or equivalent combination of education and experience is required. General knowledge of managed care and principles of population health management is preferred.

Community Health Needs Liaison

In collaboration with departmental and organizational leadership, s~~S~~upports the coordination and implementation of Partnership's Local Planning process (Population Needs Assessment or (CHA/CHIP process) ~~activities~~requirements and activities through active and meaningful engagement in identified community workgroups and initiatives. On behalf of the health plan, identifies and supports key strategic activities and interventions that support alignment of collective agency efforts that promote and support efforts to encourage member health outcomes. Identifies community service programs available within our counties, outlining resources that are culturally and linguistically appropriate as needed and shares with appropriate stakeholders as needed. Supports the development of the key deliverables for DHCS and NCQA. ~~annual PHMSD and the NCQA annual Population Needs Assessment report.~~ Required education includes bachelor's degree in public health, Community Health or related field; A minimum of 2 years of experience in public health is preferred.

Senior Health Educator

The Senior Health Educator is a public health masters-prepared (or MCHES-certified) professional who maintains administrative and regulatory oversight of member facing materials (health education and member informing materials) and supports oversight of select cultural and linguistic services. This role also implements health education activities that promote member wellness, understanding of benefits, and access to care. More specifically, plans, implements and evaluates health education activities identified through gaps found in the PNA, CHA/CHIP work, HEDIS measures in conjunction with health promotion and equity programs; and supports cultural and linguistic services as appropriate. The Senior Health Educator also performs supervisor responsibilities for the Health Education team. This role requires a Master of Public Health (MPH) degree with a health education or health promotion emphasis, or master's degree in Community Health with a specialization in health education or health promotion, or Master Certified Health Education Specialist (MCHES) awarded by the National Commission for Health Education Credentialing, Inc. This role must have a minimum of 2 years' experience developing health education programs. Previous experience in a supervisory capacity, and/or experience or capacity to manage audit activities in our provider network, and experience or equivalent academic training on identifying health disparities within different cultures is preferred.

~~A masters-prepared (or MCHES-certified) professional who ensures the delivery of health education resources for both members and primary care providers. Also oversees the creation of member informing materials. Monitors and provides administrative oversight of all regulatory requirements related to Health Education and the Cultural & Linguistics programs. Provides assistance with regulatory requirements as needed.~~

Health Educator

Trained and competent to actively participate in the design and implementation of health education activities, including the creation of health education materials and classes and member informing materials. Leads on assigned member education projects, monitors health education materials, and performs literacy reviews to ensure appropriate readability and suitability levels. Supports and helps in delegate audits to ensure accuracy, compliance, and alignment with cultural and linguistic standards. Serves as a resource to internal staff and providers to ensure compliance with state requirements for educational member materials. Required education includes a bachelor's degree in health education, Public Health, Community Health or related field, experience in Public Health Education. A minimum of 2 years of health education experience is preferred.

Healthy Living Coach

Performs outbound call campaigns to members based on identified member needs using appropriate scripts. Administers post-campaign surveys. Helps members identify and access resources for their health and social support needs. Tracks outreach efforts in approved case management system per prescribed protocols. Engages Partnership members to identify barriers to care, member concerns, and resources needed. Lead member wellness campaigns and support members using Partnership's Healthy Living Tools. Participates in health fairs and other activities where Partnership members congregate; shares learnings with other Partnership departments who promote member engagement and wellness. When applicable, refers to culturally and linguistically appropriate community services.

Wellness Guide

~~Performs outbound call campaigns to members based on identified member needs for babies and young children, using appropriate scripts. Administers post-campaign surveys. Helps members identify and access resources for their health and social support needs. Tracks outreach efforts in approved case management system per prescribed protocols. When applicable, refers members to culturally and linguistically appropriate community services, and DHCS-approved health education materials.~~ This

position provides support and guidance to Partnership HealthPlan of California (Partnership) members for wellness services and incentive programs in a call-center environment. The Wellness Guide works closely with members and their families to encourage members to engage in healthy activities (including preventative care visits and chronic care management), remind members of available benefits, and connect members to available internal and external resources. Required education includes a high school diploma or equivalent combination of experience and education required; associate's or bachelor's degree is preferred. Two (2) years of experience working in a health care setting recommended, to include experience in health coaching, behavioral change, or any work experience, training or specialized education that would likely provide the ability to perform the essential functions of the position. Preference may be given to individuals certified and/or licensed in a health-related field

Project Manager

This position is r~~Responsible for managing timelines and deliverables in department projects. Develops agendas and leads meetings to advance departmental objectives. Provides routine and ad hoc reporting for key Population Health activities and initiatives. Works closely with designated department staff and leadership to gather, compile, and distribute reports, and facilitates structured file and record management. Supports ongoing audit readiness activities by maintaining structures around audit deliverables.~~ esponsible for effectively leading assigned projects, utilizing appropriate project management methodologies to drive the planning, implementation, and tracking of projects through all aspects of the project lifecycle. Project Managers are responsible for the planning, procurement, and execution of a project. This role also provides routine ad hoc reporting for key Population Health activities and initiatives and works closely with designated department staff and leadership to gather, compile, and distribute reports, and facilitates structured file and record management. Additional duties include s~~S~~upporting~~s~~ ongoing audit readiness activities by maintaining structures around audit deliverables. Required education includes a bachelor's degree and at least one (1) year of relevant project management experience required. In lieu of a degree, a minimum of three (3) years of relevant project management experience will be considered. Other requirements include experience managing multiple projects with medium to large teams. Experience in a health plan environment is preferred.

Project Coordinator

This role supports the planning, organization, management, and implementation of projects. The Project Coordinator also o~~O~~versees timelines and deliverables for

department projects, . pProvides routine and ad hoc reporting for key Population Health activities and initiatives, and w. Works closely with designated department staff and leadership to gather, compile, and distribute reports, and facilitates structured file and record management. Supports ongoing audit readiness activities by maintaining structures around audit deliverables, meeting minutes, and the file retrieval system. Required education includes a high school diploma or equivalent. A minimum of one (1) year project coordination or relevant experience is also required.

Coordinator

~~Provides coordination and administrative support to their manager and assigned unit. Performs a variety of general clerical duties, including data entry, help desk management, referral tracking, the distribution of non-monetary member incentives to members participating in incentive programs, organizing member packets and gifts, etc.~~ The Coordinator role provides coordination and administrative support to department teams and management. This role performs a variety of general clerical duties, including data entry, report generation, managing and responding to call inquiries, managing- internal Helpdesk inquiries, managing and assigning follow up inquiries from other departments, creates and revises desktop protocols, and develops forms and presentations. Other duties include referral tracking, the distribution of non-monetary member incentives to members participating in incentive programs, organizing member packets and gifts, etc. Required education includes a High School Diploma or equivalent. One (1) year of related experience in the medical/clerical field or equivalent combination of education and experience is also required. Experience in phone-based customer service may be preferred.~~Provides coordination and administrative support to their manager and assigned unit. Performs a variety of general clerical duties, including data entry, help desk management, referral tracking, the distribution of non-monetary member incentives to members participating in incentive programs, organizing member packets and gifts, etc.~~

Note: Staffing and staff job descriptions are subject to change based upon program needs and organizational growth.

References

DHCS APL 2~~6~~2-00~~2~~6 ~~Medi-Cal Managed Care Health Plan Responsibilities For Non-~~

Specialty Mental Health Services (04/08/2022)

DHCS APL 18-016 Readability and Suitability of Written Health Education Materials (10/05/2018)

Document A (APL 18-016): Review and Approval Guidance for Written Health Education and Member Information Materials

Document B (APL 18-016): -Readability and Suitability Checklist for Written Health Education materials

DHCS APL 16-005 *Revised* Requirements for Use of Non-Monetary Member Incentives for Incentive Programs, Focus Groups, and Member Surveys (11/23/2016)

DHCS 2024 Contract

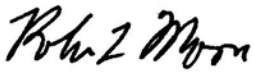
DHCS Population Health Management Policy Guide, 20264

NCQA. (2018). *Population Health Management / Resource Guide.* www.ncqa.org. Retrieved from NCQA.org.

Snyder, A. M., Willey, C., McKenna, M., Foley, P., & Coleman, R. (2005). Development of a Risk Assessment Tool for Predicting Pediatric Health Services Utilization. *Journal of Clinical Outcomes Management*, 451-458.

World Health Organization. (2023, April 3). *Health Equity*. Retrieved from World Health Organization: https://www.who.int/health-topics/health-equity#tab=tab_1

Population Health Management Strategy & Program Description Approval

	06/18/2026

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

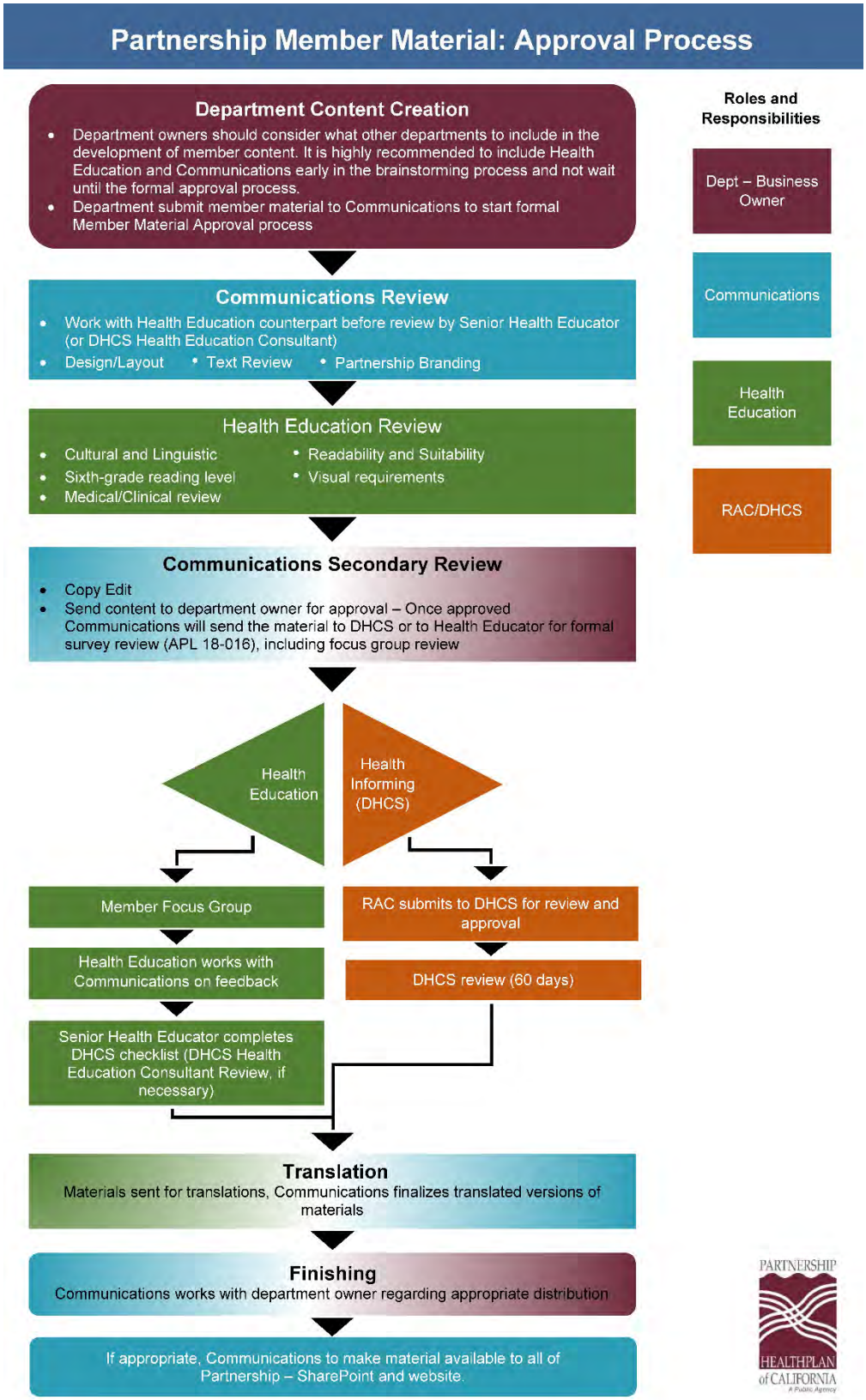
	09/09/2026

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

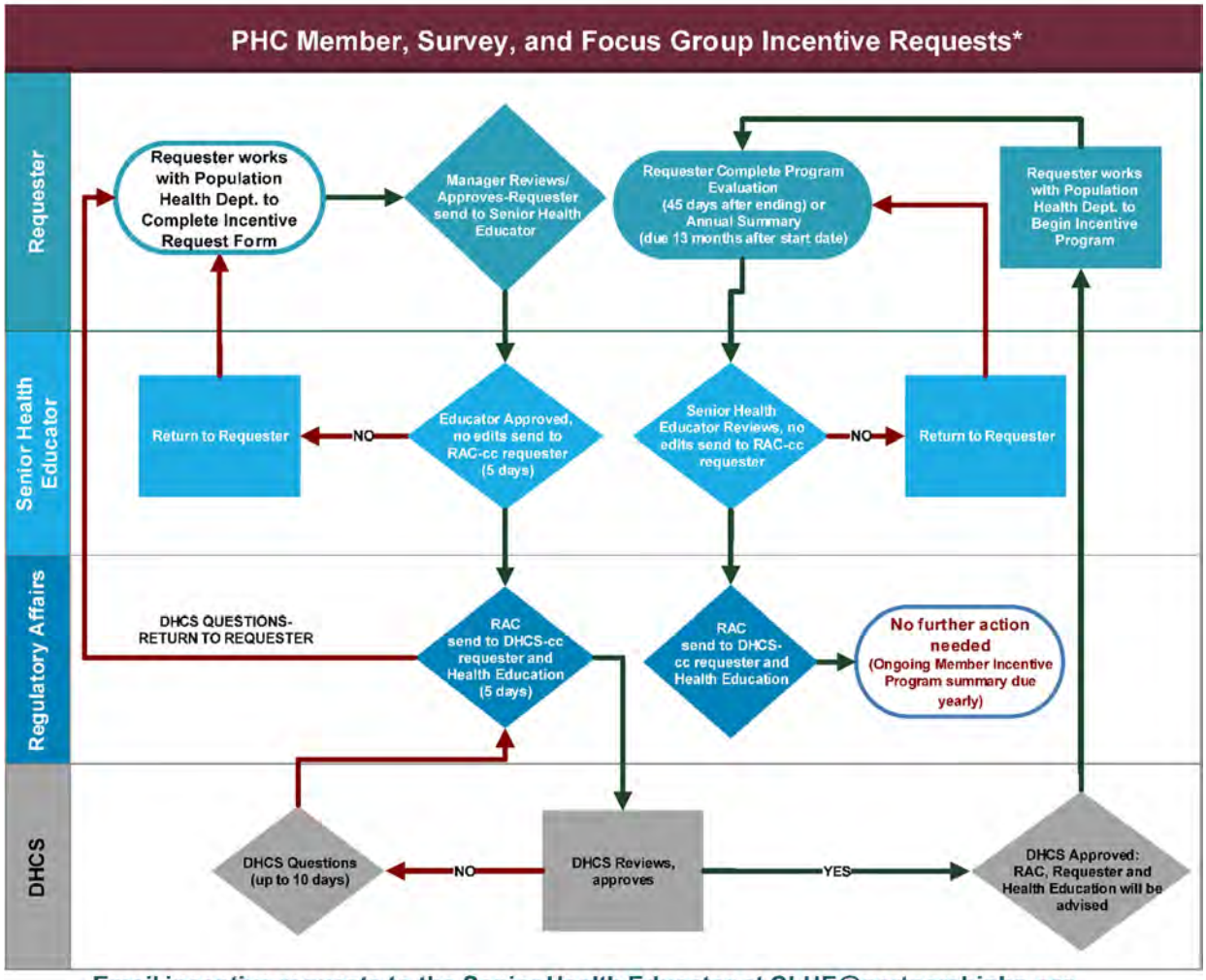
	10/28/2026

Dean Germano~~Kim Tangermann~~ *Date Approved*
Board of Commissioners Chairperson

Appendix A


Partnership Member Material: Approval Process
Department Content Creation
Department owners should consider what other departments to include in the development of member content. It is highly recommended to include Health Education and Communications early in the brainstorming process and not wait until the formal approval process.
Department submit member material to Communications to start formal Member Material Approval process
Communications Review
Work with Health Education counterpart before review by Senior Health Educator (or DHCS Health Education Consultant)
Design/Layout
Text Review
Partnership Branding
Health Education Review
Cultural and Linguistic
Sixth-grade reading level
Medical/Clinical review
Readability and Suitability
Visual requirements
Communications Secondary Review
Copy Edit
Send content to department owner for approval – Once approved Communications will send the material to DHCS or to Health Educator for formal survey review (APL 18-016), including focus group review
Health Education
Health Informing (DHCS)
Member Focus Group
Health Education works with Communications on feedback
Senior Health Educator completes DHCS checklist (DHCS Health Education Consultant Review, if necessary)
RAC submits to DHCS for review and approval
DHCS review (60 days)
Translation
Materials sent for translations, Communications finalizes translated versions of materials
Finishing
Communications works with department owner regarding appropriate distribution
If appropriate, Communications to make material available to all of Partnership – SharePoint and website.
Roles and Responsibilities
Dept – Business Owner
Communications
Health Education
RAC/DHCS

Appendix B



Email incentive requests to the Senior Health Educator at CLHE@partnershiphp.org

*As referenced by MMCD All Plan Letter (APL) 16-005 Revised

Synopsis of Changes to MPND9001

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

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

Synopsis of Changes to MPND9001

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, *i.e.*, NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	External Documentation (Notice required outside of originating department)
		Clarified that providers are informed as appropriate to support referrals and coordination of member care. **P. 43 Community Engagement and Coordination of PHM Programs:** Updated list of Partnership MOUs and refer to MCCP2036 Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities **P. 45 Delivery-System Supports for Population Health Management:** Updated this section with more detail. **P. 48 Partnership Quality Dashboard (PQD):** Added detail for data available through PQD, and information about QI trainings. **P. 50-55 Team Roles and Responsibilities:** Rewrote various department position descriptions to better mirror official job descriptions.	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCNP9004</td><td colspan="3">Lead Department: Health Services
Business Unit: Population Health</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Regulatory Required Notices</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 07/01/2017</td><td colspan="4">Next Review Date: ~~08/13/2026~~09/09/2027
Last Review Date: ~~08/13/2025~~09/09/2026</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="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~08/13/2025~~09/09/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MPND9002 – Cultural and Linguistic Program Description
B. MCUP3064 – Communication Services
C. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
D. CGA024 – Medi-Cal Member Grievance System
E. CMP03 – Compliance Approval Process
F. COM03 – Communication Standards

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Adverse Benefit Determination (ABD): The definition of an Adverse Benefit Determination encompasses all previously existing elements of an "Action" as defined under federal regulations with the addition of language that clarifies the inclusion of determinations involving medical necessity, appropriateness, setting, covered benefits, and financial liability. An ABD is defined to mean any of the following actions taken by a Managed Care Plan (i.e., Partnership HealthPlan of California) per 42 CFR § 438.400:
   1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
   2. The reduction, suspension, or termination of a previously authorized service.
   3. The denial, in whole or in part, of payment for a service.
   4. The failure to provide services in a timely manner.
   5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
   6. The denial of the member's request to obtain services outside the network.
   7. The denial of a member's request to dispute financial liability.

B. Regulatory Required Nondiscrimination Notice: Nondiscrimination Notice states that Partnership follows federal civil rights laws and does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or any other basis protected by federal or State civil rights laws as outlined in in 45 CFR §~~section~~ 92.10(a) and W&I ~~section~~ §14029.91(e)(1)-(5). It includes information on how to file a discrimination grievance directly with Partnership, as well as with the California

Department of Health Care Services' Office of Civil Rights and the U.S. Department of Health and Human Services' Office for Civil Right, as set forth by CGA024 Medi-Cal Member Grievance System.

C. Regulatory Required Notice of Availability: The Notice of Availability of Language Assistance Services and Auxiliary Aids and Services e~~E~~xplains the availability of written member information translated in the member's spoken language, provision of ~~free~~ no cost auxiliary aids and services for people with disabilities, or oral interpretation to understand the information provided, per APL 25-005 and California Welfare and Institutions Code (WIC) 14029.91(a)(3).
D. Notice of Action (NOA): A formal letter informing a member of an adverse benefit determination (ABD).
E. Notice of Appeal Resolution (NAR): A formal letter informing a member that an ABD has been overturned or upheld.
F. Other Informational Notices: References documents intended for the public, such as member-facing website, material (outreach and education) and marketing materials, but also written notices requiring a response from an individual and written notices to an individual, such as those pertaining to rights or benefits, per APL 25-005.

IV. ATTACHMENTS:

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

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

MCPs must adhere to the nondiscrimination notice and~~-~~ notice of availability requirements in APL 25-005 when sending the required grievance and appeals notifications to members.

A. Regulatory Required Notices
   1. As required by State of California statute and effectuated by DHCS All Plan Letters (APLs) 20-015 and 25-005 , Partnership encloses the Nondiscrimination Notice (Attachment A) and Notice of Availability (Notice of Availability of Language Assistance Services and Auxiliary Aids and Services) (Attachment B) inserts with member informing notices including NOAs (Attachment C), NARs (Attachment D), and grievance notices, and all Other Informational Notices targeted to members. Notices must be provided at no cost to the Member. For further details, refer to MPND-9002 Cultural and Linguistic Program Description.
B. Exceptions
   1. Nondiscrimination Notice and Notice of Availability inserts are not required if they are embedded within the member material (e.g. Partnership Medi-Cal Member Handbook).
C. NOA "Your Rights under Medi-Cal Managed Care"
   1. The NOA "Your Rights under Medi-Cal Managed Care" document (Attachment C) must accompany any member notification of an ABD.
   2. The written NOA must meet all language and accessibility standards, including translation, font, and format requirements, as set forth in APL 25-005, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services, federal and state law, and all requirements in the DHCS contract.
   ~~2.~~3. The NOA shall clearly explain the reason for the decision and the Member's appeal rights per 42 CFR §438.404.
D. NAR "Your Rights under Medi-Cal Managed Care"
   1. The NAR "Your Rights under Medi-Cal Managed Care" document (Attachment D) must accompany

member notification of a member's appeal resolution. The NAR shall state whether the decision was upheld or overturned.

2. The written NAR must meet all language and accessibility standards, including translation, font, and format requirements, as set forth in APL 25-005, Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services and Alternative Formats, federal and state law, and all requirements in the DHCS contract.

VII. REFERENCES:

A. California Welfare and Institutions Code (WIC) 14029.91(a)(3) and 14029.91(e)(1)-(5).
~~A.~~B. 42 CFR Part 438 Subpart F Grievance and Appeal System Requirements
~~B.~~C. California Department of Health Care Services (DHCS) APL 20-015 State Non-Discrimination and Language Assistance Requirements (06/24/2020)
~~C.~~D. California Department of Health Care Services (DHCS) APL 25-005 Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services and Alternative Formats (02/12/2025)
~~D.~~E. California Department of Health Care Services (DHCS) APL 21-011 Grievance and Appeals Requirements, Notice and "Your Rights" Templates (08/31/2022)
~~E.~~F. U.S Department of Health and Human Services (HHS) 45 CFR section 92.10(a).

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

MCNP9004 – Initial 09/09/20; 09/08/21; 03/09/22; 09/14/22; 06/14/23; 09/13/23; 09/11/24; 08/13/25; 09/09/26

PREVIOUSLY APPLIED TO:

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

REGULATOR APPROVAL:

DHCS – last approved 06/12/25 for APL 25-005

NONDISCRIMINATION NOTICE

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

Partnership provides:

- Free aids and services in a timely manner to people with disabilities to help them communicate better, such as:

    - ✓ Qualified sign language interpreters
    - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services in a timely manner to people whose primary language is not English, such as:

    - ✓ Qualified interpreters
    - ✓ Information written in other languages

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

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

HOW TO FILE A GRIEVANCE

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

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

- By phone: Contact Partnership's Member Services between 8 a.m. – 5 p.m. by calling (800) 863-4155. Or, if you cannot hear or speak well, please call (800) 735-2929 or California Relay 711.

- In writing: Fill out a complaint form or write a letter and send it to:

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

- In person: Visit your doctor's office or Partnership and say you want to file a grievance.

- Electronically: Visit Partnership's website at www.PartnershipHP.org.

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.

- In writing: Fill out a complaint form or send a letter to:

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

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

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

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

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

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

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

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

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

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

---

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

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

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

ខ្មែរ (Cambodian)
ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា រសូមទូរស័ព្ទទៅលេខ 1-800-863-4155 (TTY: 1-800-735-2929)។ ជំនួយនិងបសវាកម្មសម្រាប់ជនពិការ ដូចជាឯកសារសរុបសរនេះអាចរកបាន។ ទូរស័ព្ទមកប៉ុន្មានតាមលេខ 1-800-863-4155 (TTY: 1-800-735-2929) ។ សេវាកម្មទាំងនេះមិនគិតថ្លៃទេ។

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

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

हिंदी (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-800-863-4155 (TTY: 1-800-735-2929) पर कॉल करें। अशक्तता वाले लोगोंी कललए सहायता और सेवाऐं, जैसे ब्रेल और बडे लरोंट में भी दस्तावेज़ उपलब्ध हैं। 1-800-863-4155 (TTY: 1-800-863-4155) पर कॉल करें। ये सेवाऐं लन: शुल्क हैं।

Hmoob (Hmong)

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

日本語 (Japanese)

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

한국어 (Korean)

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

ພາສາລາວ (Laotian)

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອ ໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ 1-800-863-4155 (TTY: 1-800-735-2929).ຍັງມີຄວາມຊ່ວຍເຫຼືອ ແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ 1-800-863-4155 (TTY: 1-800-735-2929). ການບໍລິການເຫົ ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-800-863-4155 (TTY: 1-800-735-2929). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh

mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-800-863-4155 (TTY: 1-800-735-2929).Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-800-863-4155 (TTY: 1-800-735-2929). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਏਡਜ਼ ਅਤੇ ਸੇਵਾਵਾਂ, ਬ੍ਰੇਲ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ਾਂ ਦੀ ਤਰ੍ਹਾਂ ਵੀ ਉਪਲਬਧ ਹਨ| ਕਾਲ ਕਰੋ 1-800-863-4155 (TTY: 1-800-735-2929). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ|

Русский (Russian)

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

Español (Spanish)

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

Tagalog (Filipino)

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

ภาษาไทย (Thai)

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-863-4155 (TTY: 1-800-735-2929). น อกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ ส าหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-863-4155 (TTY: 1-800-735-2929). ไม่มีค่าใช้จ่ายส าหรับบริการเหล่านี้

Українська (Ukrainian)

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

Tiếng Việt (Vietnamese)

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

YOUR RIGHTS
UNDER MEDI-CAL MANAGED CARE

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

HOW DO I ASK FOR AN APPEAL?

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

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

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

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

- By phone: Contact Partnership HealthPlan of California between 8 a.m. – 5 p.m. by calling (800) 863-4155. If you cannot hear or speak well, please call (800) 735-2929 or California Relay 711.

- In writing: Fill out an appeal form or write a letter and send it to:

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

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

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

WHEN WILL MY APPEAL BE DECIDED?

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

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

CAN I ASK FOR A STATE HEARING?

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

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

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

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

You will not have to pay for a State Hearing.

HOW DO I REQUEST A STATE HEARING?

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

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

- Online at www.cdss.ca.gov

- By phone: Call 1-800-743-8525. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call TTY/TDD 1-800-952-8349.

- In writing: Fill out a State Hearing form or write a letter. Send it by mail or fax to:

  Mail: California Department of Social Services
  State Hearings Division
  744 P Street, Mail Station 9-17-433
  Sacramento, CA 95814

  Fax: Toll-free at 1-833-281-0903

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

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

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

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

LEGAL HELP

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

MCNP9004 Attachment C

STATE HEARING

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

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

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

- Online at www.cdss.ca.gov

- By phone: Call 1-800-743-8525. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call TTY/TDD 1-800-952-8349.

- In writing: Fill out a State Hearing form or write a letter. Send it by mail or fax to:

  Mail: California Department of Social Services
  State Hearings Division
  744 P Street, Mail Station 9-17-433
  Sacramento, CA 95814

  Fax: toll-free at 1-833-281-0903

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

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

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

LEGAL HELP

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

Quality and Performance Improvement Program Description

September 2026~~5~~
MPQD1001

Program Approval

	08/19/2026

Robert Moore, MD MPH MBA
Quality/Utilization Advisory Committee (Q/UAC) Chairperson *Date Approved*

	09/09/2026

Angela Brennan, DO
Physician Advisory Committee (PAC) Chairperson *Date Approved*

	10/28/2026

Dean Germano
Board of Commissioners Chairperson *Date Approved*

TABLE OF CONTENTS

Program Purpose and Goals	~~4~~
Scope of Quality and Performance Improvement Program	~~5~~
Authority and Responsibility	~~6~~
Approach to Quality and Performance Improvement	~~17~~
Cultural Competency	~~40~~
Communication Systems	~~40~~
Delegation	~~42~~
Sanctions	~~42~~
Annual Quality Improvement Work Plan	~~42~~
Review by Outside Licensing Agencies or Accrediting Bodies	~~42~~
Annual Quality Improvement Program Evaluation	~~43~~
Statement of Confidentiality	~~43~~
Statement of Conflict of Interest	~~44~~
Appendix A	
Standing Staff Members of Partnership HealthPlan of California's Quality Improvement Committees	~~46~~
~~Appendix B~~	
~~Partnership HealthPlan Strategic Quality Plan: Achieving Five-Star Quality~~	~~59~~
Appendix ~~C~~B	
Pathway to Excellence: Partnership HealthPlan of California's Framework for Continuous Learning	~~72~~
Appendix ~~C~~D	
Resumes for Key Leadership Roles Accountable for Implementing and Maintaining the QI/PI Program	~~103~~

Program Purpose and Goals

Partnership HealthPlan of California's (Partnership) Quality and Performance Improvement (QI/PI) program provides a series of systematic processes to monitor and evaluate the quality of clinical care and health care service delivery to all Partnership members. This includes an organized framework to:

- Review activities and identify opportunities to improve the quality of health care services provided
- Promote efficient and effective use of health plan financial resources
- Promote and improve health equity by integrating equity considerations into all quality improvement activities
- Strike a balance between compliance with and performance on regulatory standards
- Partner with internal and external stakeholders to support performance improvement
- Improve health outcomes of our members

The QI/PI program promotes consistency in assessing and improving the quality of the full scope of health care services while providing a mechanism to:

- Ensure integration with current community and population health priorities, standards, and goals that impact the health of the Partnership member population
- Ensure alignment with DHCS' Comprehensive Quality Strategy Report
- Identify and act on opportunities to improve care and service
- Identify overuse, underuse, and misuse of health care services
- Identify and act on opportunities to improve processes to ensure member safety
- Identify and act on opportunities to address disparities in health access and outcomes
- Address potential or tangible quality issues
- Review trends that suggest variations in the process or outcomes of care

The QI/PI program adheres to the following goals to improve the quality and effectiveness of clinical care and service to Partnership members:

- Improve the health of the populations Partnership serves
- Enhance the member care experience
- Support the delivery of high-quality clinical care
- Reduce disparities in health access and outcomes
- Ensure member safety
- Measure and encourage appropriate use of clinical resources
- Strengthen a culture of continuous quality improvement within the Partnership network

The QI/PI program accomplishes these goals by:

- Systematically monitoring and evaluating service and care provided
- Continuously improving our data and approach to analytics to validate care outcomes
- Actively pursuing opportunities for improvement in areas that are relevant and important to Partnership members' health
- Implementing strong interventions when opportunities for performance improvement are identified
- Addressing overall member experience by improving provider access and member awareness of the health plan's role and responsibilities
- Promoting a culture of learning and improvement through a framework called Pathway to Excellence: Partnership's Framework for Continuous Learning (P2E)

These goals align with Partnership's mission: To help our members and the communities we serve be healthy.

Applying the model of a learning organization, the measurement and analysis of selected indicators and professionally recognized standards of practice underpin the evaluation of QI/PI activities. The objectives of the program are to:

- Engage providers, members, and community stakeholders to improve quality metrics through identifying opportunities for improvement and acting on opportunities that have the greatest impact on member care. These actions are driven by rigorous data analysis, whenever possible, and through a collaborative atmosphere where new ideas can be explored and tested to enhance learning.
- Improve member experience through enhanced primary care provider (PCP) and specialty care access.
- Strengthen the data and analytics infrastructure through the development of foundational systems and processes for evaluation of results and decision-making.
- Achieve and maintain pertinent National Committee for Quality Assurance (NCQA) accreditations while ensuring compliance with contractual quality requirements, state and federal quality regulations, evidence-based standards of care, and standards of selected accrediting bodies.
- Equip PCPs to provide recommended high-quality care through provision of information, technical assistance, improvement tools, and financial incentives.
- Optimize value-based programs through measure research and incorporation of best practices.

The objectives, scope, organization, and mechanisms for overseeing effectiveness of monitoring, evaluation, and problem-solving activities in the QI/PI program are assessed and revised at least annually.

Scope of Quality and Performance Improvement Program

The scope of the QI/PI program includes the quality of clinical care and of service for all members. The program presently covers a Medi-Cal (the name for Medicaid in California) product line and includes ~~the~~ an anticipated integration of a Dual Eligible Special Needs Plan (D-SNP)~~, Partnership Advantage, in 2027~~. This is specifically defined as an Exclusively Aligned Enrollment (EAE) D-SNP. Partnership aims to become a Medicare Medi-Cal Health Plan, joining other managed care plans across California, in offering members eligible for both Medi-Cal and Medicare the opportunity for one plan to manage all of their benefits, including care coordination and other wraparound services.

The monitoring and evaluation of clinical issues reflects the population served by Partnership without regard to age group, disease category, or risk status. In partnership with other Partnership departments, the QI/PI program encompasses all aspects of medical care including:

- Diagnoses and procedures with a wide variation in cost or utilization patterns
- Identifying overuse, underuse and misuse of health care services and prescription medications
- Identifying and addressing racial/ethnic and other disparities in health care delivery or outcomes
- Identifying and addressing access or quality issues related to behavioral health services through delegated contracts
- Promoting cultural and linguistic competence of Partnership staff and network practice sites and providers
- Member Experience Outcomes
- Facility Site Reviews and ongoing monitoring to assess compliance with patient safety standards
- Ambulatory medical records review
- An assessment of physical accessibility of outpatient providers for seniors and persons with disabilities
- Preventive health care guideline compliance
- Chronic and acute care clinical practice guideline (CPG) compliance
- Continuity and coordination of care between PCPs and specialists, different levels of care, PCPs and other provider types, and PCPs and Behavioral Health Practitioners (through the Care Coordination department)
- Accessibility and quality of primary, specialty, and behavioral health care
- Member grievances (through the Grievance & Appeals department)
- Investigation and resolution of Potential Quality Issues (PQIs)
- Provider satisfaction (through the Provider Relations department)
- Provider credentialing (through the Provider Relations department)

- Supporting clinics in achieving patient centered health homes

The QI/PI program encompasses monitoring and evaluation of care and service in the following settings:

- Acute hospital services
- Ambulatory care, including preventive health care, perinatal care, chronic disease management, and family planning
- Emergency and urgent care services
- Behavioral health services* (mental health and substance use disorder)
- Ancillary care services including but not limited to: home health care, skilled nursing care, subacute care, pharmacy, medical supplies, durable medical equipment (DME), therapy services, laboratory, vision, and radiology services
- ~~Long~~ Extended care facility~~term care~~ placements in skilled nursing facilities, subacute care facilities, and intermediate care facilities.
- Dental Services (currently carved out by the state, but certain aspects are still monitored)
- Wellness and Recovery Program

Refer to the Approach to Quality and Performance Improvement section for more information on Behavioral Health Services

Authority and Responsibility

Board of Commissioners

The Board of Commissioners on Medical Care (the Commission) promotes, supports, and has ultimate accountability, authority, and responsibility for a comprehensive and integrated QI/PI program. The Commission is ultimately accountable for the quality of care and services provided to members. The Commission has delegated direct supervision, coordination, and oversight of the QI/PI program to the Physician Advisory Committee (PAC), which serves as the main Quality Improvement committee. PAC is supported by two other quality committees – the Quality and Utilization Advisory Committee (Q/UAC) and the Internal Quality Improvement Committee (IQI), which are described in more detail below. The county Boards of Supervisors for each geographic area appoints members of the Commission, which include representatives from the community, including consumers, businesses, physicians, providers, hospitals, community clinics, HMOs, local government, and County Health departments. The Commission meets six times per year.

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

Key Roles

The following leadership roles carry authority and responsibility to ensure the QI/PI Program is fully implemented and maintained. The qualifications of staff presently fulfilling these roles are detailed in Appendix D which includes documented evidence corresponding to that collected annually on behalf of DHCS. Given the personal details included, this appendix is not posted publicly.

Chief Executive Officer

The Partnership Chief Executive Officer's (CEO) primary roles in quality management and improvement are multifaceted. The CEO maintains a working knowledge of the clinical and service issues targeted for improvement and provides overall organizational leadership and direction in these efforts. In addition, the CEO identifies new and emerging opportunities to strengthen accountability among both internal teams and external partners in driving quality and performance improvement. They are actively involved in the prioritization and oversight of quality improvement activities across the organization and ensure that the necessary resources are available to support the successful implementation of the approved QI/PI program.

Chief Operating Officer

The Chief Operating Officer (COO) provides strategic leadership and guidance in all health plan operations. The COO has purview over the Member Services, Network Services, Provider Contracting, Provider Relations, Claims, Configuration, Grievance and Appeals, Transportation and the Regional Leadership departments and ensures that these departments incorporate and prioritize quality improvement work and processes in coordination with standing work. The COO's level of involvement fulfills the need for executive support and accountability for data quality improvements, and interdepartmental support for quality improvement interventions and initiatives.

Chief Health Services Officer

The Chief Health Services Officer (CHSO) works closely with leaders in Utilization Management to provide accountability for delegates to meet necessary NCQA accreditation requirements and provide strategic leadership and guidance in the review and revision of provider contracts to ensure QI reporting requirements and value-based program contingencies are met. The CHSO also has purview over the Care Coordination, Utilization Management, Enhanced Health Services, Behavioral Health and Health Equity departments and ensures that these departments incorporate and prioritize quality improvement work and processes in coordination with standing work. The CHSO's level of involvement fulfills the need for executive support and accountability for improvements with data quality ~~AND~~ and coordination of activities between QI and these departments**.** This role collaborates with the Chief Medical Officer and members of PAC, Q/UAC, and IQI in matters involving quality of care, clinical, and medical procedures.

Chief Medical Officer

The Chief Medical Officer (CMO), with the assistance of the members of PAC, Q/UAC, and IQI, as well as the other medical directors of Partnership, is responsible for providing professional judgment regarding matters of quality of care, peer review, clinical, and medical procedures. The CMO is the chair of IQI and Q/UAC and has significant involvement in all QI/PI, Pharmacy, and Health Services activities as well as providing oversight to these programs on a day-to-day basis. The CMO is a Medical Doctor (MD) or Doctor of Osteopathy (DO) with an unrestricted license in the State of California.

Deputy Chief Medical Officer

Assists the Chief Medical Officer (CMO) in oversight of the appropriateness and quality of care ~~delivered through Partnership HealthPlan of California~~. Serves as the interim CMO when the CMO is absent, unavailable or as requested, which includes representing the CMO in state policy and regulatory activities. ~~Assists the CMO with determining the medical necessity of in-patient and out-patient services including pharmacy services listed on the Medi-Cal or Partnership Treatment Authorization Request (TAR) list using Partnership adopted criteria. Monitors the effectiveness of QI activities including determination of return on investment. Serves on Quality/Utilization Advisory Committee, Pharmacy & Therapeutics Committee, Credentials Committee and Internal Quality Improvement Committee as requested by the Chief Medical Officer. Reviews potential quality issues and patient safety issues and determines their appropriateness for review by the Peer Review Committee.~~ The Deputy CMO is a Medical Doctor (MD) or Doctor of Osteopathy (DO) with an unrestricted license in the State of California.

Medical Director for Quality

Assists CMO by providing physician support for varying activities within the QI/PI department, including Performance Improvement, Member Safety, Peer Review, and the Quality Incentive Programs, as well as assists with utilization management review activities. This role also serves as the lead Medical Director for reviewing member grievances for Potential Quality Issues, ~~serves~~ ~~as~~Chair of the Credentials Committee and management oversight for the Member Safety teams within the QI/PI department. ~~.~~ The Medical Director for Quality is a Medical Doctor (MD) or Doctor of Osteopathy (DO) with an unrestricted license in the State of California.

Medical Director of Medicare Services

This role provides physician leadership in preparation for implementing ~~the~~ a future Medicare Dual Special Needs Plan (D-SNP). This medical director works closely with the CMO and QI/PI Department to develop policy, strategy,

and tactical activities with Medicare leads designated in departments across the organization. As D-SNP is implemented, this role will provide medical leadership for Partnership's Medicare activities, including utilization management, quality, care coordination, pharmacy, grievances, and compliance activities. ~~Also assists CMO, as requested, in supporting broader needs to oversee appropriateness and quality of care delivered through Partnership and for the cost-effective utilization of services.~~

Senior Director of Quality and Performance Improvement
This role works collaboratively with the CMO to define strategy, develop programs and services, and to evaluate the effectiveness of the QI/PI Program. Together with the QI management team, including the Medical Director for Quality, provides oversight of Facility Site Reviews, investigation of potential quality issues, compliance with NCQA standards, HEDIS® and other performance measure data collection and performance reporting, value-based payment programs (QIPs), performance improvement initiatives and programs, external and internal QI training, provider education on the QIPs and HEDIS®, grant application and grant management. This role works to foster greater cross collaboration of QI staff and strategic involvement of other departments to support the execution of tactics defined and maintained under Partnership's 5-Star Quality Strategy.

Chief Strategy & Government Affairs Officer
The Chief Strategy and Government Affairs Officer (CSGAO) reports to the Chief Executive Officer and is a peer to the other executive team members. The CSGAO leads the overall strategic direction of the HealthPlan in consultation with the CEO and Governing Board. This position is responsible for the operations and executive management of ~~Regulatory Affairs and Compliance (RAC);~~ Communications~~, Legal, Network Services,~~ and Project Management/Operational Excellence (PMO) departments. This position also oversees our Medicare Duals Special Needs Plan (D-SNP) program.

Senior Director of Regulatory Affairs & Compliance~~ntracting~~
This position serves as Partnership's Compliance Officer~~,~~ working to ensure the HealthPlan's ongoing compliance with all applicable federal, state, local, and administrative agency statutory and regulatory requirements. Furthermore, this position serves as Partnership's Fraud Prevention Officer and Privacy Officer; is a subject matter expert in fraud and privacy and is responsible for promoting the prevention, detection, and deterrence of fraud and privacy risks while ensuring Partnership~~HC~~ complies with all state and federal privacy and fraud laws.

Behavioral Health Clinical Director
The Behavioral Health Clinical Director holds an MD/DO, PhD or PsyD credential. With the assistance of the Behavioral Health team, this individual is responsible for providing professional judgment regarding matters of quality of care, peer review, and clinical policies and procedures through oversight of Partnership activities in the areas of mental health and substance use disorder services as provided by Partnership's providers and delegated behavioral health providers.

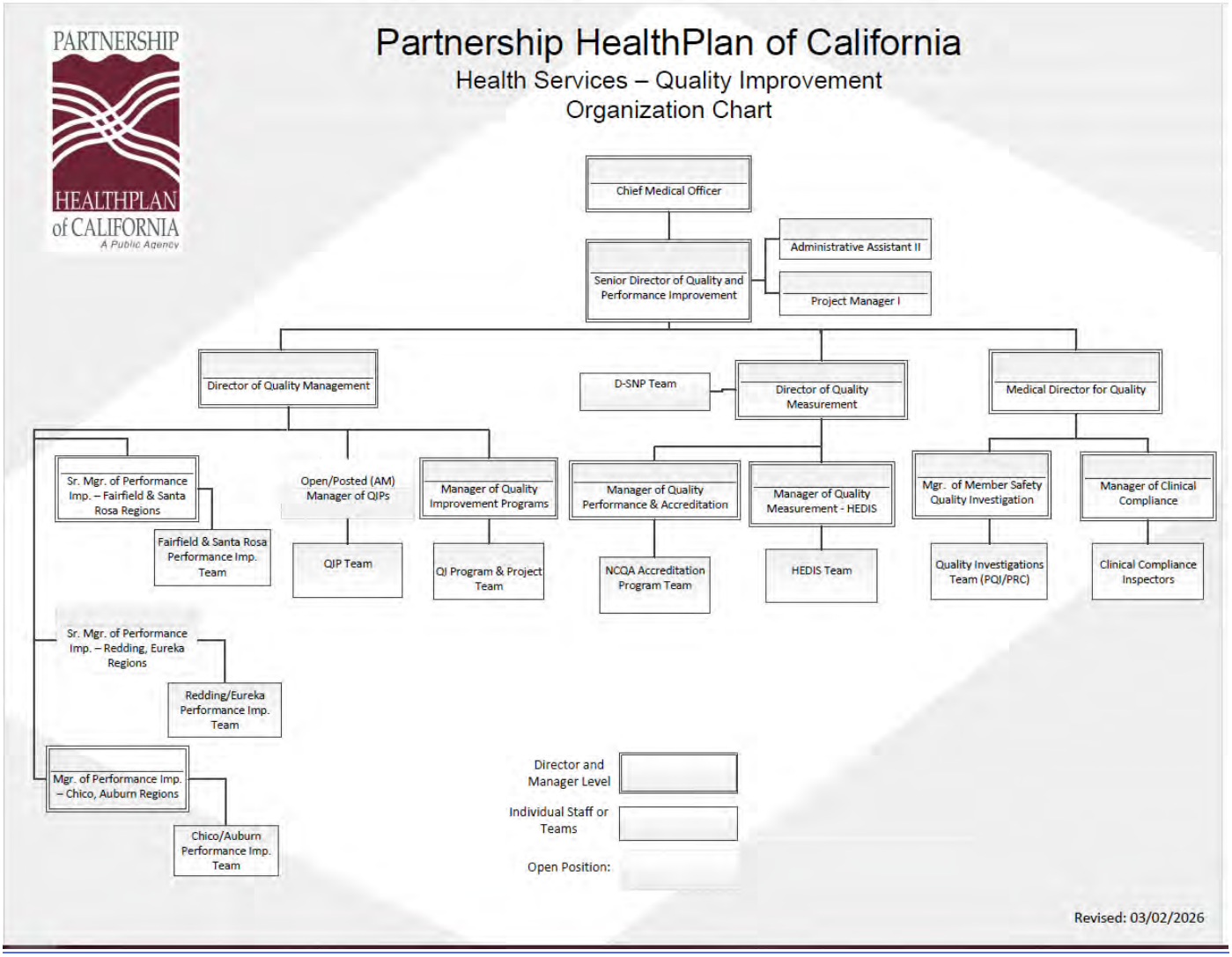
Senior Director of Behavioral Health
Under the direction of the Chief Health Services Officer (CHSO), the Senior Director of Behavioral Health leads the Behavioral Health team to oversee the operations and delegated functions of Partnership's mental health and substance use disorder services. This position plays an integral role in Partnership's annual audit of Carelon Behavioral Health, which stipulates that the organization produces evidence that specialists in Behavioral Health ~~Specialists~~ at the level of PhD and/or MD are on their QI Committee or teams that report to their QI Committee. ~~Carelon meets this standard.~~

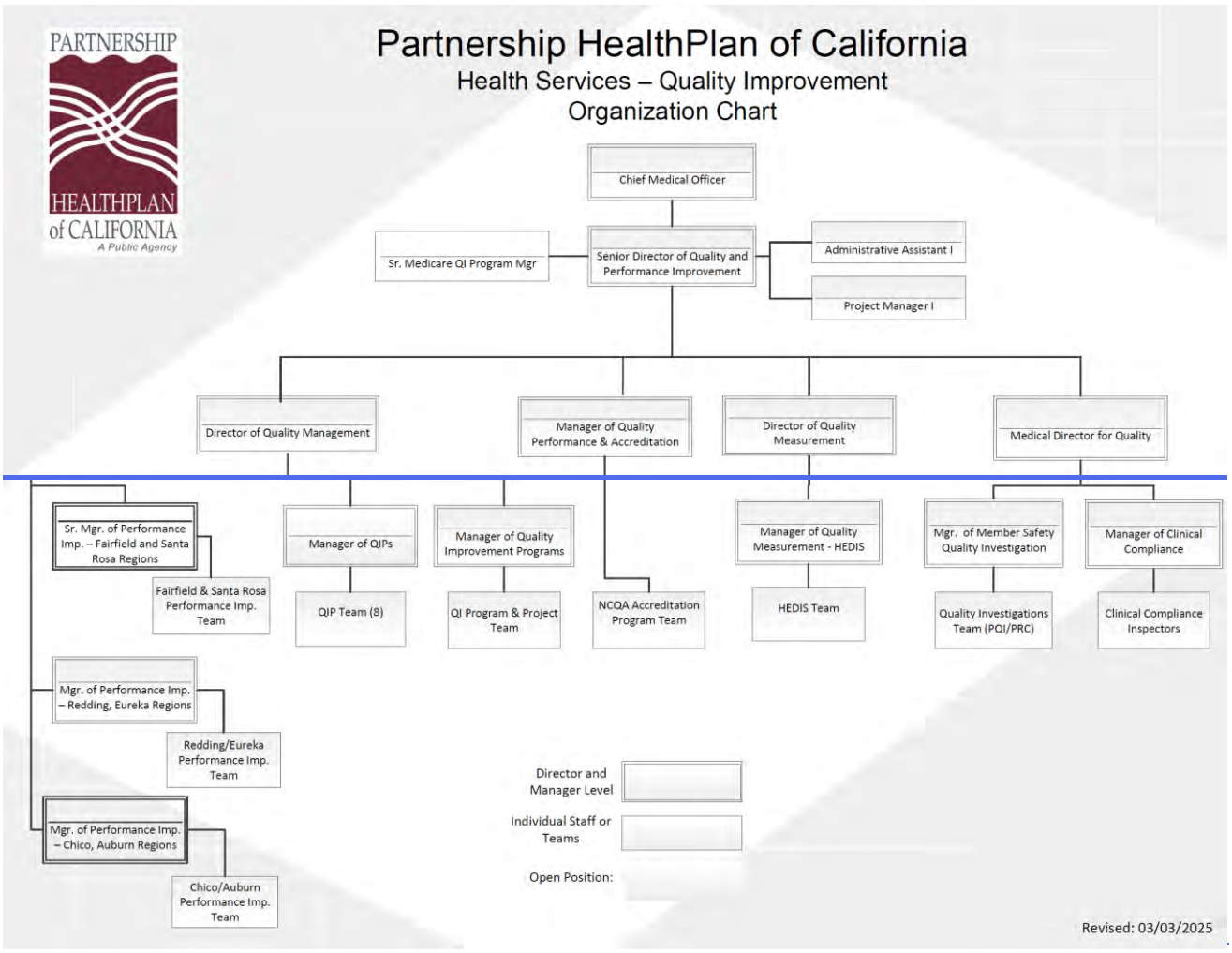
Director of Health Equity (Health Equity Officer)
The Director of Health Equity serves as the Health Equity Officer (HEO) for Partnership. In collaboration with Partnership leaders, the Director of Health Equity leads the development and implementation of strategies that advance health equity initiatives ~~diversity, equity, and inclusion~~ across the organization. This role drives systemic

change to enhance representation and cultivates programs that foster a culture of belonging. It also promotes awareness of health inequities within our membership and guides the creation of actionable plans to address them. Key responsibilities include identifying opportunities to track, analyze, and reduce disparities in care, with a focus on the varied cultural, linguistic, economic, educational, and health needs of our communities and workforce. In collaboration with the CMO, oversees the Quality Improvement and Health Equity Transformation Program (QIHETP) program operations and assists in the development and coordination of QIHETP policies and procedures.

Director of Population Health Management
The Director of Population Health Management works collaboratively with leaders across the organization, to execute the organization's Population Health Management strategy. This role provides oversight, strategic direction, and support for related initiatives, including those essential to improving quality measure performance and member experience. This role offers guidance and ensures alignment with health care policies, financing, accreditation requirements, and regulations to drive optimal improved health outcomes for members.

Program Staff
Partnership QI/PI program leadership and corresponding teams are outlined in the organizational chart below.


Partnership HealthPlan of California
Health Services – Quality Improvement
Organization Chart
Chief Medical Officer
Senior Director of Quality and Performance Improvement
Administrative Assistant II
Project Manager I
Director of Quality Management
D-SNP Team
Director of Quality Measurement
Medical Director for Quality
Sr. Mgr. of Performance Imp. – Fairfield & Santa Rosa Regions
Fairfield & Santa Rosa Performance Imp. Team
Open/Posted (AM) Manager of QIPs
QIP Team
Manager of Quality Improvement Programs
QI Program & Project Team
Manager of Quality Performance & Accreditation
NCQA Accreditation Program Team
Manager of Quality Measurement - HEDIS
HEDIS Team
Mgr. of Member Safety Quality Investigation
Quality Investigations Team (PQI/PRC)
Manager of Clinical Compliance
Clinical Compliance Inspectors
Sr. Mgr. of Performance Imp. – Redding, Eureka Regions
Redding/Eureka Performance Imp. Team
Mgr. of Performance Imp. – Chico, Auburn Regions
Chico/Auburn Performance Imp. Team
Director and Manager Level
Individual Staff or Teams
Open Position:
Revised: 03/02/2026

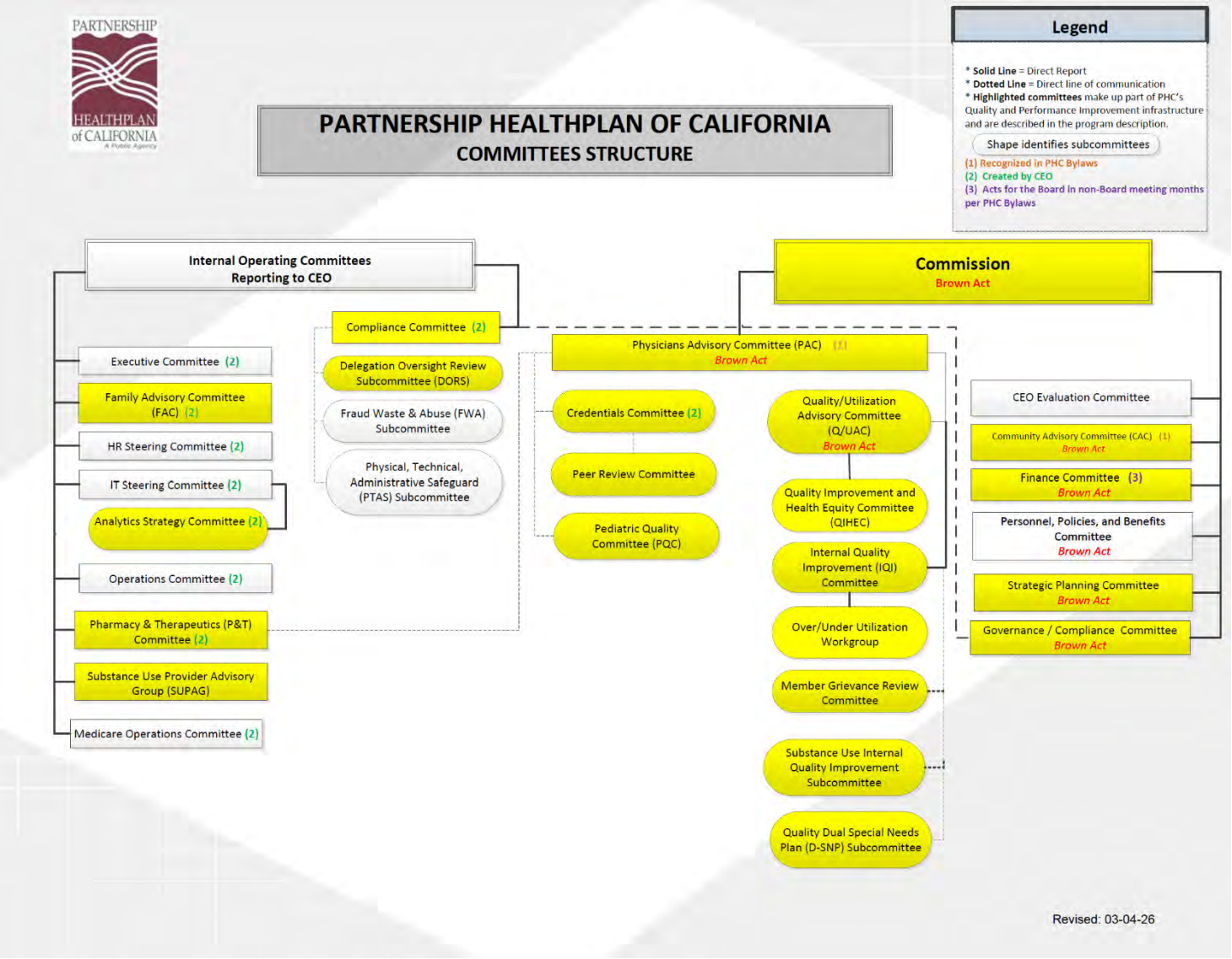


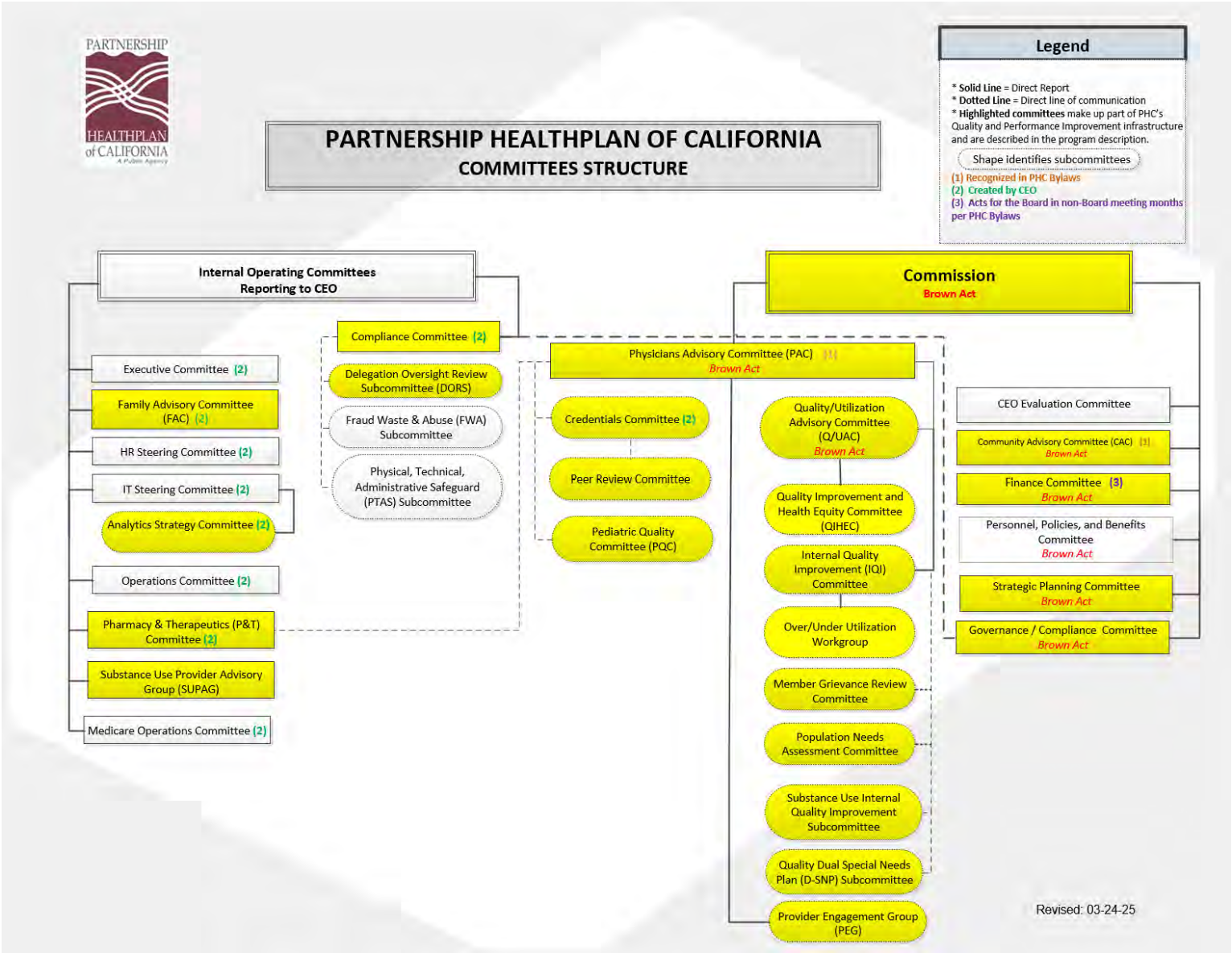
The QI/PI department is structured to provide governance over the QI program and corresponding work plan. Under the guidance of the CMO, the Senior Director of Quality and Performance Improvement and respective directors in QI/PI lead the department in the execution of QI/PI activities outlined in the QI Program Description and QI Work Plan. The department ensures the primary activities related to performance improvement, adherence to regulatory requirements, and the quality and safety of clinical care to optimize members' experience with Partnership are completed through ongoing engagement and the provision of interdisciplinary support to all areas within Partnership.

Committee Functions

Partnership has developed a robust committee structure to support the breadth and depth of multiple facets of QI/PI regulatory requirements and activities. There are several internal operating committees that report to the CEO and a number of external facing committees, principally PAC and four others that report directly to the

Board of Commissioners. Certain committees must adhere to state regulations, including the Brown Act, which provides stipulations for making meetings available to the public. The diagram below describes how committees are organized and the reporting structures. This is followed by a narrative briefly describing each committee, in alphabetical order, essential to the Quality and Performance Improvement infrastructure.





Analytics Steering Committee

The Analytics Steering Committee (ASC) is a multidisciplinary forum with representatives from Claims, QI/PI, Office of the CMO, Health Services, Members Services, Behavioral Health, Strategy and Government Affairs, Provider Relations, Finance, and IT. The ASC is part of the Analytics Center of Excellence (ACE), an enterprise-wide virtual framework that functions to promote and coordinate data analytics efforts to generate information, knowledge and wisdom to improve health outcomes, enhance the member experience of care, and reduce or maintain the cost of care by optimizing utilization of data, technology and staff.

The ASC meets every other month throughout the year with the following foci:

- Act as an advocate for data analytics initiatives and projects across the wider organization
- Provide oversight and guidance for Partnership's data analytics projects across all regions
- Provide recommendations based on data analysis and strategic planning
- Inform and advise the Data Governance Council (DGC) on relevant analytic initiatives and cooperates with the DGC to ensure alignment with overall data strategy
- Review and monitor policies to guide data analytics throughout Partnership
- Promote and foster data analytics, data interpretation, and data sharing to improve the utility of data for planning and decision-making, especially related to current issues, initiatives, and integrated problem-solving. (Analytics Champion)
- Establish project goals for the ACE as well as determine how success will be measured

- Act as final authority for resolving issues or disputes on analytics prioritization and needs
- Identify and advise on minimizing project and business risks
- Establish subcommittees as required to facilitate the work of the committee

Compliance Committee
The Compliance Committee, chaired by the Compliance Officer, is an internal committee and has general responsibility to oversee Partnership's compliance and ethics programs. The purpose of the Committee is to oversee Partnership's implementation of compliance programs, policies and procedures that are designed to respond to the various compliance and regulatory risks facing the company; provide an avenue of communication among management, those persons responsible for the internal compliance function, and the Commission; and perform any other duties as directed by the Commission or the CEO.

Community Advisory Committee (CAC)
The Community Advisory Committee (CAC) is composed of Partnership members, advocates and stakeholders who represent the diversity and geographic areas of Partnership's membership including hard-to-reach populations. The CAC may also include participation from select providers within the service area. Partnership ensures that all Subcontractors and Network Providers comply with all applicable state and federal law and regulations. The CAC acts as a~~is a~~ liaison group between our members and Partnership, advocating for members by ensuring that the health plan is responsive to the health care and information needs of all members. Additionally, the CAC provides Partnership members with a forum that allows meaningful engagement and the ability to ~~to~~ discuss common issues of interest and importance, while creating a supportive and informative environment. The CAC meets quarterly, reviews and makes recommendations regarding quality improvement activities, provides feedback on quality and health equity initiatives, and serves in the capacity of a focus group. Three CAC members are selected to serve on the Partnership Board to provide member input and report back to the CAC.

Credentials Committee
The Partnership CMO, or designee, chairs the Credentials Committee. Committee members include a minimum of five contracted network practitioners. The committee meets monthly~~, excluding July and December~~. The functions of the Credentials Committee are to:

- Participate in and make recommendations regarding the structure and process for the credentialing and re-credentialing of providers and licensed practitioners
- Participate in the development, implementation, and annual review of related policies and procedures
- Review and approve Partnership staff recommendations for credentialing of practitioners who meet criteria
- Review and approve Partnership staff recommendations for credentialing of practitioners who do not meet exception criteria

- Review qualifications and circumstantial details for contracted practitioners who meet exception criteria and make credentialing decisions
- Review and evaluate the qualifications of each practitioner seeking re-credentialing as a contracted provider at least every three years and assure compliance with established criteria
- Review ongoing sanctions monthly and member complaints quarterly for each practitioner
- Verify that each provider in the network meets credentialing requirements, including implementation of and adherence to any corrective action plans (CAPs) to meet standards
- Decisions regarding provider credentialing and re-credentialing
- Develop disciplinary or sanction actions of practitioners
- Provide oversight of any delegated credentialing activities

Summary information of credentialing activities is presented to the PAC and to the Partnership Board of Commissioners at regularly scheduled meetings.

Delegation Oversight Review Subcommittee (DORS)

The Delegation Oversight Review Subcommittee (DORS) comprises representatives from operational departments that have oversight responsibility wherein Partnership has assigned authority to an external entity (delegated entity) to perform on its behalf. DORS meets no less than four times per year and is responsible for overseeing performance under agreements and fulfillment of responsibilities between Partnership and its delegated entities. The Subcommittee is tasked with overseeing that delegates are compliant with all applicable state and federal regulations, contractual obligations, and accreditation requirements.

Quality Dual Special Needs Plan (D-SNP) Sub-Committee

The Quality D-SNP Sub-Committee is led by the ~~Medical Director of Medicare Services~~Deputy Chief Medical Officer and includes members from each of the following departments: Quality and Performance Improvement, Care Management, Finance, Strategy and Government Affairs, Pharmacy, Population Health, Health Equity, Information Technology, Health Analytics, Health Services, Utilization Management, Grievance and Appeals, Transportation Services, and Provider Relations. The committee meets a minimum of ten times per year with the option of adding additional meetings if needed. The purpose of this committee is to report on the Model of Care (MOC), CMS and DHCS requirements for Partnership's D-SNP program to ensure this vulnerable population of members is receiving quality care. The Quality D-SNP Sub-Committee will serve as a vessel to monitor, plan and ~~correct~~improve D-SNP program performance. A summary of activity from the committee is annually reported to IQI and Q/UAC (as part of D-SNP required reporting under Utilization Management) and Partnership's Compliance Committee. The scope of the annual summary includes all information related to the Medicare/D-SNP program including but not limited to:

- MOC performance
- CAPs
- Over/Under Utilization Committee updates as they relate to Medicare
- P&T Committee updates as they relate to Medicare

Family Advisory Committee (FAC)

The Family Advisory Committee (FAC) is a member advisory group to the CEO and staff of Partnership. The FAC provides a forum for parents, guardians and caregivers of children with CCS conditions to discuss common issues of interest and importance, to create a supportive and informative networking environment and to advocate for members by ensuring that Partnership is responsive to the diversity of health care needs for all members. Minutes from FAC meetings are reviewed by the PQC.

The FAC membership is comprised of representatives throughout Partnership's geographic service areas who advocate for CCS-eligible children of diverse cultures, ethnicities, genders, ages and disabilities. Meetings are held at least four (4) times per year with the option for additional meetings as needed.

The mission of FAC is to leverage the Whole Child Model (WCM) to enhance the quality of how CCS-eligible children ~~beneficiaries~~ – and their families – experience care.

Finance Committee

The Board of Commissioners authorizes the Finance Committee to act on matters of urgency when the Board does not meet. Items approved by the Finance Committee are ratified by the full Board at a subsequent full Board meeting. The Finance Committee is comprised of an appointed group of members from the Board, which encompasses representation from across Partnership's entire service region. The Finance Committee meets monthly.

The Finance Committee has the following authority to:

- Review and make recommendations on the annual budget
- Review and make recommendations on financial policy
- Review major capital expenditures
- Monitor the financial status of the organization and overall leadership for better management in alliance with the executive team and other Partnership staff

The Committee also advises the Board of Commissioners on the fiscal impact of any changes pertaining to value-based programs as related to:

- Payment structure
- Annual budget
- Prioritizing programs

Governance and Compliance Subcommittee

The Governance and Compliance Committee is a subcommittee of the Commission, has the fiduciary responsibility to oversee Partnership's regulatory Compliance Program, and shall ensure the establishment and maintenance of an effective compliance and ethics program by assuring compliance activities are reasonably designed, implemented, and generally effective in preventing and detecting risks or compliance violations. The subcommittee meets quarterly.

Internal Quality Improvement (IQI) Committee

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

~~An internal Partnership committee~~IQI standing members is comprised of appropriate Partnership department directors and staff, ~~the Internal Quality Improvement (IQI) Committee tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation. The IQI Committee meets monthly, at least ten (10) times per year, with the option to add additional meetings if needed, to review policies, procedures, and QI activities. The~~which includes but not limited to, ~~-~~Partnership's CMO (Chair of the Committee), ~~Director of Health Equity,~~ Medical Director for Quality (Vice Chair), Senior Director of Quality & Performance Improvement, and ~~the~~ leadership from the Health Services and external facing departments mentioned above ~~Manager, Member Safety - Quality Investigations and Health Services leadership as described for Q/UAC attend IQI Committee meetings regularly~~. Other Partnership staff attend on an ad hoc basis to provide expertise on specific agenda items. ~~Multidisciplinary improvement teams may be designated to complete analysis and intervention recommendations for quality improvement issues and activities. Evaluations and recommendations put forward at IQI represent strategies used in local entity engagement to address deficiencies in performance measures for members 21 years of age or less. The IQI Committee serves to integrate quality activities organization-wide, which are then reported to Q/UAC and PAC.~~ The IQI Committee meets monthly, at least ten (10) times per year, with the option to add additional meetings if needed, to review policies, procedures, and QI activities.

~~An internal Partnership committee comprised of appropriate Partnership department directors and staff, the Internal Quality Improvement (IQI) Committee tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation. The IQI Committee meets monthly, at least ten (10) times per year, with the option to add additional meetings if needed, to review policies, procedures, and QI activities. The Partnership CMO (chair of the committee), Director of Health Equity, Medical Director for Quality, Manager, Member Safety - Quality Investigations and Health Services leadership as described for Q/UAC attend IQI Committee meetings regularly. Other Partnership staff attend on an ad hoc basis to provide expertise on specific agenda items. Multidisciplinary improvement teams may be designated to complete analysis and intervention recommendations for quality improvement issues and activities. Evaluations and recommendations put forward at IQI represent strategies used in local entity engagement to address deficiencies in performance measures for members 21 years of age or less. The IQI Committee serves to integrate quality activities organization-wide,~~

~~which are then reported to Q/UAC and PAC.~~

Member Grievance Review Committee (MGRC)
The Member Grievance Review Committee (MGRC) represents a multidisciplinary oversight forum with representatives from Claims, QI/PI, Office of the CMO, Pharmacy, Care Coordination, Utilization Management, Population Health, Member Services, Provider Relations, RAC, Behavioral Health, Enhanced Health Services, and Transportation Services to track and trend Grievances, Appeals, Exempt Grievances, and State Hearing cases. It serves as a collaborative work group to discuss complex cases or improvement opportunities with the following key focus areas: quality improvements, clinical oversight, operational excellence, member experience, and regulatory compliance. Findings may be presented in the Q/UAC, IQI, CAC, Delegation Oversight Review Subcommittee (DORS), and/or Substance Use Internal Quality Improvement Subcommittee (SUIQI) meeting. MGRC is held on a quarterly basis.

Over/Under Utilization Workgroup
The Over/Under Utilization Workgroup is an internal Partnership committee that evaluates services that may be over-or under-utilized compared to optimal utilization. The Over/Under Utilization Workgroup meets quarterly. Its goals are to use the results of the analysis to drive quality improvement activities, accuracy of data collection and analysis, and the most cost-effective use of resources. A designated Partnership Medical Director chairs the committee, and the Health Analytics department supports it. Representatives from Health Services (e.g. Pharmacy, Population Health, Health Equity, Quality Improvement, and Utilization Management), Compliance, Member Services, Operational Excellence/Project Management Office (Op-Ex/PMO), Provider Relations, and Claims also attend. A summary of activity from the committee is annually reported to IQI and Q/UAC, (as part of the Utilization Management Grand analysis) and Partnership's Compliance Committee.

Pediatric Quality Committee (PQC)
The Pediatric Quality Committee (PQC) is the clinical advisory committee for the Whole Child Model (WCM) program. The PQC meets at least four (4) times per year with the option for additional meetings if needed.

The membership of PQC includes the Partnership Whole Child Model Medical Director (Chairperson), CMO (Vice Chairperson), Chief Health Services Officer (CHSO), Pharmacy Director, at least four California Children Services (CCS) paneled clinician providers, CCS Medical Directors designated by each Partnership County, and Nurse Director or Manager~~-~~ as designated by each County CCS program. Other health plan staff and outside experts may make special or periodic reports to the committee or may attend selected meetings by invitation from the committee chair or designee.

Peer Review Committee (PRC)
The Peer Review Committee (PRC) reviews concerns and complaints about the quality of clinical care and services provided to Partnership HealthPlan of California's (Partnership's) members and makes recommendations for actions to prevent reoccurrence of any issues. The PRC also reviews sentinel conditions identified as having quality concerns. PRC discussions and documents are protected by federal and state laws (Cal. Civ. Code §43.7.) governing confidentiality of health care peer review activities conducted in good faith.

The Peer Review Committee (PRC) membership includes ~~-~~external practitioners representing PCPs, board certified specialists and non-physician medical practitioners (NPMP), which include nurse practitioners, physician assistants, certified nurse midwives, and licensed midwives. ~~The~~ Partnership staff physicians are voting members and include, but are not limited to, the Chief Medical Officer, the Deputy Chief Medical Officer, the Medical Director for Quality, the Behavioral Health Clinical Director,~~ CMO,~~ Regional and Associate Medical Directors~~ are also voting members of the PRC~~. Additional Partnership non-voting staff attending and supporting the PRC include the Senior Director of Health Services; the Director of Pharmacy or designee; the Director of Health Equity; members of the Member Safety-Quality Investigations team and Clinical Quality & Member Safety teams. ~~Partnership's RN Quality Investigators and the Manager of Member Safety - Quality Investigations support the Committee.~~ Partnership's Medical Director for Quality, CMO, or other designated Partnership Medical Director chairs the committee. NPMP may vote to rate providers and/or systems only in areas in which they possess subject matter expertise. All committee members are eligible to vote on issues brought before the committee. The committee meets at least quarterly and on an as needed basis. Peer Review functions are to:

~~The Peer Review Committee (PRC) membership includes external practitioners representing PCPs, board certified specialists and non-physician medical practitioners (NPMP), which include nurse practitioners, physician assistants, certified nurse midwives, and licensed midwives. The Partnership CMO Regional and Associate Medical Directors are also voting members of the PRC. Partnership's RN Quality Investigators and the Manager of Member Safety - Quality Investigations support the Committee. Partnership's Medical Director for Quality, CMO, or other designated Partnership Medical Director chairs the committee. NPMP may vote to rate providers and/or systems only in areas in which they possess subject matter expertise. All committee members are eligible to vote on issues brought before the committee. The committee meets at least quarterly and on an as needed basis. Peer Review functions are to:~~

- Review potential and actual quality issues and provider/member complaints and appeals related to quality of care
- Make recommendations for Corrective Action Plans (CAP) and practitioner discipline or sanctions to the Credentials Committee
- Make recommendations on improvements to systems of care based on specific occurrences

Physician Advisory Committee (PAC)

The Physician Advisory Committee (PAC) monitors and evaluates all Health Services activities and is directly accountable to the Board of Commissioners for the oversight of the QI/PI program. PAC meets at least ten (10) times a year. Voting members~~hip~~ represent active medical staffs of hospitals, community-based practices, and medical groups in the Partnership service area, ~~.~~and are ~~includes external~~ physician representatives from primary and specialty care, including at least one behavioral health provider, or are advanced practice clinicians such as certified nurse midwives, nurse practitioners, or physician assistants. ~~PCPs, board certified high-volume specialists and non-physician clinicians.~~ A voting provider member of the committee chairs PAC. The Partnership CEO, COO, Chief Financial Officer (CFO), CMO, Deputy CMO, Medical Director for Medicare Services, Medical Director for Quality, Regional Medical Director(s), Behavioral Health Clinical Director, and leadership from the following departments including; QI/PI, Provider Relations, Care Coordination, Utilization Management, Network Services, and Pharmacy attend PAC meetings regularly. Other Partnership staff attend on an adhoc basis to provide expertise on specific agenda items. PAC oversees the activities of Q/UAC and other quality- related committees and reports QI/PI activities to the Board of Commissioners.

Pharmacy and Therapeutics (P&T) Committee

The Pharmacy and Therapeutics (P&T) Committee is comprised of Partnership staff and network practitioners including pharmacists, PCPs, and specialists, including behavioral health. The Chief Medical Officer (CMO) or Pharmacy Director (when designated by the CMO) chairs the P&T. The committee makes decisions and recommendations on development and review of the medical benefit drug formulary, pharmacy policies and procedures, new drugs, and drug approval criteria. The P&T meets quarterly, providing regular activity reports and recommendations to PAC, the approval authority for P&T related activities. The P&T Committee also serves as Partnership's Drug Utilization Review (DUR) Board. Partnership's DUR Board conducts retrospective analysis on drug utilization to identify patterns of fraud, waste, and abuse or inappropriate or medically unnecessary care. In addition, the DUR Board makes recommendations for education programs and bulletins to improve drug safety and therapeutic outcomes.

~~***Provider Engagement Group & Networking Meeting (PENG)***~~

~~Meetings are held quarterly. This group will include network staff and vary based on subject matter. The purpose of PENG is to educate and update the network about new Partnership programs, benefits, and/or changes mandated by DHCS or Partnership. The Plan staff will target specific network invitees depending upon subject matter to be presented or discussed. Targeted provider audience and invitees include clinic managers, supervisors and other mid-management staff. Minutes of the meetings will be presented to PAC.~~

~~***Population Needs Assessment Committee (PNA)***~~

~~The Population Needs Assessment Committee (PNA) is an internal committee serving as a multi-departmental decision-making body whose goal is to carry out the DHCS mandate to meaningfully participate in each Local~~

~~Health Jurisdiction's (LHJs) Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). The PNA Committee meetings occur annuallyon a bi-monthly basis to review the status of requests from the counties and , and general progress towards shared work on the CHA/CHIP collaborative in Partnership's service areas, including the approval andthe implementation of the shared SMART (Specific, Measurable, Attainable, Relevant, Time-Bound) goals between Partnership and each of the LHJs in Partnership's service. This committee also meets annually to review and make recommendations for the Population Needs Assessment (PNA) used to fulfill NCQA requirements. The PNA Committee activities and recommendations will be shared with the Internal Quality Committee (IQI), Quality/Utilization Advisory Committee (Q/UAC), Physician Advisory Committee (PAC) and Partnership's Board of Commissioners.~~

Quality Improvement and Health Equity Committee (QIHEC)

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

The QIHEC provides recommendations to Q/UAC. Q/UAC provides recommendations to PAC.

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

Quality/Utilization Advisory Committee (Q/UAC)

The Quality/Utilization Advisory Committee (Q/UAC) is responsible for monitoring the quality of comprehensive medical care and services provided to Partnership HealthPlan of California's members. The committee's goals are to ensure quality improvement efforts are prioritized, resources are appropriate, and processes are in place for providing quality, appropriate and safe healthcare to members. The Q/UAC reviews Partnership's Health Services departments' activities, makes recommendations, and serves as an appeal body on certain medical care issues. On occasion, the Q/UAC may review Grievance & Appeals, Member Services, and Provider Relations policies. The Q/UAC may establish inpatient and ambulatory review subcommittees as needed to accomplish its responsibilities. A subcommittee of the Q/UAC serves as the Peer Review Committee (PRC).

The Q/UAC has oversight responsibility for the development, implementation, and effectiveness of the quality improvement and utilization management programs. The Q/UAC is accountable to the PAC, and through this body, to the Partnership Board of Commissioners on Medical Care.

~~The Quality/Utilization Advisory Committee (Q/UAC) is responsible to assure that quality, comprehensive healthcare and services are provided to Partnership members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. This responsibility includes providing significant input on the QI Program Description, Annual Evaluation and Work Plan.~~Q/UAC voting membership includes consumer representative(s) and external clinicians who represent hospitals, medical groups, and practice sites in geographic sections of Partnership's service area. Physician and non-physician clinician members also serve on the Peer Review Committee. The Partnership CMO (Chair of the Committee), Senior Director of Quality & Performance, Behavioral Health Clinical Director, Director of Health Equity, Medical Director for Quality (Vice Chair), Manager of Member Safety - Quality Investigations, and leadership from the Health Services departments (e.g. QI/PI, Utilization Management, Care Coordination, Pharmacy, Population Health, Health Equity, Enhanced Health Services), Grievance and Appeals, and Provider Relations departments attend Q/UAC meetings regularly. Other Partnership staff attend on an ad hoc basis to provide expertise on

specific agenda items. The committee meets monthly at least ten (10) times per year, with the option to add additional meetings if needed. Q/UAC activities and recommendations are reported to PAC and at least quarterly to the Commission.

~~The Quality/Utilization Advisory Committee (Q/UAC) is responsible to assure that quality, comprehensive health care and services are provided to Partnership members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. This responsibility includes providing significant input on the QI Program Description, Annual Evaluation and Work Plan. Q/UAC voting membership includes consumer representative(s) and external clinicians who represent hospitals, medical groups, and practice sites in geographic sections of Partnership's service area. Physician and non-physician clinician members also serve on the Peer Review Committee. The Partnership CMO (chair of the committee), Behavioral Health Clinical Director, Director of Health Equity, Medical Director for Quality, Manager of Member Safety - Quality Investigations, and leadership from the Health Services departments (e.g. QI/PI, Utilization Management, Care Coordination, Pharmacy, Population Health, Health Equity, Enhanced Health Services), Grievance and Appeals, and Provider Relations departments attend Q/UAC meetings regularly. Other Partnership staff attend on an ad hoc basis to provide expertise on specific agenda items. The committee meets monthly at least ten (10) times per year, with the option to add additional meetings if needed. Q/UAC activities and recommendations are reported to PAC and at least quarterly to the Commission.~~

Activities include but are not limited to:

- Review and approve the QI/PI Program Description, Program Evaluation and Work Plan annually
- Review and approve standardized utilization review criteria and protocols
- Approve and ensure implementation of evidence-based guidelines and policies of medical practice including preventive, chronic care, and behavioral health initiatives
- Analyze summary data and make recommendations for action plans for quality improvement activities
- Assure that appropriate follow-up activities occur for all CAPs and QI/PI activities
- Provide oversight of delegated QI activities except for credentialing activities, which the Credentials Committee reviews

Strategic Planning Committee

The Strategic Planning Committee advises the Board of Commissioners and the CEO on long-range strategic issues affecting Partnership. Committee activities include, but are not limited to, development of Partnership's three-year strategic plan, legislative advocacy, planning for annual Board retreat, and more. This committee is appointed by the Board of Commissioners and is comprised of some Board of Commissioners' members and other leaders from the community who are not members of the Board. This committee meets on a quarterly basis.

Substance Use Internal Quality Improvement Subcommittee (SUIQI)

A committee comprised of appropriate Partnership and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, regulatory requirements and accreditation for Partnership's administration of substance use disorder services and oversight. The Substance Use Internal Quality Improvement Subcommittee (SUIQI) meets at least quarterly. Activities and progress are reported to IQI. This also includes review of:

- Utilization management retroactive and appeals review
- Inter-rater reliability for peer review and utilization management
- Quality of service, quality of facility, and grievances and appeals
- Investigation of potential over-use, under-use, and misuse of services
- Policies related to provision of substance use disorder services

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

Substance Use Services Provider Advisory Group (SUPAG)

The Substance Use Services Provider Advisory Group (SUPAG) monitors Partnership substance use disorder services treatment activities. The committee will meet at least four times per year. Membership includes licensed

and certified substance use disorder service providers and clinicians and others involved in substance use disorder care. The Committee also includes county substance use disorder services administration representatives.

Meeting Frequency

~~Note:~~ Meeting frequency indicated with each committee is subject to change based on business needs.

Membership in committees is voluntary and open to all who meet the minimum criteria and who are willing to serve. When positions become available, Partnership looks for committee members who reflect the diversity of our communities. Partnership continually evaluates key diversity factors (including, but not limited to: race, ethnicity, language, gender identity, sexual orientation, disability status, etc.) to ensure that committee membership reflects Partnership's membership and provides diverse views. The committee chair will make a good faith effort to review and verbally report (to committee members) key membership demographic information after the publication of the Partnership community reports when a position becomes available, annually. As opportunities present, special efforts will be made to invite candidates who reflect such attributes to continually encourage diversity within committees.

As a tool for evaluating meaningful improvements in diversity, equity, and inclusion (DEI), Partnership may on occasion distribute a DEI Survey to various Partnership Committees. This activity is no longer a requirement under the 2026 NCQA Health Outcomes Accreditation (HOA) Standards and Guidelines and is not conducted for the purpose of preparing for accreditation. Committees that previously participated included Q/UAC, PAC, P&T, CAC, PRC, and QIHEC. When conducted, committee members may be provided with aggregate Partnership membership demographic data for informational comparison purposes. Information gathered may be used to identify at least one (1) opportunity to enhance inclusive practices.

Effective January 15, 2026, NCQA's Health Equity Accreditation has been renamed Health Outcomes Accreditation, and NCQA's Report Card will list Partnership as Accredited in Health Outcomes.~~As a tool for evaluating meaningful improvements in DEI and for preparing for Health Equity Accreditation, Partnership will distribute a DEI Survey on an annual basis to assess the diversity of key committees starting in 2024. The annual DEI Survey will allow committee members to provide feedback on improving the diversity, equity, and inclusion within their respective committee. Certain committees are more involved in the decisions for services regarding member experience and clinical care, and therefore such key committees will be prioritized in assessing their respective DEI compositions and opinions. The key committees identified to receive the DEI Survey in 2024 were Q/UAC, PAC, P&T, CAC, PRC, and QIHEC. Committee members will be provided with updated Partnership membership demographic data to compare with the makeup of the organization itself. This information will be utilized to identify at least one (1) opportunity to improve the DEI of key committees.~~

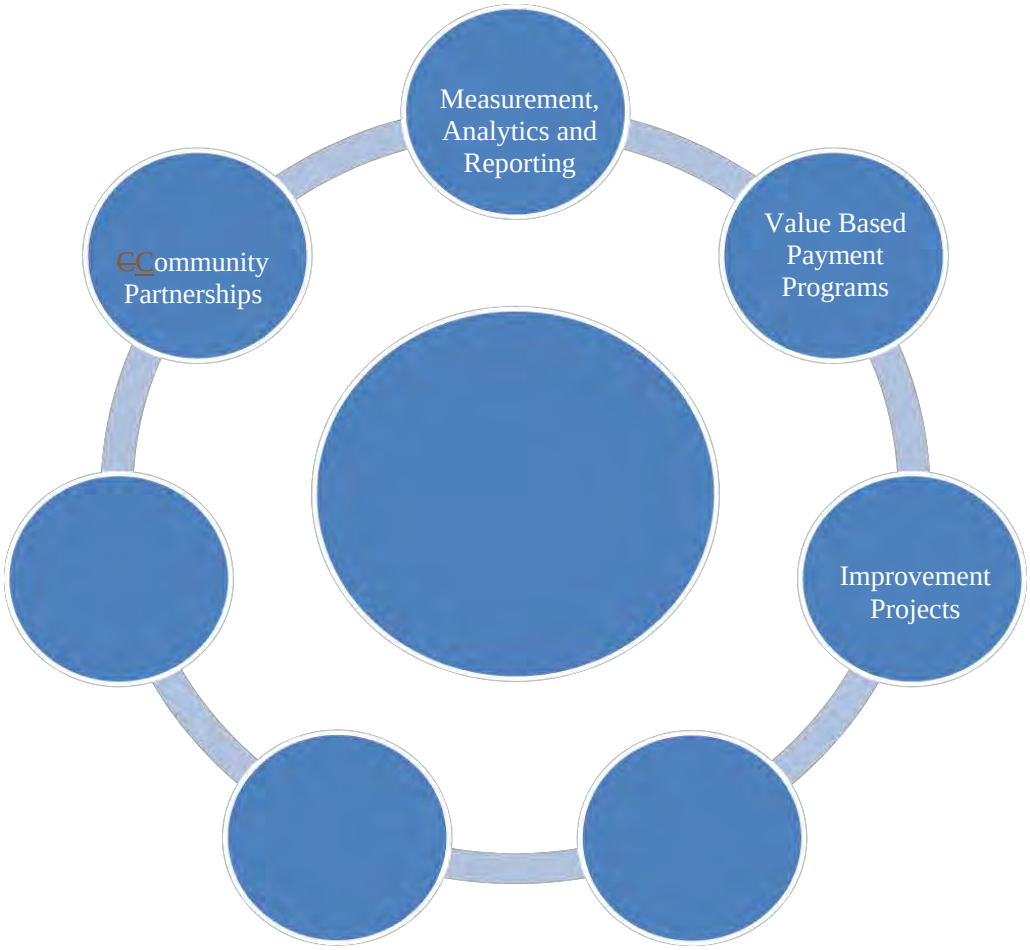
Approach to Quality and Performance Improvement

Partnership's Quality and Performance Improvement program focuses on ~~simultaneous pursuit of~~advancing the Institute for HealthCare Improvement (IHI) Quintuple Aim – improving population health, enhancing patient experience, promoting cost efficiency, supporting workforce well-being and advancing health equity – ~~via~~ through seven primary levers:

- Measurement, Analytics and Reporting
- Value Based Payment Programs
- Improvement Projects
- Care for Members with Complex Needs
- Quality Assurance and Member Safety Activities
- Training and Coaching
- Community Partnerships

~~In addition to the Triple Aim (population health, patient experience and cost efficiency),~~ Through this approach, Partnership is committed to ~~pursuing the fourth aim of achieving workforce well-being. This aim ensures~~ supporting providers and care teams in delivering high-quality, efficient, and member centered care. ~~across our~~

~~network have adequate resources to provide high-quality care to our members.~~ This includes ensuring providers have the resources and support needed to sustain workforce well-being. Additionally, Partnership is dedicated to ~~pursuing a fifth aim of~~ achieving equitable health for all of our members. This aim supports an increased understanding of social determinants of health and working to address disparities that impact the quality and sufficiency of health care provided to Partnership members.



Measurement, Analytics and Reporting
Value Based Payment Programs
Improvement Projects
Care for Members with Complex Needs
Quality Assurance / Member Safety Activities
Training and Coaching
Community Partnerships
Population Health
Patient Experience
Cost Efficiency

Mental Health Services:
Since January 1, 2014, Partnership has provided mental health services for those with mild to moderate treatment needs, pursuant to the Plan's Medi-Cal contract with the State of California. This mandate is detailed in the California Department of Health Care Services (DHCS) All Plan Letter 262-0026 (Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services) issued February 2April 8, 202602. Partnership delegates some of the administration of these services to Carelon Behavioral Health, formerly known as Beacon Health Options, in all 24 counties served by Partnership. By the start of 2026, Partnership will no longer delegates member-facing responsibilities to Carelon Behavioral Health, including its member access line, grievances & appeals, and care coordination functions. Carelon continues to administer the network, claims payment and quality program activities on behalf of Partnership.The exact scope and timing of de-delegation is pending finalization in early 2025-2026.

DHCS assigns Specialty Mental Health Services for mental health conditions deemed to be moderate to severe in terms of level of impairment (also referred to as serious and persistent mental health conditions or SMI) to County Behavioral Mental Health Plans (BMHPs). These include all conditions that meet the medical necessity criteria pursuant to the DHCS Behavioral Health Information Notice (BHIN) 261-00273, issued January ,December 2010, 202601.

Mental health QI management and improvement activities are delegated in part by Partnership to Carelon Behavioral Health. Partnership oversight of these delegated QI functions is achieved through: 1) annual and ad hoc audits, 2) semi-annual review of QI reports produced by these entities, and 3) discussion of quality management and development of quality improvement projects, (e.g., improved PCP referral forms, review and monitor quality issues related to neuropsychological testing, additional reports related to QI, and access standards).

Wellness and Recovery Program:
On July 1, 2020, on behalfPartnership and of seven counties (Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano) Partnership began administeringimplemented the "Wellness and Recovery" program, a regional substance use disorder services program. As Partnership does for other services, this program description includes the planned structure of quality and performance improvement activities Partnership uses for the overall program.

The quality infrastructure of the Wellness and Recovery Program is designed to help achieve one of the key goals of the program: the integration of substance use disorder services with the existing physical and mental health service delivery system. It reflects the incorporation of the county-focused quality structure outlined in the state and federal Organized Delivery System (ODS) waiver requirements into the strong, foundational quality structure of Partnership.

Measurement, Analytics and Reporting
The QI/PI department collects data annually on clinical indicators for Medi-Cal through the Health Effectiveness Data & Information Set (HEDIS®) program. DHCS and NCQA Accreditation are two governing entities that mandate HEDIS® annual reporting. NCQA is the governing entity at the national level, whereas DHCS is the governing entity at the CA State level.

DHCS and NCQA select sets of clinical quality measures that are sourced directly from the NCQA measure library and/or Center for Medicare & Medicaid Services (CMS) measure library in which managed care plans are required to report. The DHCS and NCQA clinical quality measure sets also identify measures requiring stratification by race/ethnicity and language per NCQA's designated categorizations.

Partnership annually conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, which measures member experience in the last six months across a set of standard questions. In addition, Partnership cooperates with the CAHPS® survey conducted annually by DHCS for its Medi-Cal population. The CAHPS® survey results, combined with the final rate performance of the HEDIS® clinical quality measures are calculated by NCQA to provide Partnership's overall Medicaid Health Plan Star Rating. Partnership participates

in compliance audits for HEDIS® and CAHPS® with the state-contracted External Quality Review Organization (EQRO) and Partnership's contracted audit firms to ensure that survey results and measure rate calculations are in accordance with NCQA and CMS specifications. Utilizing an NCQA certified software vendor, Partnership calculates and reports the performance, including health equity-based stratifications, as required by NCQA and DHCS at the reporting unit level. Separately, Partnership reports CAHPS® survey results at the plan-wide level, and HEDIS® measure performance results at the reporting unit level for its fully delegated subcontractors. Partnership works with the EQRO to report audited results ~~per~~by due dates defined by NCQA and DHCS annually. Partnership utilizes DHCS' EQRO File Transfer Protocol (FTP) website when sending communications containing patient-level data, as required per the direction of the EQRO during the annual performance measure validation audit.

Once submitted to NCQA and DHCS, Partnership further evaluates its performance, and that of its fully delegated subcontractors, versus the NCQA National and DHCS established Quality and Health Equity Performance measure benchmarks. The resulting Annual HEDIS® Performance Summary includes analysis of whether or not Partnership, including its fully delegated subcontractors, met or exceeded the NCQA National and DHCS established benchmarks. Currently DHCS defines high performance level (HPL) for a measure in the Managed Care Accountability Set (MCAS) as being above the 90th percentile of all Medicaid Health Plans nationwide, as promulgated by NCQA. DHCS defines the minimum performance level (MPL) on MCAS measures as being the *average* (median) score of Medicaid Managed Care plans nationally (i.e. the 50th percentile), as promulgated by NCQA. Managed care plans are required to exceed the MPL on MCAS measures, as determined by DHCS. Measure rates are generated at the plan-wide and county level for each of Partnership's 24 counties. DHCS has multiple accountability programs that are triggered by performance below the minimum performance level (MPL) on MCAS measures, including quality financial sanctions (based on county-level performance), the Quality Withhold and Incentive Program (based on regional performance), and the Community Reinvestment Program (based on county-level performance).

Partnership must conduct additional quality improvement and health equity improvement projects when DHCS established MPLs are not met, per DHCS mandate in the DHCS Quality Improvement and Health Equity Framework Policy Guide. In ~~reporting units~~ counties where DHCS defined minimum performance levels (MPLs) and health disparity reduction targets were not met, the QI program and Quality Improvement and Health Equity Transformation Program (QIHETP) teams collaborate to present recommended action plans centered around performance improvement to IQI and Q/UAC. Partnership also reviews and acts on items identified through periodic reports made available through DHCS, including but not limited to: the Technical Report, Health Disparities Report, Preventive Services Report, and Focus Studies. Partnership responds timely to DHCS actions that may include subsequent focused studies, ongoing technical assistance from the EQRO, financial sanctions, administrative sanctions, and/or Corrective Actions in cases where below MPL performance is reported.

Aside from compliance audits for HEDIS® and CAHPS®, Partnership also conducts annual Encounter Data Validation (EDV) studies, at the direction of the state-contracted EQRO. The goal of this annual study is to evaluate DHCS' encounter data completeness and accuracy through a review of medical records for a specified 12-month study period. The study ~~is focused~~focuses on a member population continuously enrolled to Partnership during the specified study period with at least one professional visit during the study period. The EQRO selects a random sample of members from which Partnership procures corresponding medical records via provider outreach, submitting the records timely using a process defined annually by the EQRO. Partnership responds timely to actions identified through the EQRO and DHCS in the resulting Encounter Data Validation Report.

Analytics support for the QI program is primarily provided by staff in the Finance, Information Technology (IT), and Quality and Performance Improvement departments. Health analytics including population assessment, case management member stratification, and monitoring of utilization patterns is conducted by the Director of Health Analytics and Health Analytics Analysts who are part of the Finance department. Data Analysts in the QI and IT departments also work collaboratively with Health Analytics to support the following work:

- Partnership Pay-for-Performance Programs (also known as Quality Incentive Programs or QIPs)
- Sourcing and integration of data for HEDIS® annual and monthly reporting
- Monthly reconciliation of QIP data that is used to support tools for providers to monitor their

performance, at a site and organization level, on quality metrics and services
- Partnership Quality Dashboard (PQD) front end development and maintenance of this provider-facing HEDIS® and QIP performance monitoring tool
- Development and execution of data collection plans that identify baseline performance and capture the impact of performance improvement interventions
- Analysis of performance data to identify areas for improvement, including creating dashboards and reports to actively measure targeted processes and performance changes over time
- Provision of actionable recommendations and informing stakeholders of the impact of key decisions based on final measure performance data

The Health Analytics team also includes more senior analytics roles, including Data Scientists and Senior Health Data Analysts, who conduct statistical comparisons and analysis when stratifying member level data and corresponding quality outcomes is needed to inform the design and decision-making in quality improvement interventions.

In addition to HEDIS® and CAHPS®, summary results from access studies, grievances, Initial Health Appointments (IHA), facility site and medical record reviews, PQIs, targeted improvement projects, performance improvement activities (including practice facilitation and other quality capacity building activities) are presented to IQI and physician committees at least annually. Measure performance trends are reviewed more regularly through a monthly project and during improvement team meetings. Partnership completes a robust, comprehensive evaluation annually for major programs and quality improvement projects and initiatives.

At the organizational level, the Executive Team and Board of Commissioners review a comprehensive dashboard including metrics across the organization every six months. Each year, the executive team sets organization-wide priorities. A board advisory group on Quality meets three to four times annually to provide feedback and advice on strategic quality issues.

Performance results are shared with external and internal stakeholders through data reports and data presentations given at quality committee meetings, medical director meetings, conferences, provider site visits, webinars, and community meetings.

Through Partnership's value-based programs, providers receive reports showing their performance against established thresholds and Partnership network averages (and/or across peer groups) at least annually, but this information is available on a monthly basis for providers participating in certain QIPs. The Primary Care Provider Quality Incentive Program (PCP QIP) provides PCPs aggregate and member-level data through two interactive online tools: eReports and PQD. eReports refreshes twice a week and allows PCPs to identify those members with gaps in preventive and chronic disease care in support of compliance on the PCP QIP's clinical measures. It also allows PCPs to upload additional data to support measure-specific numerator compliance or exclusion criteria. PQD is a Tableau-based online data visualization and analytics tool that supports analysis of Partnership's HEDIS® and PCP QIP performance data.

Substance Use Disorder - focused performance improvement projects are managed by Partnership and administered centrally. The SUIQI reviews data at least annually from eligibility, claims, encounter, and provider data to analyze adherence to protocols and identification of those in need of services; timely access measures; initial and engagement of clients into treatment; fidelity to American Society for Addiction Medicine (ASAM) requirements; and outcome and recovery data. The SUIQI aligns their efforts, where possible, with the EQRO evaluation processes and support their evaluation criteria.

In addition, review of the substance use disorder service system and its integration into overall Plan services are incorporated into the ongoing Partnership measurement and reporting programs. This includes summary results from access studies, grievances, IHAs, facility site and medical record reviews, PQIs, targeted improvement projects, and training activities. These are presented to SUIQI on an ongoing basis and reported to SUPAG, IQI, Q/UAC, and PAC at least annually. Substance use disorder services performance reports are also shared at various meetings, trainings, and webinars and community meetings.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Program

The Agency for Healthcare Research and Quality (AHRQ), in collaboration with the Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA), governs the administration of the CAHPS® survey through a nationally recognized set of standard and survey design principles.

As an NCQA accredited health plan, Partnership is required to contract with a certified NCQA survey vendor to administer the annual regulated CAHPS® survey. These survey results capture accurate and complete information about Partnership's member-reported experiences with their health care and provide insights to the quality of care delivered across the Primary Care Provider (PCP) network.

Partnership includes both adult and child populations in its CAHPS® survey sampling. The data collected informs our assessment of service delivery and helps identify areas for improvement to enhance member satisfaction and health outcomes. CAHPS® results are integrated into ongoing quality improvement efforts, supporting targeted interventions and performance monitoring.

Partnership generates the CAHPS® sample frames, obtains auditor approval, and coordinates with the certified survey vendor to ensure compliance with state and federal survey administration requirements.

For additional CAHPS® program inter-department dependencies related to DHCS and NCQA accreditation requirements, please reference the following sections in this document.

- Measure, Analytics and Reporting
- NCQA Accreditation Program Management

Program Scope

The CAHPS® Program team oversees the annual survey cycle from implementation through completion. Program oversight includes vendor management and contracting with a certified NCQA® survey vendor.

Additionally, the CAHPS® program team provides oversight for CAHPS Score Improvement goal development and implementation, supported by inter-department collaboration with the QI HEDIS® and NCQA Accreditation Team, as well as the external department partners including Administration, Communications, Grievance and Appeals, Health Services, HR/Workforce Development, Member Services, OpEx/PMO, Population Health, ~~and~~ Transportation, and Behavioral Health~~Transportation~~.

Survey Results

The contracted NCQA-certified survey vendor conducts a comprehensive analysis of CAHPS® survey results, comparing current-year respondent rates and measure performance to year-over-year results. HEDIS® benchmarks, and nationally derived Medicaid benchmarks through NCQA's Quality Compass®. This analysis provides critical insight into member experiences and highlights trends in care delivery and satisfaction.

Performance is assessed across a core set of CAHPS® measures, including the following rating and composite domains:

Rating Measures	Composite Measures
Rating of Health Care	Coordination of Care
Rating of Health Plan	Customer Service
Rating of Personal Doctor	Ease of Filling Out Forms
Rating of Specialist	How Well Doctors Communicate
	Getting Care Quickly
	Getting Needed Care

These measures support Partnerships broader quality improvement goals by identifying strengths and opportunities to improve member experience, access and communication across the provider network and plan services.

Health Plan Rating

The CAHPS® results are an important component of the NCQA 5-star Health Plan Rating (HPR). As an NCQA Accredited Health Plan, Partnership is required to submit and publicly post the annual CAHPS® scores for one or both survey populations.

The HPR is calculated using a weighted methodology that combines HEDIS® clinical performance measures with CAHPS® survey results. In reporting year 2025~~4~~, Partnership earned an NCQA HPR of 2~~3~~.5 (out of 5) Stars, based on submission of the ~~adult~~ child survey population.

Current CAHPS® scores across both the adult and child populations highlight significant opportunities for improvement. To address this, the QI CAHPS® Program Charter guides cross departmental efforts and collaboration with the provider network to drive meaningful improvements and increase star ratings across all survey populations.

Value Based Payment Programs

Partnership has value-based programs in the areas of primary care, hospital care, specialty care, palliative care, perinatal care, behavioral health, extended care, and enhanced care management. These value-based programs align with Partnership's organizational mission to help our members and the communities we serve be healthy. Partnership uses nine (9) guiding principles to build and strengthen its provider network through value-based program management that promotes the delivery of high-quality, affordable, and equitable care to our members.

1. Pay for outcomes, exceptional performance, and improvement
2. Offer sizeable incentives
3. Actionable Measures
4. Feasible data collections
5. Collaboration with providers
6. Simplicity in the number of measures
7. Comprehensive measure set
8. Align measures that are meaningful
9. Stable measures

The aforementioned guidelines and design of these programs assures no payments are made directly or indirectly to providers as an inducement to reduce or limit Medically Necessary Covered Services to members, per 42 CFR sections 438.3(i) and 438.10(f)(3). Additionally, these value-based programs and corresponding financial payments comply with the requirements of APL 19-005. All financial incentive programs, per contract requirements, are reported in the form, manner, and frequency specified by DHCS. Partnership utilizes its value-based programs to compensate its network providers in ways that assure provider accountability for both quality outcomes and total cost of care across the populations served. The same approach will be utilized as alternative payment models are introduced to network providers. Partnership monitors quality performance under these value-based programs and alternative payment models and responds timely, within 90 calendar days, to any DHCS requested reporting. Additionally, on an annual basis, Partnership reports on its network payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) framework categories. Partnership supports the delivery of effective primary care and integrated care through the emergence and use of alternative payment models. In evaluating the effectiveness of primary care, Partnership fulfills DHCS required reporting that reflects its investment in primary care service delivery and promotion of primary care delivery through alternative payment models.

Primary Care Provider Quality Incentive Program (PCP QIP)

This program provides financial incentives, data reporting, and technical assistance to PCPs to improve key domains of quality: clinical care, patient experience, access and operations, and resource use. PAC reviews and approves proposed clinical measures selected for the PCP QIP. A group of providers and administrators across counties and practice types recommend measures for the PCP QIP each year in QIP Advisory Group. Following the QIP Advisory Group's recommendations and internal discussions with various Partnership department stakeholders, the draft measures are released to the Partnership provider network during a public comment period.

Feedback from the public comment period is shared with the QIP Advisory Group and at internal stakeholder meetings, at which time measure recommendations are forwarded to PAC for review and approval. The measures and detailed specifications can be found on the Partnership website.

Hospital Quality Incentive Program (HQIP)

The HQIP, established in 2012, is a pay-for-performance program for invited hospitals serving Medi-Cal members in the Partnership network. The goal of the HQIP is to improve the quality of care provided to members by offering participating hospitals substantial financial incentives in exchange for meeting selected performance targets.

Participants report on measures across the following measurement domains: advance care planning, clinical quality, operations and efficiency, patient safety, and patient experience. To support improving coordination of care after discharge and increase support for patient self-management, the HQIP includes a 7-Day Follow-Up measure for all Partnership adult members admitted to the hospital. Like the PCP QIP, Partnership collaborates with hospital partners and internal Partnership department stakeholders to design the program, and PAC reviews and approves the measures selected. The measures and detailed specifications can be found on the Partnership website.

Palliative Care Quality Incentive Program (PC QIP)

All Partnership contracted Intensive Outpatient Palliative Care provider sites are automatically enrolled in the PC QIP. Providers may earn incentives from the program based on care provided to members who have serious illnesses and have an approved intensive outpatient palliative care treatment authorization request (TAR) on file. Partnership has designed the PC QIP, which offers significant financial incentives to support and improve the access to and quality of palliative care provided by Partnership's contracted palliative care providers. The program also incentivizes the completion of POLST (Physician Order for Life-Sustaining Treatment) for these members and for actively participating in a data collection system addressing quality assessments reviewed against established quality thresholds.

Perinatal Quality Incentive Program (QIP)

The Perinatal QIP provides financial incentives to participate in the Comprehensive Perinatal Services Program (CPSP) and select non-CPSP providers providing quality and timely prenatal and postpartum care to Partnership members. Participation is by invitation and requires signing a Letter of Agreement. For this incentive program, a simple and meaningful measurement set has been developed and currently includes the following measures: Prenatal Immunization Status, Timely Prenatal Care, Timely Postpartum Care, and Electronic Clinical Data System (ECDS). The current ECDS measure reflects Partnership's efforts to partner with an approved HEDIS data aggregator. These efforts contributed to the success of this measure and have positively impacted Partnership's HEDIS® rates and other QIPs who share this measure in their measurement set.

~~Behavioral Health Quality Incentive Program (QIP)~~

~~The Plan's delegated mental health administrator, Carelon Behavioral Health, manages the quality incentive program for the network. The Behavioral Health QIP is administered through the Carelon Behavioral Health network and focuses on measurement-based care by utilizing member screenings over time in participating practices to inform clinical interventions and measure results. The QIP for substance use disorder services focuses on a provider's ability to address members with co-occurring substance use disorder and mental health needs.~~

Enhanced Care Management (ECM) Quality Incentive Program (QIP)

The ECM Program is a Medi-Cal benefit that replaces the current Whole Person Care (WPC) Pilot and Intensive Outpatient Care Management (IOPCM) activities. As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the objective of ECM is to motivate, modify, and improve the health outcomes of seven identified groups of individuals by standardizing a set of care management services and interventions, then build upon the positive outcomes from those programs. Participants are incentivized for the timely reporting of enrolled members in ECM benefits as the basis for determining the incentive pool amounts for the quality measures. The four quality measures include: Care Plan and Release of Information Upload into PointClickCare, PHQ-9 Depression Screening, Blood Pressure Screening, and timely Review of ED/Admission Notifications.

Behavioral Health Quality Incentive Program (QIP)
The Plan's delegated mental health administrator, Carelon Behavioral Health, manages the quality incentive program for the network. The Behavioral Health QIP is administered through the Carelon Behavioral Health network and has focuseds on measurement-based care by utilizing member screenings over time in participating practices to inform clinical interventions and measure results. The QIP for substance use disorder services focuses on a provider's ability to address members with co-occurring substance use disorder and mental health needs.

Extended Care Center (EXT) Quality Incentive Program (QIP)
The Extended Care Center Quality Incentive Program (EXT QIP) (formerly the LTC QIP) was established and implemented in 2016. The program was suspended in August 2020 during COVID-19, reestablished in January 2022, and sunset in December 2023 in response to the Skilled Nursing Facility Workforce Quality Incentive Program (WQIP) launched by DHCS. Following APL 26-006 (March 30, 2026), which established requirements for the Skilled Nursing Facility Workforce Quality Incentive Program (WQIP), the program was subsequently phased out of California's budget, and Partnership's Board of Commissioners authorized restarting the EXT QIP program in January 2026. Applicable program requirements, including any required attestations or compliance reporting mechanisms, are incorporated consistent with DHCS guidance. Partnership will review and update program policies and procedures as needed to comply with applicable DHCS All Plan Letters and complete any required attestations within required timeframes.

The EXT QIP offers financial incentives to support and improve the quality of long-term care provided to our members. Partnership has developed a measurement set aligned with DHCS guidance and program requirements which includes measures in the following domains: Clinical, Functional Status, Resource Use, and Operations / Satisfaction. Program administration and oversight, including Quality Improvement involvement, are defined in accordance with applicable APL guidance. Partnership will communicate program requirements and methodologies to participating providers and maintain appropriate transparency consistent with DHCS guidance. Program data collection, reporting, and reconciliation activities are conducted in alignment with DHCS specifications. Processes are established to address provider inquiries and disputes related to program implementation consistent with DHCS requirements. Partnership ensures that participating providers and contracted entities comply with applicable program and regulatory requirements.~~The Extended Care Center Quality Incentive Program (EXT QIP) (formerly the LTC QIP) was established and implemented in 2016. The program was suspended in August 2020 during COVID-19, reestablished in January 2022, and sunset in December 2023 in response to the Skilled Nursing Facility Workforce Quality Incentive Program (WQIP) launched by DHCS. Starting 2026, the WQIP was phased out of California's budget, and Partnership's Board of Commissioners authorized restarting the EXT QIP program in January 2026.~~

~~The EXT QIP offers financial incentives to support and improve the quality of long-term care provided to our members. Partnership has developed a simple and meaningful measurement set which includes measures in the following domains: Clinical, Functional Status, Resource Use, and Operations / Satisfaction.~~

Improvement Projects
Partnership considers a number of factors to determine where and how to focus its improvement efforts. The Managed Care Accountability Set (MCAS), a subset of HEDIS® measures for which DHCS holds Managed Care Plans accountable; a subset of HEDIS® measures which carry weight for NCQA health plan accreditation; and most recently the advent of CMS, DHCS and Model of Care measures aligned with the D-SNP, are prioritized by QI. In addition, QI prioritizes recommendations from the QIHEC's annual evaluation of quality measure performance data. These recommendations are focused on addressing health-equity performance deficiencies and ensuring appropriate equity-focused interventions are identified to reduce health disparities in alignment with the requirements of the NCQA health ~~equity~~ outcomes accreditation and per DHCS mandates.
Additional criteria for selection include:

- Meaningful clinical or service areas to both providers and members
- Measures where improvement projects would impact large populations of members
- Over or underutilization of services
- Clinical or service areas where provider variation in practice is greatest
- Clinical or service areas that present opportunities to address health inequities

Data sources used to determine focus areas include:

- Annual, monthly, and year-to-date performance on HEDIS® measures
- Performance on Partnership's pay-for-performance measures that provide financial incentives to provider organizations to drive improvement, including data on disparities based on factors such as race and ethnicity, preferred language, and zip codes
- CMS Administrative Data
- CAHPS® and other Member Satisfaction surveys
- Grievances and appeals
- Facility site and medical record review results
- IHA rates
- Utilization data
- County level and/or public health data
- Clinical data derived from Health Information Exchange (HIE) with providers

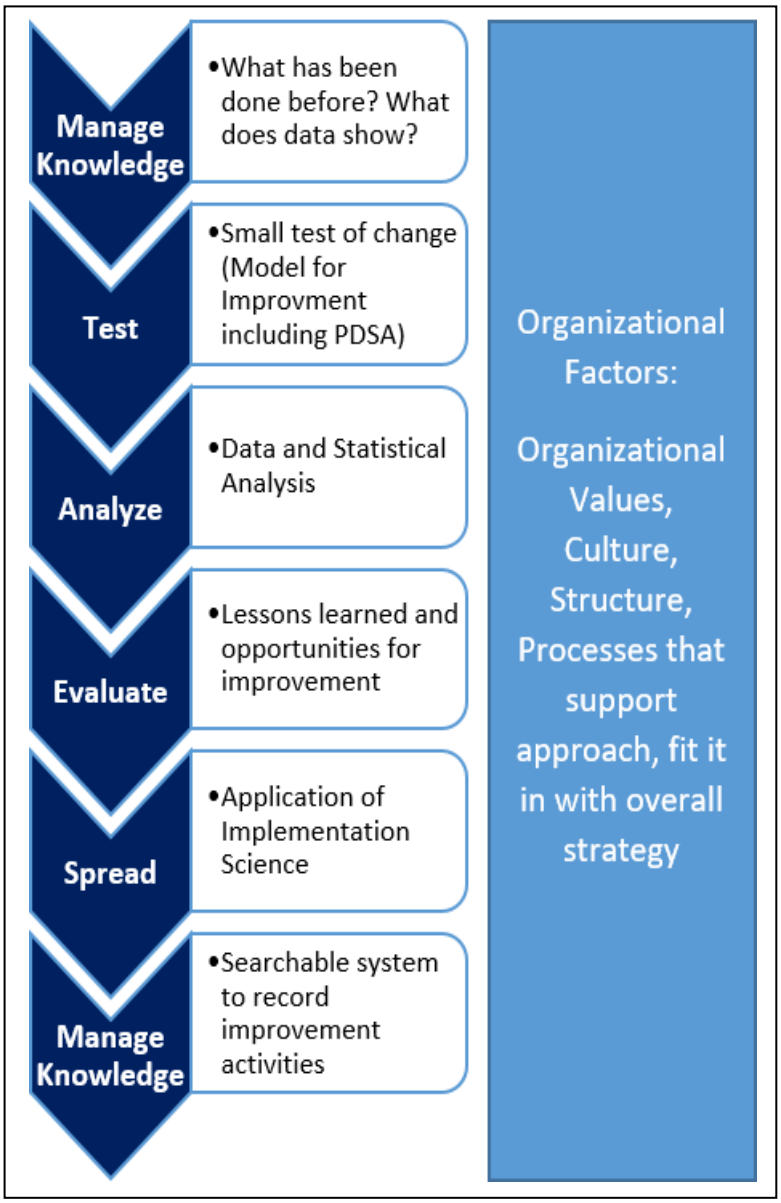
Based on the department ~~that will lead~~leading an improvement effort, ~~its~~ leadership and management propose focus areas and projects, ~~-~~with guidance from their executive sponsor, other members of the executive leadership team, medical directors, other departments and key stakeholders. For improvement efforts focused on reducing health disparities, the QIHEC ensures appropriate follow-up~~s~~ on equity-focused interventions and related activities aimed at ~~Partnership commits itself to in~~ addressing quality measure performance ~~deficiencies~~gaps. Additionally, the QIHETP team supports ongoing QI efforts ~~in the identification of~~ by identifying potential quality or equity of care issues~~,~~ and improvement of HEDIS® quality measures in context with social determinants of health. For member-facing improvement efforts, the CAC and other member focus groups are often consulted to ensure the member perspective is incorporated.

The QI/PI department is often the lead for many improvement efforts, particularly those that are mandated or due to poor performance on the Managed Care Accountability Set (MCAS), which are the set of measures that Department of Health Care Services (DHCS) selects for annual reporting by Medi-Cal managed care health plans. This can include mandated improvement efforts to meet disparity reduction targets for specific populations and/or measures as identified by DHCS. Partnership participates in DHCS mandated statewide collaborations and initiatives focused on improving quality and equity of care for its members. Partnership designates staff to attend, at a minimum, quarterly regional collaborative meetings, including those designated as in-person. The QI/PI department also takes the lead on mandated Performance Improvement Projects (PIPs) that are assigned by DHCS. On an ongoing basis, Partnership is required to complete a minimum of two PIPs per Centers for Medicare & Medicaid Services' (CMS) mandates. PIPs are led by the QI/PI program based on criteria defined by DHCS and overseen by the EQRO, and include at least annual status reports to DHCS. The involvement of fully delegated subcontractors is considered in both mandated short-term improvement projects (Plan-Do-Study-Act) and the PIPs. Once the objective and scope of improvement projects are approved, an improvement team is formed with a lead or project manager and individuals who are involved in the improvement effort. Current year performance priorities are outlined in Partnership's QI Program Work Plan.

For ~~2024~~2025-~~2025~~ 2026 Partnership has set metrics for success which includes NCQA Health Plan Ranking (HPR) targets. Partnership has formed, in recent years, measure-family-focused workgroups to better coordinate service and performance across the organization and to raise Partnership's overall quality measure performance. This effort is referred to as Quality Measure Score Improvement (QMSI) and consists of cross-functional workgroups led by Quality staff with support from Medical Directors and includes representation from across the organization, including: Care Coordination, Claims, Health Education, Office of the CMO, Pharmacy, Population Health, Provider Relations and Regional Leadership. Each workgroup is focused on measure performance analysis, identification of measure focus priorities and efforts needed to close performance gaps. QMSI workgroup areas include pediatrics, chronic diseases, ~~, ,,,~~ behavioral health, women's health and perinatal care, and elder care. Together these workgroups ~~will~~ identify opportunities and barriers to be addressed to improve care outcomes for members and increase HPR.

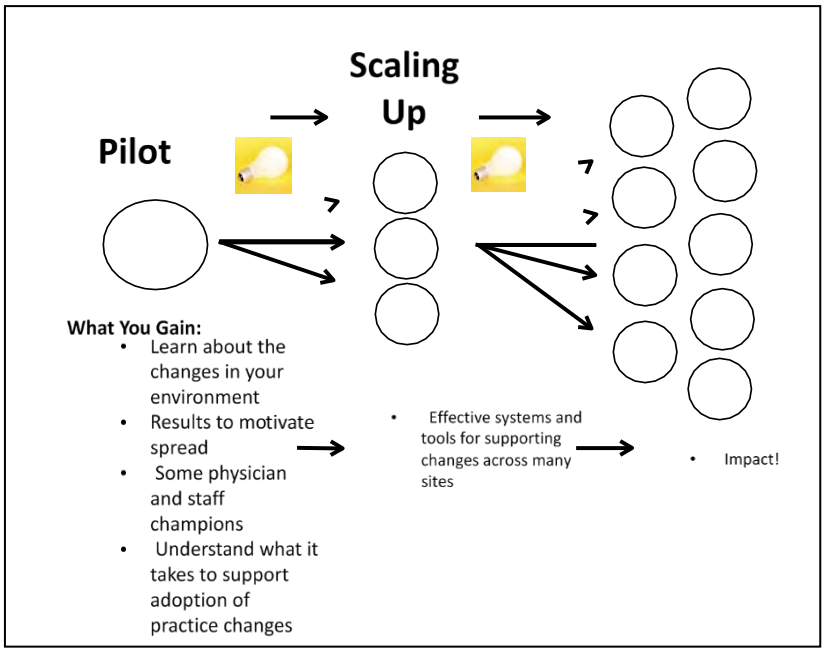
Partnership has developed the Pathway to Excellence (P2E) framework for improvement activities. This

framework includes six major components as noted below:



This framework includes several performance improvement methodologies including small tests of change using the Model for Improvement and the Plan-Do-Study-Act (PDSA) cycle, optimizing spread through the application of implementation science with robust project management infrastructure to guide strategic improvement initiatives and targeted improvement projects. Appendix C has a detailed description of the P2E framework.

Partnership supports spreading effective interventions within and across sites and regions as more is known about the problem, resources, and infrastructure needed to support the change on a larger scale. Within provider organizations and throughout Partnership's provider network, spread is challenging and highly dependent on provider organizations' leadership, culture, and quality improvement infrastructure to do this effectively. The figure below outlines this approach.



A list of current year improvement projects and outcomes are available in Partnership's QI Program Work Plan and annual QI Evaluation, respectively.

Care for Members with Complex Needs (CCM)
Complex Case Management (CCM) is a voluntary program that provides tailored interventions aimed at improving the member's self-management of their health; and increasing the appropriate usage of health and medical resources while reducing the inappropriate utilization of health care resources. These goals are achieved by working with the member/caregiver and the member's interdisciplinary care team to:

- Educate about the member's benefits with managed care and how to use available resources
- Identify and help with understanding of member's medical condition(s)
- Support and encourage self-management skills to promote and optimize the member's personal health goals and well-being
- Coordinate necessary health care services and
- Refer to appropriate medical or social community resources when applicable

Please see the Care Coordination program description for further information regarding the populations targeted and the specific interventions used for Partnership members.

Quality Assurance and Member Safety Activities
Quality Assurance and Member Safety activities include investigation of PQIs; facility site and medical record reviews; assessing the level of physical accessibility of provider sites including specialists and ancillary providers that serve a high volume of seniors and persons with disabilities; and monitoring IHA rates.

All Plan Letters (APLs)
Member safety activities are governed in large part by DHCS directives. To stay aware of updates and guidance on conducting member safety activities, Partnership maintains a multi-department system to monitor and implement regulatory guidance, including but not limited to All Plan Letters (APLs) and contract amendments, like those that inform the QI program. APLs are also available and searchable by all staff via the DHCS website.

Potential Quality Issues (PQI) and Peer Review
A PQI is defined as a possible adverse variation from expected clinician performance, clinical care, or outcome of care. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists. A quality issue is defined as a confirmed adverse variation from expected clinician performance, clinical care, or outcome of care, as determined through the PQI process. The PQI investigation and Peer Review process provide a systematic method for the identification, reporting, and processing of a PQI to determine opportunities for improvement in the provision of care and services to Partnership members, and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity.

PQIs are identified through the systematic review of a variety of data sources, including but not limited to:

- Information gathered through concurrent, prospective, and retrospective utilization review
- Referrals from any Health Plan staff
- Facility Site Reviews
- Claims and encounter data
- Pharmacy utilization data
- HEDIS® medical record review process
- Medical record reviews/audits
- Grievances and Appeals
- Ancillary providers/vendors/delegates such as Carelon, VSP, etc.
- Provider sentinel/adverse events such as provider preventable conditions that are reported as required by the State

All cases are initially reviewed by an RN Quality Investigator and then forwarded to the CMO or Medical Director for Quality in accordance with Policy MPQP1016. Medical records and other supporting documentation are collected, and where issues are identified, the provider of concern may be given an opportunity to respond. The CMO/Medical Director for Quality review includes assessment of, but is not limited to, appropriate level of care, appropriate tests, therapy and treatment, technical expertise, referral, consultation, timeliness, and adequate documentation.

The RN Quality Investigators, pharmacist representative, and identified Medical Directors review potential quality issue cases at PQI rounds. Severity ratings are designated to identify "Practitioner performance," "System issues," or both. Sometimes, multiple provider performance issues or system issues are identified in the same case and rated accordingly. Upon determination by a Medical Director that a case requires review by the Peer Review Committee, the RN Quality Investigator prepares the PQI case file for Peer Review (see MPQP1053 for the Peer Review Committee policy). The Peer Review Committee reviews concerns and complaints about the quality of care and services provided to Partnerships' members and makes recommendations for actions to prevent reoccurrences of the identified issues. The Committee also reviews sentinel conditions identified as having quality concerns. Cases with significant concerns are communicated to the Credentials Committee at the recommendation of the Peer Review Committee.

Annual reports are presented to IQI and Q/UAC showing trends related to referral patterns and quality of care concerns. A monthly report is presented to the CMO and Medical Director for Quality which includes cases open, closed, referrals, and pending PRC review.

Pharmacy Department Patient Safety Initiatives

Partnership has a number of activities in place to ensure medication safety and adherence for Partnership members. These activities include:

- *Managing Pain Safely (MPS)*. Pharmacy leads an ongoing multi-year initiative to promote the safe use of opioids.
- The Pharmacy Department uses Medi-Cal Rx Contractor pharmacy data to monitor opioid prescribing and utilization against opioid-related HEDIS® measures: HDO (high dose opioids), POD (opioid use 31 days), UOP (multiple prescribers/pharmacies), and BZD/Opioid concurrent use.
- The Pharmacy Department monitors and evaluates naloxone prescriptions to help promote access and utilization to improve patient safety.
- The Pharmacy Department reviews and analyzes drug utilization to identify high-risk members taking antipsychotic and opioid medications and provides interventions against identified risks.
- The Pharmacy Department monitors antipsychotic pharmacy claims to identify suboptimal medication regimens and adherence for members taking antipsychotic medications. Interventions aim to address and reduce risk for metabolic syndrome induced by antipsychotic medications.
- *Smoking Cessation*. In collaboration with Care Coordination, Partnership offers smoking cessation counseling services to members who indicate "yes" on the Health Risk Assessment (HRA) question, "Would you like help quitting?" Functions include provider outreach, educating members on medication adherence to tobacco cessation products, and assisting with enrollment in the California Smokers Helpline program.
- *Latent Tuberculosis Therapy (LTBI) Monitoring*. LTBI medication treatment ~~12 dose~~ monitoring to ensure patients receive appropriate therapy and interact with providers and county public health departments to ensure completion of therapy and identify patients that may have fallen out of therapy.

Site Reviews

Partnership conducts Site Reviews that include a review of the physical site, medical records, and a review that evaluates accessibility for Seniors and Persons with Disabilities (SPDs). Site Reviews are conducted for primary care, OB/GYN, palliative care, substance use disorder services providers, non-accredited sites, mobile/street medicine, PCP providing Urgent Care for non members, free standing urgent care clinics and private duty nurses. With the Sunset of Comprehensive Perinatal Service Program (CPSP), Partnership now conducts Site Reviews on all OB providers up to every three years. Partnership is awaiting an official OB tool and/or APL and further guidance on this topic from DHCS. The internal and external quality improvement committees review the results from the Site Reviews, Initial Health Appointments (IHAs), and Physical Accessibility Review Survey (PARS) ~~Results~~ at least annually. Results from Site Reviews are reported to the DHCS twice per year. The Credentials Committee is notified when Site Reviews are completed.

Initial Health Appointments (IHA)

In January 2026, DHCS released a new APL 26-001 addressing dual membership.~~2023, DHCS issued APL 22-030 which changed the name of Initial Health Assessment to the Initial Health Appointment (IHA) and discontinued the requirement of a Staying Healthy Assessment (SHA) questionnaire to be completed by the member and reviewed by the Primary Care Physician (PCP) annually. The Staying Healthy Assessment (SHA) was replaced by the Member Risk Assessment.~~

The Initial Health Appointment must be completed within 120 days of enrollment to the health plan or within 120 days of assignment to a primary care provider (whichever is most recent). The visit must be conducted in the primary care setting and be provided in a way that is culturally and linguistically appropriate for the member.

Partnership collaborates with network practitioners and providers to improve IHA compliance by:

- Identifying areas where training is needed
- Identifying and sharing best practices
- Seeking input from network practitioners about systems Partnership can put in place to improve IHA compliance
- Providing technical assistance, resource materials, and training ~~in areas where indicated~~
- Reminding providers monthly to review their list of newly assigned members and track outreach attempts to the members
- Publishing provider and member facing newsletter articles
- The Site Review Team offers 1:1 educational training with sites about IHA requirements at every site review exit interview. The Partnership Billing Guide and information on IHA are provided during the site review exit interview process.
- Sending monthly mailers along with address labels for newly enrolled members so providers can reach out to members and schedule an IHA appointment
- Clinical Operational meetings are designed to collaborate between both parties (Partnership and Facility) on procedures and operations to ensure patient quality of care and outcome. Partnership uses this opportunity to present on IHA, Blood Lead testing, and offers additional education on Site Review.

~~CHDP Training Replacement with Sunset effective 7/1/2024~~Comprehensive Health Interventions for Lifelong Development (CHILD) trainings

Under the CalAIM initiative, DHCS has transitioned the Child Health and Disability Prevention Program (CHDP) effective July 1,2024 to Partnership. This transition aligns with the desire to streamline efforts and consolidate care responsibilities, for members 21 years of age and younger.

The Inspections Team now offers training CHILD Trainings. Compliance with training is monitored through the site review process. ~~on all CHDP topics and is reviewed during the Site Review process.~~ Training topics include Audiometric, Vision, Anthrometric/BMI, Dental Fluoride Varnish Application and Preventative Care, which covers immunizations, CAIR, and blood lead screening. Training courses are offered through a live WebEx session, or they are available online. Once training is completed, a certificate of completion is sent to the site and is valid for 3 years.

Quality Improvement Coaching and Training Support

The Performance Improvement (PI) team offers a variety of coaching and training opportunities to clinicians, administrators and staff to gain quality improvement expertise and to learn from peers. Each initiative prepares provider sites to optimize population health, enhance their patients' experiences of care, promote provider and care team satisfaction, and foster a culture of continuous quality improvement.

Provider Tiering and Enhanced Provider Engagement: In 2022, Partnership began strategic planning to expand provider engagement to engage a wider group of provider organizations (PO's) in building their capacity for quality improvement work. Using the previous year's PCP QIP clinical measure scores, provider organizations are organized into tiers, with coaching programs designed to align with the priorities and needs of the respective organizations.

2025-26 provider tiers and respective coaching opportunities are:

- Tier 1 PO's (< ~~33~~25% of clinical points earned in previous year's PCP QIP): ~~Strong candidates for~~

participating in the Modified PCP QIPEnhanced Provider Engagement is provided, which includes coupled with a written plan for improvement sponsored by a health center executive, completion of a Needs Assessment, and regular ongoing improvement coaching.

- Tier 2 PO's (3325-7975% of clinical points earned in previous year's PCP QIP): Practice Coaching, Joint Leadership Initiative meetings for high volume practicesJL. Practices in this tier are often good candidates for regional improvement projects focused on DHCS priority MCAS measures. I's, improvement pilot or PIP partnership on established MCAS measures
-
- Tier 3 PO's (>8075% of clinical points earned in previous year's PCP QIP): These practices are asked to share successes with our network through Voices from the Field presentations at regional quality meetings or at our Improving Measure Outcomes Webinar series. These practices are well positioned to implement, innovativeon pilots and inform Partnership on emerging measures.
- PO's at any tier: Regional meetings, Improvement Academy trainings

Modified PCP QIPEngagement of Low-performing practices: In 2023 QI introduced aThe Modified QIP (MQIP) for low performing practices. MQIP is amandated a simplified set of four measures forgiven to Provider Organizations with low PCP QIP Scores. Providers weare evaluated annually to determine participation. Thresholds for participation are reevaluated and adjusted annually, according to need and available coaching resources. After running MQIP from 2023-2025, and evaluating it in 2025, the QI team has endedretired the MQIP because a group of providers were not successfullythe program did not prove widely successful at helping all practices to progressssing out of the modified measure set. and is insteadIn 2026, we are implementing Enhanced Provider Engagement to focusing on engaging low performing practices with a dedicated Improvement Coach who will help them develop an improvement action plan of focus , focusing on for four (4) high priority QIP measures.

Needs Assessment and Relationship Building: The Needs Assessment is the initial step for provider organizations assigned to the Modified PCP QIP or who are at risk of placement in it in the following measurement year. Members of the provider organization's leadership team will complete an in-person Needs Assessment with a member of the PI team. The Needs Assessment is a modified version of the Building Blocks of Primary Care Assessment (BBPCA), a tool developed by the UCSF Center for Excellence in Primary Care and is designed to identify an organization's strengths and improvement opportunities within their quality program. Alternatively, a provider organization can complete a Population Health Management Capabilities Assessment Tool (PhmCAT), a tool published by DHCS as part of their Equity Practice Transformation initiative. The PhmCAT tool is also based on the BBPCA tool, and contains additional questions on health equity, behavioral health, and social health strengths and improvement opportunities within the organization. Completed PhmCAT tools are reviewed in detail with a member of the PI team.

Completing the Needs Assessment allows the provider organization to assess themselves and fosters relationship building with Partnership; it also provides a framework for prioritizing improvement opportunities and committing to activities to build their quality infrastructure and organization-wide culture of quality.

Once the provider organization has chosen areas for improvement, Partnership will offer support through various means including: providing coaching, training opportunities, grant application opportunities and resources, and connecting with outside resources.

Practice Coaching: In 2020, Partnership initially began offering practice facilitation, a narrower set of coaching tools and support, to PCP organizations with large member assignments and some existing quality infrastructure that had opportunity for improvements in clinical performance. Partnership expanded and broadened support via practice coaching, to meet the evolving needs of the network as it transitioned through the COVID-19 public health emergency. The coaching format is nowPractice coaching is offered to all provider organizations that score between 33-79%below 75% of clinical points on their PCP QIP and to any health center that requests it due to low performance in a particular measure or set of measures.

Practice coaches assist primary care practices in the application of evidence-based best practices to quality

improvement activities. Working alongside organizational ~~quality~~ teams, the practice coach provides guidance and resources to facilitate system-level changes. The practice coach provides a framework for ~~translating evidence-based research into~~implementing evidence-based clinical practices by building relationships, improving communication, and facilitating change.

The following are areas where Partnership practice coaches offer support:

- Provide guidance on inter-disciplinary project team formation and collaboration for QI projects
- Project management – provide guidance and tools on framing and managing QI projects
- QI project development and use of QI tools, methodologies, and best practices
- Provide data analytics training and support
- Provide guidance on change management aspects of QI projects
- Coach provider organizations on adopting a culture of quality and advancing quality improvement efforts throughout the organization

Partnership Improvement Academy

The Partnership Improvement Academy ~~encompasses different types of~~offers a multi-faceted approach to training, designed to support and educate provider organizations about quality improvement. Trainings are continuously added, adjusted, or abandoned based on the needs of the network and are regularly evaluated ~~regularly for~~ to identify opportunities for improvement. ~~to improve.~~

- **ABCs of QI:** This ~~program~~ is a one-day in-person training designed to teach healthcare organizations the basic principles of quality improvement including developing aim statements, measures, and change ideas; how to use data and run charts, and testing change ideas on a small scale. The program is offered regionally, several times per year, to meet the needs of the expanding network.

- **Improving Measure Outcomes:** These trainings are 1~~-1.5-~~hour webinar learning sessions offering CME/CE and cover the PCP QIP measures

  The objectives of the learning sessions are:
  - Overview of clinical measure specifications and threshold definitions
  - Present documentation recommendations/highlights to maximize measure adherence
  - Review regional performance data on clinical measures, including data that show disparities by race and ethnicity
  - Review best and promising practices to close gaps in care
  - Showcase Voices from the Field, high-performing providers who present their best practices for closing care gaps
  - Overview of performance improvement strategies and tools

  The target audience is clinicians, practice managers, quality improvement team, and staff who are responsible for~~participating~~participating in and leading quality improvement efforts within their organization.

- **Micro-learnings:** these are short-form recordings that are designed to cover specific topics and can be ingested in between duties when staff are unable to watch the hour-long IMO sessions or attend in-person ABCs of QI. Topics include but are not limited to use of e~~Reports~~Prompts, Preventative Care Reports, and running clinical huddles.

- Quality Improvement Project Training: This six-session live training series is designed to support our partners in leading and managing quality improvement initiatives. Building on the foundational knowledge gained through ABCs of QI, this program offers the tools and structure needed to turn concepts into action, empowering participants to plan, launch, and sustain impactful quality improvement projects.

Northern Region Consortia & Partnership Northern Region QI Collaboration: This partnering occurs formally on

an annual basis via a written scope of work agreement under which they jointly promote and support QI capacity building in the clinic setting through trainings, improvement advising, peer-to-peer sharing, and conducting annual clinic profiles/assessments. The Northern Consortia membership is comprised of Federally Qualified Health Centers (FQHCs) in the Partnership ~~Northeast, Northwest, East, and Southwest~~Redding, Eureka, and Auburn Regions and represent the largest PCP organizations, in terms of assigned member volume. Partnership benefits from the peer network forums the consortia leaders have established amongst its members' QI leadership and CMOs. The QI Peer Network and CMO Peer Network meet every other month, including longer in-person meetings on a biannual basis. Within these peer networks, Partnership is invited to share measure level education, guidance, and technical assistance on the application of performance improvement tools and methods. These interactions occur either as part of recurring peer network meetings or separate webinar offerings targeting peer network members.

Clinically Led HEDIS® Measure Education: HEDIS® Measure Education is also incorporated into provider interactions with Partnership's Member Safety Team. Partnership Member Safety nurses have unique opportunities through their Site Review visits to build rapport with PCP clinical leadership and staff. During the completion of the medical record review portion of Site Reviews, Partnership nurses incorporate measure education and corresponding medical record-keeping best practices during their reviews with providers.

Pharmacy Academic Detailing: Partnership's Pharmacy Department offers provider organizations detailed analysis of their patient's adherence to medication for a number of chronic conditions, to identify opportunities to improve medication management of their condition. Topics covered in Academic Detailing sessions include:

- Increasing prescriber and pharmacist knowledge of the HEDIS® measures for diabetes, hypertension and asthma, Medi-Cal Rx formulary, and proper documentation of diabetes, hypertension, cardiovascular disease, asthma and other diagnoses (e.g., ADHD)
- Analysis of provider organization's pharmacy fill data and measure compliance to highlight prescribing and refill best practices
- Increasing member knowledge and engagement in chronic disease management

Substance Use Disorder Services Support and Training

The Partnership DMC-ODS (Drug Medi-Cal Organized Delivery System) Regional Model program provides clinicians, administrators and staff with quality improvement expertise. Sites are supported so as to encourage integrated care across the Partnership system, to optimize population health, enhance their patients' experiences of care, promote provider and careteam satisfaction, and foster a culture of continuous quality improvement. Trainings provided on a regular basis include American Society for Addiction Medicine (ASAM) criteria and application.

Partnership provides a range of support and services to contracted Drug Medi-Cal Providers. These include:

- Training and technical assistance to help providers improve services and clinical documentation and regulatory compliance
- Conduct regularly scheduled chart compliance reviews, offering guidance and written feedback focused on quality improvement of services
- Provision of resources such as sample forms, audit instruments and other tools that would help providers develop effective systems of quality records management
- Responding to technical questions related to regulations or practices
- Communication with providers and other agencies in order to better understand and interpret program regulations and to address treatment needs
- Responding to grievance and appeals from Partnership members or other concerned individuals in the areas of access, quality, billing, critical incidents or client rights

Community Partnerships

In many cases, the quality improvement efforts that have the biggest impacts on the health of members involve significant community collaboration and coalitions with local entities. Local entities are crucial partners in developing strategies for Partnership to address deficiencies in performance measures. Local entities in Partnership's communities engaged in this collaboration include: county health departments (including public

health officers), county behavioral health, the four consortia that serve FQHCs in Partnership's community, law enforcement, schools, and various Community Based Organizations (CBOs) or nonprofit agencies. Many providers in Partnership's network provide health care services to Partnership's members and are also partners in larger community-level interventions. This includes primary care physicians, FQHCs, Rural Health Centers, Indian Health Service HealthCenters, hospitals, long-term care facilities, specialist physicians, hospice agencies, and community pharmacies. Community partnerships can take place on various levels, from engaging with partners and networking, to actively participating in or convening larger groups to drive change and further large-scale initiatives.

Partnership's participation in community partnerships can be in one of five roles: Leader, Convener, Participant, Funder, and Advocate. Multiple job positions within Partnership attend meetings with various partners and stakeholders and take on one of these roles depending on their scope of knowledge and decision-making authority.

Some current major initiatives involving community partnerships with local entities include:

1. Mental Health Integration
2. Improving Access to Specialty Care Services
3. Regional Approach to Treating Substance Use Disorder
4. Integrating Medical Records through HIEs
5. Implementing CalAIM including establishing partnerships within each county Partnership serves
6. Improving preventive care quality outcomes for members less than 21 years of age
7. Community Health Assessment & Community Health Improvement Plan (CHA/CHIP) collaboration
8. Population Health Community Engagement
~~8.~~9. Participate in county Behavioral Health Services Act (BHSA) Community Planning Process

To further elaborate on the community partnerships, the table below highlights a few examples of current and ongoing initiatives, specific to mental health integration and treating substance use disorder:

Community Activities		
Wellness and Recovery	**Mental Health**	**Other Initiatives**
Collaboration with local hospitals to integrate Community Health Workers within emergency departments to provide warm handoffs to substance use disorder service providers.	Collaborating with counties and Sac Valley Medshare to improve data sharing~~solution~~ through a common ~~single~~ source.	Multi-Payer Fee Schedule – participating with school districts to provide school-linked behavioral health services.
Shasta County Substance Abuse Coalition	Collaborating with counties to provide resources and support for clients diagnosed with an eating disorder.	Conduct monthly Learning Collaborative with our school partners around behavioral health service delivery.
Humboldt County Drug Medi-Cal Huddle	Engaging with non-contracted providers to provide alternate solutions for services to clients with an eating disorder.	Meet quarterly with all county Child Welfare Partners to review utilization, coordination of care and discuss services.
Drug Safe Solano Substance Use Coalition	Streamlining processes internally to offer an option for Partnership to take the "lead" on eating disorder cases where county capacity is lacking.	Meet quarterly with all First Five partners to review utilization, coordination of care and discuss services.
Meet quarterly with all county Behavioral Health partners to review SUD referrals, coordination of care and discuss services.	Streamlining processes internally with other departments for coordinating care for eating disorders and other mental health conditions.	
	Coordinating with other departments to improve reporting measures related to mental health and eating disorders.	

Community Activities		
Wellness and Recovery	**Mental Health**	**Other Initiatives**
	Meet quarterly with all county Mental Health Plan partners to review utilization, coordination of care and discuss services.	

Member Input

Members are also crucial partners in informing strategies and interventions Partnership pursues to address deficiencies in performance measures and reduce health disparities. Member input is obtained from member outreach events, member experience surveys, member focus and engagement groups, member grievance and appeals data, CAC feedback, FAC feedback, PCP/specialist access and availability data, Member Services telephone access reports, and member suggestions~~, and member requests for PCP transfers~~. Consumers are also represented on the Q/UAC and Partnership Board of Commissioners. Member feedback on Health Equity-related interventions is encouraged and requested in our Health Equity playbook, which emphasizes the importance of outreaching and gaining insight from those who are actually experiencing the disparities. Provider organizations are also encouraged to employ similar playbook tactics to improve care within their practices. Various workgroups meet to review the data collected at least quarterly and the workgroups recommend areas for improvement and action plans. These are presented and monitored by IQI. Performance on HEDIS® measures and progress made in other QI activities are shared with Partnership's members through the Q/UAC, CAC, FAC, and member newsletter.

Physician and Other Clinician Input

Through Partnership's committee structure, clinicians provide input on the quality improvement program including focus areas, strategies to improve care and service, and effective ways for measuring performance in projects. In addition, clinician input is provided on various projects such as the pay-for-performance programs for primary care, specialtycare, and hospitals. Partnership holds "provider comment periods" where physicians and their staff can provide input on priorities for these programs. Across all work, Partnership solicits input on priorities and interventions through committee meetings and other meetings with provider practices and clinic consortiums.

Population Health Community Engagement and Partnerships

The Population Health Management (PHM) department participates in continuous community engagement and outreach, including community partner collaboration. PHM attends various in-person community outreach events and works to build trust among members within each community, as well as community partners. Attendance at community events is imperative for strengthening the relationship between Partnership and external stakeholders. Outreach at these events includes promotion of well-child visits, timely prenatal care and postpartum visits, adult wellness care, and general education about Partnership benefits. Partnership's regional liaisons and leaders in various departments actively participate in both internal and external workgroups to share information and reduce duplication of effort. Through collaborative meetings, these staff members identify community resources that may benefit Partnership members, ~~and~~ share these resources with the organization to promote integration into program offerings that meet member ~~needs~~needs and address any gaps in care or services. Programs within the community or offered through providers may include:

- Enhanced Case Management (ECM)
- Community Supports
- Regional Center participation
- Behavioral Health and Wellness & Recovery services
- Eating Disorder treatment
- Outpatient palliative care
- Other community programs such as WIC, First 5, support groups, community collaboratives, etc.

Furthermore, in alignment with DHCS' Population Health Management Policy Guide and ~~2024~~most recent

Contract, Partnership works collaboratively with Local Health Jurisdictions (LHJ), county Behavioral Health, hospitals, community providers, other payers, community-based organizations, member representatives, and other community stakeholders on each county's CHA and CHIP process to produce a triannual report. This collaborative work, referred to as the Local Planning requirements, has replaced DHCS' historically mandated Population Needs Assessment. Together with these agencies, Partnership works with community stakeholders to prioritize local needs and agree upon a shared plan of action to keep the communities and members it serves be healthy.

See ~~MCND 9001~~MPND 9001 for further details of Population Health Management's community engagement.

Population Health Management Strategies

Since 2017, Partnership has made significant inroads in establishing practices to lay the foundations for creating a Population Health Management (PHM) program. In February 2020, Partnership established the Population Health department. The Population Health, QI/PI, and Health Equity departments and teams conduct coordinated work to support the objectives of quality and equitable care and services for Partnership members through the following activities:

- Provision of guidance and updates on the NCQA standards related to PHM
- Participation in creating and executing QI and Health Equity initiatives that address identified health disparities andopportunities for member engagement/strategic program development
- Assistance in evaluation of initiatives, state-mandated work and performance improvement projects to determine the effectiveness of developed PHM programs
- Review and analysis of HEDIS® measure performance to help determine necessary targeted interventions to improve member health outcomes and well-being
- Development of broad-based member outreach strategies designed to engage members and direct them to their PCP network.
- Review ~~and~~ periodic revision to value-based programs to ensure they are supporting providers in their attempts to complete recommended missing services for members
- Execution of Partnership Improvement Academy workshops and training programs, as needed
- Local community stakeholder engagement, including support of local LHJ's Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP) processes

Population Health, QI/PI, and Health Equity reside within Health Services. The Population Health and QI/PI departments report up to the CMO and the Health Equity department reports up to the CHSO. The Population Health department maintains a series of documents similar to those maintained by the QI/PI department including the Population Needs Assessment (PNA), Population Health Management Strategy and Program Description, the Population Health Work Plan, ~~and~~ the Segmentation Report, and the Impact Analysis, which are then presented at IQI, Q/UAC, ~~and~~ PAC, and QIHEC. ~~,~~ Of note, the Population Needs Assessment is ~~first reviewed by the internal Population Needs Assessment Committee prior to being~~also reviewed by ~~reviewed by the remainder of the committees, including~~ several additional committees beyond what are listed above. The Population Health Department also oversees the writing and implementation of the ~~Health Equity~~ Cultural and Linguistic (C&L) Trilogy documents consisting of the C&L~~/QIHETP~~ workplan (previously known as the C&L/QIHETP workplan), the C&L Program Evaluation, and the C&L Program description; all three of these documents are also reviewed and approved by IQI, Q/UAC, and PAC; they are also reviewed by QIHEC. ~~Each department is led by a director that has a standing meeting time to discuss shared and separate work priorities to further support alignment of activities and optimal outcomes.~~

See the Population Health Management Strategy and Program Description, (MP~~C~~ND9001) and the C&L Program Description (MP~~C~~ND9002) for further details.

NCQA Accreditation Program Management

Partnership strives to improve the health status of members and their care experience to become one of the highest quality health plans in California. The NCQA Health Plan Accreditation (HPA) and Health ~~Equity~~ Outcomes Accreditation (H~~E~~OA) support Partnership's vision, mission, and strategic goals and fulfill Partnership's contractual obligations with DHCS.

Partnership is an NCQA Health Plan accredited organization as of January 2021, having successfully achieved renewal as of December 2023. HPA

- Provides a framework to guide our operational and quality improvement activities.
- Provides a nationally recognized standard and definition for a high-quality health plan, performance against which will allow Partnership to compare ourselves objectively against other high-quality plans.
- Offers the only widely available health plan assessment that bases results on clinical performance (HEDIS®) and member experience (CAHPS®).

Partnership is an NCQA Health Outcomes accredited organization as of August 2025~~on a journey to obtain NCQA HEA. HEA focuses on the foundation of health equity work. HEA Builds an internal culture that supports the organization's external health equity work~~. HOA

- Allows us to understand our population and its unique or special needs~~Collects data that helps the organization create and offer language services and provider networks mindful of individuals' cultural and linguistic needs~~.
- Identifies disparities or differences in health outcomes, experience or access, and act to address barriers~~opportunities to reduce health inequities, improve care and member experience~~.
- Monitors progress continuously using measures tailored to our unique population.

Program objectives are outlined separately for HPA and HO~~E~~A:

Health Plan Accreditation

- Maintain compliance of all NCQA ~~Health Plan Accreditation (~~HPA~~)~~ Standards and Guidelines, following the 2026 Standards and Guidelines, Triannual Policy Updates and Monthly FAQs.
- Monitor plan-wide compliance of HPA requirements through Renewal Survey.
- Successfully submit Partnership's HPA Renewal Survey on September ~~22~~15, 2026.
- Obtain the renewal of Accredited status by December 2026.

Health ~~Equity~~ Outcomes Accreditation

- Maintain compliance of NCQA HOA Standards and Guidelines, following the 2026 (or 2027, once it becomes available) Standards and Guidelines, Triannual Policy Updates, and Monthly FAQs~~Develop knowledge and build readiness for Initial Survey~~.
- Monitor plan-wide compliance of HO~~E~~A requirements for ~~Initial~~ Renewal Survey.
- Successfully submit Partnership's HOA Renewal ~~Initial~~ Survey on ~~June 17~~May 16, 202~~5~~8.
- Obtain the Accredited status by ~~September 2025~~August 2028.

The NCQA Accreditation Program is managed via a tiered approach. A description of each tier is provided to define roles and responsibilities for each level of the program's governance.

- NCQA Program Management Team
  - Leads and coordinates efforts across each level of NCQA governance.
  - Manages the plan-wide NCQA Accreditation process, specifically:
    - Updates and maintains ownership of NCQA requirements through a plan-wide project work plan.
    - Updates and maintains the plan-wide evidence submission library, a list of required documents that are used to demonstrate compliance.
    - Identifies data needs and reports completion/approval dates through a grand analysis report schedule.
    - Coordinates a plan-wide mock survey with the NCQA consultant.
    - Reviews and assesses the Standards and Guidelines, coordinates any follow-up questions based on NCQA T~~t~~ri-~~a~~Annual ~~p~~Policy ~~u~~Updates and ~~m~~Monthly FAQs.
  - Provides advisory support and guidance across NCQA Accreditation processes, standards/requirements, ~~and HEDIS®~~ and CAHPS® reporting, as needed.
  - Maintains and updates the HPA and HOA NCQA compliance dashboards to evaluate progress.
  - Monitors and reports program status, escalates risks/barriers in a timely fashion.
  - Recommends changes to new and/or existing business practices to support and sustain program structure.
  - Fosters collaboration between departments and determine roles and responsibilities where co-ownership of subset requirements is needed.
  - Facilitates the NCQA Steering Committee.
  - Serves as liaison with Business Owners across the health plan and as the primary liaison to NCQA,our consultant, and Medicaid health plans.
- NCQA Steering Committee
  - Leads NCQA Accreditation efforts by defining Partnership's NCQA program vision and purpose, and provides overall strategic direction.
  - Monitors and reviews program progress relative to goals, timelines and metrics.
  - Champions NCQA Accreditation ~~readiness~~ compliance across the organization.
  - Resolves program conflicts and disputes, reconciling differences of opinion and approach.
  - Evaluates and approves major program components including program timelines, resource allocations, budget, risk management strategies, and program management/governance practices.
- NCQA-Related Key Activities
  - Standards are assigned to departments where the Business Owners reside.
  - Activities take place over the fiscal year to ensure compliance is maintained for all HPA and H~~E~~OA

Standards and Guidelines.
    - All Business Owners are required to complete the key activities to maintain compliance of all assigned NCQA Standards and Guidelines.
- Business Sponsor
    - Holds a Partnership leadership position and is usually from the same department as the Business Owner. This person has formal authority/ownership for assigned requirements based on business practices.
    - Supports the Business Owner in achieving compliance and addressing any obstacles or barriers to the work and escalates project risks if needed. Escalation will include, but is not limited to, identifying needs for additional communication with stakeholders from regional counterparts, contributors, operational leadership, and the NCQA Steering Committee.
- Business Owner
    - Manages and/or executes the day-to-day work in order to achieve and maintain compliance of the assigned NCQArequirements, in alignment with NCQA's look-back period and frequency.
    - Maintains deep subject matter expertise across the requirements, which includes reviewing and addressing changes to NCQA standards timely, including Tri-annual Policy Updates and Monthly FAQs.
    - Collaborates and coordinates activities and deliverables with the contributors. Collaboration will include, but is not limited to, communicating the project's timeline, scope of work, roles and responsibilities.
    - Tracks and reports progress toward compliance with the requirements.
    - Provides periodic updates, at least quarterly, to the NCQA Program Management Team and contributor(s). Updates will include, but are not limited to, progress updates, risks and/or barriers, and staffing changes.
    - Raises issues to the Business Sponsor should challenges occur.
    - Primary contact for evidence preparation and responsible for all submissions.
- Contributor
    - A staff member outside of the Business Owner's department who holds subject matter expertise related to the assigned NCQA requirement(s).
    - Collaborates actively with the Business Owner to ensure successful completion of NCQA-related tasks. This includes, but is not limited to, providing expertise, data, policies, documents, and/or work deliverables timely to meet NCQA Standards.
    - Notifies the Business Owner and the NCQA Program Management Team of any staffing changes.

As part of the NCQA HPA process, Partnership reports HEDIS® and CAHPS® annual results to NCQA in June of each year. Evaluation of HEDIS® and CAHPS® performance is separate from Standards and Guidelines scoring. NCQA assesses Medicaid Health Plan quality based on various clinical measures, including preventive services to keep members healthy and treatments in response to illnesses and chronic diseases. NCQA also evaluates a Health Plan based on customer satisfaction. In September 20242025, Partnership earned a Health Plan Rating (HPR) of 3.5 stars.

Partnership's next HPA reaccreditation survey, or Renewal Survey, is scheduled for September 22, 2026. The table below summarizes key HPA and HOA survey dates, as well as HEDIS® and CAHPS® reporting and scoring requirements.

HPA Survey Option	Partnership Survey Status	HEDIS®/CAHPS® Reporting and Health Plan Rating (HPR) Scoring
HPA Renewal	December 2023: Reaccreditation Status received September 2215, 2026: Next Renewal Survey submission date November 9-102-3, 2026: Two-day HPA file review audit	Annual HEDIS®/CAHPS® reporting (MY 20242025) in June 2025-2026 and annual HPR scoring in September 20252026.

	December 2026 (targeted): Health Plan Accredited	
HOA Renewal	August 2025: Accreditation Status received May 16, 2028: Renewal Survey submission date August 2028 (targeted): Health Outcome Accredited	Not Applicable.

~~At the time of preparing the QI Program Description, Partnership is positioned to obtain Health Equity (HE) Initial Survey Accreditation in September 2025, to fulfill the January 1, 2026 DHCS mandated timeline. Partnership will continue its process of sustaining compliance with the HEA Standards and Guidelines throughout the fiscal year. All key stakeholders are required to review NCQA changes and clarifications, including the Triannual Policy Updates and Monthly FAQs, and initiate revisions, as needed, in alignment with NCQA's expectations and look-back period.~~

Cultural Competency and Health Equity Training

Partnership is committed to delivering culturally and linguistically appropriate services (CLAS) to all eligible beneficiaries. The Health Education, Cultural and Linguistic (HEC&L) team regularly assesses and documents member cultural and linguistic needs to determine whether covered services are available and accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability. The HEC&L team also ensures that all cultural and linguistic services are provided in an appropriate manner.

Currently, the Population Health department is responsible for the operations of the Health Education, Cultural and Linguistic Services Program. Additionally, CAC and FAC provide recommendations on the development and implementation of culturally and linguistically accessible services.

Partnership's policies and procedures comply with standards and performance requirements for the delivery of culturally and linguistically appropriate health care services. Partnership has systems and processes to:

- Assess, identify, and track linguistic capability of bilingual employees
- Identify and track linguistic capability of contracted staff in medical and non-medical settings
- Collect data on cultural, ethnic, racial and linguistic needs and prepare biennial analysis to ensure Partnership and its providers deliver services that meet the needs of Partnership's culturally diverse population
- Conduct a PNA and disparity assessment every year to: identify member health needs and health disparities to promote health equity; evaluate Health Education, C&L and QI activities and available resources to address identified concerns; and implement targeted strategies for Health Education, C&L and QI programs and services. Please see the PNA for detailed findings and the related Action Plans.
- Collaborate with the Director of Health Equity to provide cultural competence, sensitivity, and diversity training to staff, providers and relevant delegates per recommendations from the 24-016 All Plan Letter

Currently, the Health equity department is responsible for reviewing discrimination grievances and providing recommendations to the Grievance and Appeals team to determine whether practitioners are recommended to take DEI training per the All Plan Letter (APL) 24-016 and any future related or superseding APLs..

Partnership monitors and evaluates the effectiveness of cultural and linguistic services by reviewing and responding to:

- CAHPS® Survey data
- Member grievance and appeals

- Reports of utilization of interpreter services by language
- Provider assessments and Site Reviews
- Disparities in HEDIS® data
- ~~Diversity~~Diversity, equity, and inclusion training completion rates

See the Cultural and Linguistic Program Description (MCND9002) and Quality Improvement and Health Equity Transformation Program Description (MCED6001) for additional details.

Communication Systems

Partnership communicates its QI/PI program activities internally and externally through the following mechanisms:

Internal Communications

- Monthly QI/PI department meetings to provide program and project updates, department priorities and identify critical issues and plans of action
- QI/PI directors and managers communicate more frequently with their respective teams and individual staff throughout each month. This is accomplished via meetings, huddles, and email communications.
- The QI/PI leadership team meets monthly with the Senior Director of QI/PI to assure timely organizational updates, consistent messaging and prioritization across the QI/PI department. The CMO attends when available or gives input through regular 1:1s with the Senior Director of QI/PI and Medical Director for Quality.
- Recurring meetings with PR, Regional leadership, and Population Health to provide information on key QI/PI projects and other updates on QI programs
- Recurring Health Services Department Leadership Committee meetings to share information regarding improvement activities within the Health Services department
- 5 Star Room QI/PI key information and performance displays in Fairfield and Redding offices
- Department SharePoint pages
- Written department updates provided to all department heads and senior leadership as part of monthly Operations meeting hosted by the COO
- Partnership's internal website PHC4ME
- Quality Measure Score Improvement initiative and corresponding cross-functional workgroups categorized and focused by clinical measure domain
- NCQA Newsletter

External Communications

- Quarterly CAC meetings to provide~~r~~ updates on pertinent activities and allow committee members to provide input on initiatives, program design and evaluation
- FAC meetings that occur at least four times per year to share information and solicit input on topics and initiatives that impact CCS members
- Standing Consortia meetings to solicit input from providers
- Regional medical director/quality meetings
- QIP Advisory Groups to solicit input on value-based programs
- Periodic feedback from providers via "provider comment periods" on performance metrics and QIP measures
- Quarterly input on QI programs and proposed initiatives via the Board Advisory Group
- Monthly QI/ PI update document that summarizes activities for the QI department and is included in IQI andQ/UAC meeting packets
- Texting campaigns related to closure of quality gaps, relationship building, as well as health education are sent via Partnership's texting platform.
- Partnership makes ad-hoc updates as needed and conducts bi-annual audits to ensure QI project and program information on the website remains accurate and up to date.
- Member newsletters released two times per year that include articles covering preventive health and QI/PI projects

- Quarterly Provider Newsletters that include articles specific to QI/ PI in the designated "Quality Corner" section of the document
- Outbound and inbound calls and communication fielded by the Member Services department
- Care Coordination calls with members
- Population Health member outcall projects and campaigns
- Monthly external QI newsletters that describe activities and training resources ddto improving quality of care
- Conferences, trainings, onsite meetings, webinars to share best practices across regions
- ePrompts member level reminders about HEDIS® related preventive health services incorporated into Partnership's Call Center system, Provider Online Services system, and online Member Portal

Delegation

Performance and oversight outcomes of ~~D~~delegated quality activities ~~to contracted providers~~ are reviewed and approved at least annually by DORS~~, IQI, Credentials and Q/UAC committees~~. A delegation agreement, including a detailed list of activities delegated and reporting requirements, is signed by both the delegate and Partnership. Partnership delegates QI for behavioral health to Carelon Behavioral Health.

- Reporting quality improvement activities and analyses to Partnership on a quarterly or semi-annual basis is done for delegated QI activities
- Evaluation includes a review of both the processes applied in carrying out delegated activities, and the outcome achieved toward quality improvement in accordance with the respective policy(ies) and agreement governing the delegated responsibility
- The DORS~~, IQI, Credentials, and Q/UAC~~ committee~~s~~ reviews evaluations and make recommendations regarding opportunities for improvement and continuation of delegated functions
- Partnership QI/PI staff communicates feedback from ~~the~~ DORS~~, IQI, and Q/UAC~~ to ~~contract providers~~applicable delegates and incorporates improvement activities initiated in the annual QI/PI work plan.

Review by Outside Licensing Agencies or Accrediting Bodies

Medi-Cal is a federal and state-funded program and CMS has delegated administration of the state program to the California DHCS. CMS permission is required in order for the state to delegate program administration to Partnership. The State must document the cost-effectiveness of the program and provide assurance that program beneficiaries are not negatively impacted by this delegation. Partnership operations, including the QI/PI program, are audited annually by DHCS.

Partnership submits periodic compliance reports to DHCS and undergoes periodic compliance audits. Opportunities for improvement identified through all compliance or regulatory audits are addressed by multidisciplinary teams and corrective action plan development. Implementation of CAPs and other interventions aimed at addressing opportunitiesfor improvement are reported to the IQI and Q/UAC. Partnership maintains a compliance plan that includes monitoring and reporting of fraud, waste, and abuse. The Partnership Compliance Committee consists of representatives of each department including QI/PI.

Sanctions

Sanctions may be imposed on Partnership by an established regulatory agency or purchaser due to failure to meet quality metrics or benchmarks, fulfill data quality and reporting requirements, or meet Corrective Action Plan (CAP) requirements. In any of these cases, a quality review team will collaborate and recommend action plans needed beyond those already established through the annual QI Trilogy and organizational goal-setting processes Resulting action plans will be presented for review and approval by the CEO, COO, CMO, Chief Health Services

Officer, and Senior Director of Quality and Performance Improvement. Action plans and progress reports are shared with Q/UAC.

Annual Quality Improvement Work Plan

The QI/ PI Annual Work Plan is used to track progress on key QI activities and initiatives throughout the year. The document outlines major activities for the QI/PI department and organization ~~as a whole that~~that advance quality
and performance improvement. The QI/PI Work Plan supports the comprehensive annual evaluation and planning process that includes the annual review and revision of the QI/PI program.

Approved annually by the Q/UAC, PAC, and Board of Commissioners, the QI/PI Annual Work Plan indicates planned QI activities and objectives, timelines, and accountable person for each activity. It includes progress updates on planned activities and objectives for improving quality of clinical care, safety of clinical care, quality of service, and member experience. The annual evaluation of the QI/PI program is also listed as a specific activity on the QI/PI Work Plan. Goals and associated deliverables are included in the work plan and progress tracked at the level of deliverables. Forms for providing status updates are sent to staff one month in advance of the semi-annual and annual update deadlines to be completed by work plan contributors.

The work plan also includes information on issues that were previously identified. Updates on the monitoring of these issues is provided semi-annually, when work plan contributors provide status updates on whether deliverables driving goals are complete, on track, delayed or require additional explanation. These issues are tracked in a separate worksheet within the work plan.

Annual Quality Improvement Program Evaluation

The overall effectiveness of the QI/PI program is evaluated in writing annually by IQI and Q/UAC and is approvedby Q/UAC, PAC, and the Commission. The QI Program Evaluation includes:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.
- Trending of data on key measures to assess performance in the quality and safety of clinical care and quality of service.
- Analysis and evaluation of distinct programs, initiatives and QI-related work as well as the overall effectiveness of the QI/PI program and of its progress toward influencing network-wide safe clinical practices. The summary of effectiveness also addresses the adequacy of the organizational resources involved in the QI/PI program.
- The annual QI Work Plan goals and associated deliverables are informed by the QI Evaluation. The evaluation provides summations and analysis of many of the key activities outlined in the accompanying work plan. In turn, if there are opportunities for improvement identified in the evaluation of prior year initiatives and work conducted to support the goals of the quality improvement program, these opportunities are translated into goals with actionable deliverables for the next year's work plan. The results in the QI Evaluation, particularly those tied to the need to revisit allocated resources, for committees, standing programs and other related activity are assessed, and if changes are deemed necessary, they are reflected in the QI/PI program in the subsequent year.
- The annual QI Work Plan goals and associate deliverables informed by the Model of Care and the performance improvement efforts aligned with the D-SNP program, specifically those associated with CMS and DHCS-specific quality metrics.

The following are separate evaluations and not included in the QI Program Evaluation:

- Evaluation of the Cultural and Linguistic Program activities
- Evaluation of Utilization Management and Care Coordination activities
- Evaluation of the Population Health program
- A comprehensive evaluation of member grievance and appeals

- Evaluation of the Quality Improvement and Health Equity Program and corresponding work plan activities, as defined in the program description for the Quality Improvement and Health Equity Transformation Program (QIHETP)

A summary of the QI Program Evaluation, including a description of the program, is provided to members or practitioners upon request.

Statement of Confidentiality

Confidentiality of provider and member information is ensured at all times in the performance of QI/PI program activities through enforcement of the following:

- All members of the Q/UAC and Credentials Committee are required to sign a confidentiality statement that is maintained and securely stored in the respective QI or Provider Relations files.
- All QI/PI and Utilization Management documents are restricted solely to authorized Health Services department staff, members of the PAC, Q/UAC, PRC, and Credentials Committee, and reporting bodies as specifically authorized by the Q/UAC.
- Confidential documents may include, but are not limited to, Peer Review and Credentials meeting minutes and agendas, QI and Peer Review reports and findings, PQI and QI files, Utilization Management reports, or any correspondence or memos relating to confidential issues where the name of a provider or member is included.
- Confidential peer review documents that are protected by California Evidence Code §1157 are designated "Confidential – Protected by CA Evidence Code 1157."
- Confidential documents are stored in locked file cabinets or restricted network folders with access limited to authorized persons only.
- Confidential documents are destroyed by shredding.
- Partnership has designated a Privacy Officer responsible to oversee compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other state and federal privacy laws.

- Partnership maintains administrative structure, reporting procedures, due diligence procedures, training programs and other methods to ensure effective compliance in use and disclosure of members' Protected Health Information (PHI).

Statement of Conflict of Interest

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

Original Date: QI/UM Program Description 04/22/1994 – Effective 05/01/1994
Revision Date(s): 08/16/95
As: Quality Management Program – July 1997
Revision Date(s): January 2000, March 2002, (QD100101) October 2002, September 2004, May 2006, (MPQD1001) May 2007, April 2008, May 2009, October 2009 *(re-signed)*, May 2010, April 2012, March 2013, March 2014, March 2015, March 2016, March 2017, November 2017, *October 2018, February 2019 *(Amended)*, September 2019 *(Amended);* September 2020; September 2021; September 2022; September 2023, September 2024, September 2025, September 2026

*Effective October 2018, Approval Date reflects the month in which the Physician Advisory Committee reviewed and approved.

Appendix A: Quality and Performance Improvement Program Description
Standing Staff Members of Partnership QI Committees

(Does not include external physician or consumer membership;
see committee description for those details)

Partnership Analytics Steering Committee Standing Members	
Department Represented	**Position Title**
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Chief Health Services Officer
	Senior Director of Quality and Performance Improvement
	Director of Health Equity
Provider Relations	Senior Director of Provider Relations
Claims	Senior Director of Claims
Finance	Chief Financial Officer
	Deputy Chief Financial Officer
	Director of Health Analytics
	Senior Director of Financial Planning and Analysis
Information Technology	Chief Information Officer
	Senior Director of Enterprise Information Management
	Director of Data Warehouse
	Director of Data Governance
Behavioral Health	Senior Director of Behavioral Health
Administration	Chief Strategy & Government Affairs Officer
Member Services	Senior Director of Member Services and Grievance~~Director of Member Services~~

Partnership Board Meeting Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Strategy and Government Affairs Officer
	Senior Director of Regulatory Affairs and ~~Program Development~~Compliance
	~~Behavioral Health Services Administrator~~
	~~Sr. Executive Director of Operations~~
	Regional Directors
	~~Associate~~ Director of Communications and Public Affairs
	Assistant Board Clerk / Executive Assistant to the CEO
	Board Clerk
Claims	Director of Claims
Finance	Chief Financial Officer
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	~~Director of Care Coordination Operations (NR)~~ Senior Director of Behavioral Health
	Chief Health Services Officer
	Senior Director of Quality and Performance Improvement
	Director of Health Equity
Human Resources	Chief Human Resources Officer
Information Technology	Chief Information Officer
Member Services	Senior Director of Member Services and Grievance~~Director~~

Partnership Board Meeting Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
	~~of Member Services~~
Provider Relations	~~Senior~~ Director of Provider Relations

Partnership Compliance Committee Standing Staff Invites *Note: Partnership Staff are not committee members;* *attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Strategy and Government Affairs Officer
	Senior Director of Regulatory Affairs & ~~Contracting~~Compliance
	Senior Director of Behavioral Health
	Regional Directors
Claims	Senior Director of Claims
	Director of Claims
Configuration	Director of Configuration
Finance	Chief Financial Officer
	Director of Internal Audit (Finance)
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Chief Health Services Officer
	Director of Pharmacy Services
	Manager Quality Assurance and Patient Safety
	Senior Director of Care Management
Human Resources	Chief Human Resources Officer
Information Technology	Chief Information Officer
Member Services	Director of Member Services
	Senior Director of Member Services and Grievance~~Senior Director of Member Services~~
	Director of Grievances and Appeals
Network Services	Director of Network Services
Project Management/ Operational Excellence	Director of Operational Excellence and Program/Project Management Office
Provider Relations	Senior Director, Provider Relations

Partnership Community Advisory Committee (CAC) Standing Staff Invites *Note: Partnership Staff are not committee members;* *attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Strategy and Government Affairs Officer
	Senior Director of Behavioral Health
	Director of Regional Operations ~~Regional Director(s)~~
	~~Director of Regional Operations~~Regional Director(s)~~Regional Manager(s)~~
	Manager of Communications
	Program Manager I, Communications
	Communications Specialist
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Regional Medical Director(s)
	Chief Health Services Officer
	Director of Health Equity
	Director of Population Health
	Associate Director of Population Health
	Manager of Population Health
	Senior Health Educator
Member Services	Senior Director of Member Services and Grievance
	Director of Member Services
	Associate Director of Member Services
	Manager of Member Services
	Member Services Representative
	Member Engagement Specialist
	CAC Coordinator
	Administrative Assistant(s) of Member Services
Grievance & Appeals	Director of Grievance and Appeals
	Supervisor of Grievance and Appeals

Partnership Credentials Committee Standing Staff Invites *Note: Partnership Staff are not committee members;* *attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Regional Medical Director(s)
	Associate Medical Director(s)
	Medical Director for Quality
~~Provider Relations~~ Network Services	Senior Director of ~~Provider Relations~~ Network Services
	Associate Director of ~~Provider Relations~~ Network Services
	Senior Manager of Systems Team and Credentialing
	Credentialing Supervisor
	Credentialing Specialist(s)

Partnership Delegation Oversight Review Sub-Committee Standing Members	
Department Represented	**Position Title**
Administration	~~Chief Operating Officer~~
	Regional Director
	~~Sr.~~Associate Director of Regulatory Affairs and ~~Program Development~~Compliance
	Delegation ~~Compliance~~ Program Manager (RAC)
	~~Project Coordinator~~ Program Coordinator II
	~~Supervisor of Program Integrity~~
	~~Associate Director of Operational Excellence and Program/Project Management Office~~
	~~Senior Manager of Regulatory Affairs and Compliance~~
	~~Sr. Director Behavioral Health Services Administrator~~
	~~Director of Grievance and Appeals~~
	Compliance Auditor
Claims	Director of Claims
	Manager of Claims
Finance	Sr. Manager of Business Decisions and Analysis
	Sr. Director of Financial Analysis
Pharmacy	Clinical Pharmacist Director of Pharmacy Services
Quality ~~Control~~ Improvement	Manager of Member Safety Quality Inventory Manager of Quality Improvement Programs
Utilization Management	Associate Director of UM Regulations Program Manager II Director of UM Program Manager I
Enhanced Health Services	Director Enhanced Health Services Manager Enhanced Health Services Associate Director Enhanced Health Services
Population Health	Sr. Health Educator Director of Population Health Management Associate Director of Population Health Management
Care Coordination	Associate Director of Care Coordination Clinical Advisor Associate Director of Clinical Integration Manager of Care Coordination Sr. Director of Care Management
Medicare ~~Office~~	Director of Medicare Program
Transportation	Associate Director of Transportation Services Director of Transportation Services
~~Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health~~)	~~Director of Pharmacy Services~~
	~~Clinical Pharmacist~~
	~~Director of Health Equity~~
	~~Director of Care Coordination~~
	~~Senior Director of Health Services~~
	~~Associate Director of Utilization Management Regulations~~
	~~Sr. Director of Care Management~~
	~~Sr.Associate Director of Care Coordination~~
	~~Director of Population Health~~
	~~Director of Utilization Management~~

Partnership Delegation Oversight Review Sub-Committee Standing Members	
Department Represented	**Position Title**
	~~Manager, Member Safety Quality Investigations~~
	~~Medical Director~~
	~~Director of Enhanced Health Services~~
	~~Director of~~ ~~Transportation~~Manager of Care Coordination
	~~Director of~~Manager, Quality Improvement Programs
	~~Supervisor of Health Education~~
Member Services	Senior Director of Member Services and Grievance~~Sr. Director of Member Services & Grievance~~ Supervisor of Member Services Project Coordinator I
	Associate Director of Member Services
	~~Director of Grievance and Appeals~~
	~~Manager Grievance and Appeals Compliance~~
Project Management/Operational Excellence (PMO)	~~Associate~~ Director of Operational Excellence and Program/Project Management Office Sr. Manager Operational Excellence and Program/Project Management Office Senior Program Manager
Provider Relations	~~Senior Director of Provider Relations~~
	Director of Provider Relations
Network Services	Director of Network Services Program Manager II Manager of Network Services Compliance Program Manager I
	~~Sr. Manager of Provider Network Education and Credentialing~~
Behavioral Health	Sr. Director Behavioral Health Manager of Behavioral Health Sr. Manager of Behavioral Health
Grievance & Appeals	Director of Grievance & Appeals Manager Grievance & Appeals Compliance

Partnership Quality Dual Special Needs Plan (D-SNP) Subcommittee Standing Members *** Indicates that attendance is optional**	
Department Represented	**Position Title**
Administration	Regional Director(s)*
	~~Senior Director of Northern Region*~~Chief Operating Officer
	Director of Operational Excellence and Program/Project Management Office
	Chief Financial Officer
	~~Deputy Chief Financial Officer~~
	Chief Strategy & Government Affairs Officer
	Sr. Director of Regulatory Affairs and ~~Program Development~~Compliance
	~~Sr. Manager of Governance and Compliance~~Assoc. Director of Regulatory Affairs and Compliance
	Medicare Program Manager
Claims	Sr. Director of Claims ~~Director~~

Finance	Director of Health ~~Data~~ Analytics
	Manager of Health Analytics
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	~~Senior Medicare Quality Improvement Program Manager~~Manager of Medicare Quality
	Chief Medical Officer
	~~Medical Director for Medicare Services~~Deputy Chief Medical Officer
	Chief Health Services Officer
	Medical Director for Quality
	Sr. Director Behavioral Health
	Manager of Care Coordination
	Associate Director(s) of Utilization Management
	Director of Pharmacy Services
	Senior Director of Quality and Performance Improvement
	Director of Health Equity
	Senior Director of Care Management
	Associate Director of Care Coordination
	Director of Population Health
	Director of Quality Management
	Senior Manager of Population Health
	Manager of Performance Improvement
	Manager of Quality Incentive Programs
	Regional Medical Director(s)*
	Director of Quality Measurement
	Manager(s) of Quality Improvement Programs*
	Sr. Manager of Performance Improvement*
	Manager of Clinical Compliance
	Manager of Member Safety Quality Investigation
Information Technology	Sr. Director, Enterprise Information Management
	IT Medicare Manager
	Director, Data Warehouse
Provider Relations	Sr. Provider Representative Manager

Partnership Family Advisory Committee (FAC) Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Director of Care Coordination
	Associate Director of Care Coordination
	Chief Health Services Officer
	Senior Health Educator
	Manager of Grievance and Appeals
	Senior Director of Care Management

Partnership Finance Committee Standing Members	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Health Services Officer
	Chief Strategy and Government Affairs Officer
Behavioral Health	Senior Director of Behavioral Health
	~~Northern Region Executive Director (ad hoc)~~
Finance	Chief Financial Officer
	~~Deputy Chief Financial Officer~~
	Senior Director of Accounting/Controller

Partnership Finance Committee Standing Members	
	~~Senior Director of Fiscal Policy and Strategy~~
	Senior Director of Financial Analysis
	Director of Internal Audit
	Director of Facilities
Human Resources	Senior Director of Human Resources (ad hoc)
Information Technology	Chief Information Officer
Provider Relations	Senior Director of Provider Relations

Partnership Governance and Compliance Subcommittee	
Department Represented	**Position Title**
PHC Governance & Compliance Committee Standing Staff Invites	Chief Strategy & Government Affairs Officer
	Director of Regulatory Affairs and ~~Program Development~~Compliance
	Chief Executive Officer
	Chief Operating Officer
	Chief Information Officer (Optional)
	Chief Financial Officer
	Chief Medical Officer (optional)
	Board Clerk
Five (5) members from the Board of Commissioners, with at least one board member representing each of the geographic regions.	

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

Partnership Internal Quality Improvement (IQI) Committee Standing Members	
Department Represented	**Position Title**
	Manager of Care Coordination Regulatory Performance
	Manager Member Safety – Quality Investigations
	Manager of Clinical Compliance – Quality Inspections
	Senior Director of Care Management
	Senior Health Educator
	Associate Medical Director(s)
	Regional Medical Director(s)
	Utilization Management Policy Analyst
Member Services	Senior Director of Member Services ~~&~~and Grievance
Provider Relations/Network Services	Senior Director of Provider Relations
	Director of Network Services

Partnership Member Grievance Review Committee (MGRC) Standing Members	
Department Represented	**Position Title**
Administration (e.g. Regulatory Affairs & Compliance, Network Services, and Legal Affairs)	Regional Director
	~~-~~Chief Operating Officer
	Legal Analyst
	~~Senior Manager~~Associate Director of Regulatory Affairs & Compliance
	Program Manager II
Grievance & Appeals	Director of Grievance & Appeals
	Grievance & Appeals Compliance Manager
	Grievance & Appeals Compliance Analyst
	Senior Manager of Grievance & Appeals
	Senior Grievance & Appeals Nurse Specialist
	~~Senior Manager of Behavioral Health~~
Behavioral Health	Senior Manager of Behavioral Health
Claims	Director of Claims
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Chief Health Services Officer
	Medical Director of Quality
	Director of Pharmacy Services
	Senior Clinical Pharmacist
	Director of Care Coordination
	Director of Care Coordination Operations
	Director of Utilization Management Strategies
	Manager, Member Safety - Quality Investigations
	Program Manager II, Quality Improvement
	Health Equity Officer
	~~-~~Culture & Linguistics Liaison
	Manager of Population Health
Member Services	Senior Director of Member Services and Grievance~~Senior Director of Member Services~~
	Director of Member Services
Provider Relations	Senior Director of Provider Relations
	Senior Manager of Provider Relations Representative
	Senior Program Manager
	Lead PR Representative
	Supervisor of Education Specialist Team
	Senior Provider Relations Representative
Transportation Services	Director of Transportation Services
	Associate Director of Transportation Services
	Manager of Transportation Programs

Partnership Over/Under Utilization Workgroup Standing Members	
Department Represented	**Position Title**
Administration	~~Regulatory Affairs Manager~~Associate Director of Regulatory Affairs & Compliance
	~~Regulatory Affairs Specialist~~Regulatory Affairs Manager
	Senior Director of Northern Region
	Director of Operational Excellence and Program/Project Management Office
Claims	Director of Claims (SR)
Finance	~~Associate~~ Director of Health ~~Data~~ Analytics
	Senior Manager of Cost Efficiency
	Senior Health Data Analyst
	Manager of Health Analytics
	Project Manager II
	Cost Avoidance Manager
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Chief Health Services Officer
	Medical Director
	Behavioral Health Clinical Director
	Director of Care Coordination Operations (NR)
	Associate Director(s) of Utilization Management
	Director of Pharmacy Services
	Senior Director of Quality and Performance Improvement
	Director of Health Equity
	Associate Director of Housing and Incentive Programs
	Associate Director of Care Coordination
	Director of Population Health
	Director of Utilization Management Strategies
	Director of Pharmacy Services
	Regional Supervisor of Utilization Management
	Director of Quality Management
	Senior Manager of Population Health
	Manager of Performance Improvement
	Manager of Clinical Pharmacy
	Manager of Quality Incentive Programs
	Manager of Care Coordination
	Program Manager
Information Technology	Director of Enterprise Information Management
Provider Relations	Senior Director of Provider Relations
	Senior Provider Relations Representative Manager
	Senior Manager of Provider Relations Representatives
	Senior Manager of Provider Network Education and Credentialing
	Manager of Provider Relations Representatives (SR)
	Manager of Provider Relations Representatives (NR)
	Program Manager
	Senior Provider Relations Representative
	Provider Relations Representative

Partnership Pediatric Quality Committee (PQC) Standing Staff Invites *Note: Partnership Staff are not voting committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Medical Director
	Chief Medical Officer
	Director of Health Equity
	Senior Director of Care Management
	Chief Health Services Officer
	Director of Pharmacy Services
	Director of Care Coordination

Partnership Peer Review Committee Standing Staff Invites *Note: Non-Medical Director Partnership Staff are not voting committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer
	Medical Director for Quality
	Manager, Member Safety-Quality Investigations
	Supervisor of Member Safety-Quality Investigations
	Quality Investigator, Member Safety
	Project Coordinator, Member Safety-Quality Investigations
	Manager, Clinical Compliance Inspections Team
	Supervisor, Clinical Quality and Member Safety-Quality Inspections
	Clinical Compliance Inspectors, Clinical Quality and Member Safety-Quality Inspections
	Chief Health Services Officer
	Director of Health Equity
	Regional Medical Director(s)
	Associate Medical Director(s)
	Director of Pharmacy Services or Designated Pharmacist
	Behavioral Health Clinical Director

Partnership Pharmacy & Therapeutics (P&T) Committee Standing Staff Invites *Note: Partnership Staff are voting committee members; attendance is not mandatory nor is adelegate required* **P&T invitees, not standing PNT committee members*	
Department Represented	**Position Title**
Health Services	Chief Medical Officer
	Director of Pharmacy Services
	Clinical Pharmacist(s)
	Sr. Clinical Pharmacist(s)
	Behavioral Health Clinical Director
	Regional Medical Director(s)
	Associate Medical Director(s)
	Chief of Health Services Officer

Partnership Pharmacy & Therapeutics (P&T) Committee Standing Staff Invites *Note: Partnership Staff are voting committee members; attendance is not mandatory nor is adelegate required* **P&T invitees, not standing PNT committee members*	
	Pharmacy Operations Supervisor

Partnership Physician Advisory Committee (PAC) Standing Staff Invites *Note: Partnership Staff are not voting committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Behavioral Health Clinical Director
Finance	Chief Financial Officer
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Population Health, and Care Coordination) ~~Provider Relations~~	Chief Medical Officer
	~~Medical Director for Medicare Services~~Deputy Chief Medical Officer
	Medical Director for Medicare Services~~Senior Director of Quality and Performance Improvement~~
	Senior Director of Quality and Performance Improvement~~Chief Health Services Officer~~
	Chief Health Services Officer~~Director of Pharmacy Services~~
	Director of Pharmacy Services~~Associate Director(s) of Utilization Management~~
	Associate Director(s) of Utilization Management~~Director of Health Equity~~
	Director of Health Equity~~Director of Population Health~~
	Director of Population Health~~Medical Director for Quality~~
	Director of Enhanced Health Services~~Senior Director of Care Management~~
	Medical Director for Quality~~Regional Medical Director(s)~~
	Senior Director of Care Management~~Senior Director of Provider Relations~~
	Regional Medical Director(s)
Provider Relations~~Network Services~~	~~Senior~~ Director of Provider Relations~~Director of Network Services~~
Network Services	Director of Network Services

~~**Partnership Population Needs Assessment (PNA) Committee**~~	
~~**Department Represented**~~	~~**Position Title**~~
~~Population Health~~	~~Director of Population Health~~
	~~Associate Director of Population Health~~
	~~Manager of Population Health~~
~~Administration~~	~~Regional Director (South)~~
	~~Regional Director (Northeast)~~
	~~Regional Director (East)~~
	~~Regional Manager (North)~~
	~~Chief Medical Officer~~ ~~or Deputy Chief Medical Officer~~
	~~Chief Operating Officer~~
~~Behavioral Health~~	~~Senior Director of Behavioral Health~~
~~Health Equity~~	~~Director of Health Equity~~
~~Health Services~~	~~Chief Health Services Officer~~
~~Office of CMO~~	~~Medical Director (South~~Fairfield~~)~~

~~Partnership Population Needs Assessment (PNA) Committee~~	
	~~Medical Director (Northeast)Redding~~
	~~Medical Director (EastAuburn)~~
	~~Medical Director (NorthEureka)~~ ~~Medical Director Santa Rosa~~ ~~Medical Director Chico~~
~~OpEx/PMO~~	~~Director of OpEx/PMO~~
	~~Senior Manager of OpEx/PMO~~
~~Transportation Services~~	~~Director of Transportation Services~~
~~Utilization Management~~	~~Associate Director of Housing & Incentive Programs~~
~~Quality Improvement~~	~~Senior Director of Quality and Performance~~
	~~Director of Quality Management~~

~~Partnership Provider Engagement Group & Networking (PENG) Standing Members~~	
~~Department Represented~~	~~Position Title~~
~~Administration~~	~~Chief Executive Officer~~
	~~Chief Operating Officer~~
~~Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)~~	~~Chief Medical Officer or Deputy Chief Medical Officer~~
	~~Regional Medical Directors~~ ~~Regional Directors~~
~~Provider Relations~~	~~Senior Director of Provider Relations~~ ~~Director of Member Services and Provider Relations~~ ~~SR ManagerAssociate Director of Provider Relations Representatives~~ ~~Managers of PR Representatives, SR and NR~~ ~~Supervisor of Network Education & Training~~

Partnership Quality Improvement and Health Equity (QIHEC) Committee Standing Members	
Department Represented	**Position Title**
Administration	Director of Grievance and Appeals
	Chief Operating Officer
	Associate Director of Communications
Finance	Director of Health Analytics
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer or Deputy Chief Medical Officer
	Director of Health Equity
	Senior Director of Quality and Performance Improvement
	Medical Director for Quality
	Director(s) of Care Coordination
	Director(s) of Utilization Management
	Director(s) of Population Health
	Senior Health Educator
	Chief Health Services Officer
	Director of Pharmacy Services
	Regional Medical Director(s)
	Associate Medical Director(s)
Provider Relations	Senior Provider Relations Representative Manager

Partnership Quality Improvement and Health Equity (QIHEC) Committee Standing Members	
Members Services	Senior Director of Member Services and Grievance~~Senior Director Member Services~~

Partnership Quality/Utilization Advisory (Q/UAC) Committee Standing Staff Invites *Note: Partnership Staff are not committee members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Associate Director of Grievance and Appeals
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordinationand Population Health)	Chief Medical Officer – Committee Chair
	Medical Director for Quality – Committee Vice Chair
	Deputy Chief Medical Officer
	Medical Director for Medicare Services
	Behavioral Health Clinical Director
	Regional and Associate Medical Director(s)
	Chief Health Services Officer
	Senior Director of Quality and Performance Improvement
	Director of Health Equity
	Director of Population Health Management
	Director of Enhanced Health Services
	Director(s) and Associate Director(s) of Utilization Management
	Director(s) and Associate Director(s) of Care Coordination
	Director of Pharmacy Services
	Manager, Member Safety Quality Investigation
	Manager of Clinical Compliance – Quality Inspections
Provider Relations	Senior Health Educator
	Senior Provider Relations Rep Manager

Partnership Strategic Planning Committee Standing Staff Invites *Note: Partnership Staff are not committee voting members; attendance is not mandatory nor is a delegate required*	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Strategy and Government Affairs Officer
	Behavioral Health Services Administrator
	Regional Directors

Partnership Strategic Planning Committee Standing Staff Invites *Note: Partnership Staff are not committee voting members; attendance is not mandatory nor is a delegate required*	
	~~Senior Director of Regulatory Affairs and Contracting~~
	~~Director of Communications and Government Affairs~~
	~~Policy Analyst~~
Communications	Director of Communications and Government Affairs
	Associate Director of Government Affairs
	Policy Analyst
Finance	Chief Financial Officer
	Director of Financial Planning and Analysis
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Chief Medical Officer or Deputy Chief Medical Officer
	Director of Health Equity
Information Technology	Chief Information Officer
Regulatory Affairs and Compliance	Senior Director of Regulatory Affairs and Contracting

Partnership Substance Use Internal Quality Improvement Subcommittee Standing Members	
Department Represented	**Position Title**
Administration	Senior Director of Behavioral Health
	Behavioral Health Clinical Director
	Senior Manager of Behavioral Health
	Program Manager, Behavioral Health
	Director of Grievance and Appeals
	Regional Director
	Grievance and Appeals Compliance Manager
Health Services (e.g. Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination and Population Health)	Behavioral Health Clinical Specialist
	Manager of Member Safety – Site Inspections
Claims	Customer Service Manager (NR)
Compliance	Director of Regulatory Affairs and Program Development
Member Services	Supervisor of Member Services
Provider Relations / Network Services	Senior Director of Provider Relations
	Provider Relations Representative (NR & SR)
	Senior Manager of Network Education and Credentialing Manager of Provider Relations Representatives (NR & SR)

Partnership Substance Use Services Provider Advisory Group Standing Members	
Department Represented	**Position Title**
Administration	Senior Director of Behavioral Health
	Behavioral Health Clinical Director
	Program Manager, Behavioral Health
	Senior Manager of Behavioral Health
	Grievance and Appeals Compliance Manager

Appendix B: Quality and Performance Improvement Program Description
Partnership HealthPlan Strategic Quality Plan: Achieving Five-Star Quality

2020-2025

Introduction

In 2017, Partnership HealthPlan of California (Partnership) created a HEDIS® measure score improvement strategic plan, directed at dramatically improving HEDIS® scores by sub-region. Two imperatives have led us to a major revision of this plan. First, the HEDIS® score improvement strategic plan did not address thelink between the member experience and overall quality. Second, Partnership is on the road to NCQA accreditation, which includes a number of standards outside the patient experience and clinical quality scores and defines many activities throughout the organization that impact both.

The purpose of this 2020 update to the strategic plan is to clearly articulate the long and short-term initiatives Partnership will engage in over the next five years to achieve 5-star NCQA Health Insurance Plan Rating status. NCQA accreditation is the gold standard for measuring performance of health plans in the United States. Full accreditation by NCQA categorizes overall health plan performance from zero to five stars, analogous to the Medicare Stars rating system. A 5-star rating is the highest possible score achieved by just 2 of 171 Medicaid plans nationally in 2019; a score of 4-star or above is considered above average, achieved by 40 health plans nationally.

This document serves as a communication tool for Partnership leadership and staff, Board members, providers and other stakeholders and lays a solid foundation from which an operational plan will be created.

This Five-Star Strategic Plan is an elaboration of the first focus area of Partnership's organizational Strategic Plan: to ensure high quality health care to all our members. This strategic plan also aligns with Partnership's vision - to be the most highly regarded Health Plan in California - and its mission, which transcends service to our members to include the greater community, "To help our members, and the communities we serve, be healthy."

Improving quality not only has intrinsic benefits to our members, but it carries intangible benefits to the organization and the community. When quality improvement activities are aligned with the "quadruple aim" of better health, lower cost, better care and caring for the providers, it assists with making the overall health care system function more effectively and efficiently. A focus on quality also improves the reputation of Partnership in the state, allowing further innovation and influence among state-wide stakeholders.Finally, the principles of quality improvement can influence the organization to more efficiently execute on operational priorities not directly related to quality.

Lastly, in 2019, DHCS moved aggressively towards the use of larger scale health plan sanctions for performance on measures that are below average performance. This places additional financial pressure on Partnership to improve quality measure results within our network.

Organizational Values Supporting Quality

To achieve 5-star quality, Partnership must have an organizational culture of quality which is nurtured by the executive leadership team and Board of Commissioners. Core to this culture are these organizational values (from our organizational strategic plan), with aphorisms reflecting these values.

- Partnerships: Fostering strong partnerships with members, providers, and community leaders to collectively improve health outcomes. "Putting our members first."

- Overall focus on Quality: Focusing on continuous quality improvement in every aspect of the organization and in collaboration with our partners. "Doing the right thing right, the first time andevery time."
- Integrity: Set a standard of professionalism, integrity, and accountability. "Striving for perfection, but embracing the opportunity to learn from imperfection. Excellence is achievable!"
- Innovation: Striving to be innovative and seeking creative solutions. "Willingness to challenge the status quo and insist on change when needed."

In addition, the Partnership leadership team has several conceptual frameworks focused on quality:

- Balancing Compliance and Performance: Balancing rigid attention to regulatory requirements with flexibility and innovation needed to drive improvement. "Not all change is improvement, but all improvement requires change."
- Promoting Health Equity: Ensuring an organizational culture that recognizes the diverse backgrounds of our employees and supports the institution of practices that consider social determinants of health, the impacts of implicit bias and the provision of fair and judicious healthcare and services to meet the broad-based needs of our members. "Everyone has a fair and just opportunity to be as healthy as possible."
- Becoming a Learning Health Plan. "Making decisions based on rigorous data analysis wheneverpossible (instead of based on hope or wishful thinking)." "Creating an atmosphere where new ideas can be explored and where strong, independent teams can test these ideas."

The term "Learning Health Plan" is new in this strategic plan, although many associated tactics are not new. More background and explanation is presented next.

Learning Health Plan

A common underlying theme in most Quality Improvement frameworks is that organizations and teams must embrace continuous learning to achieve their highest potential. Tom Nolan, one of the creators of theModel for Improvement, said "What are the necessary and sufficient conditions for improvement in large systems? **Will, ideas and execution!"**

Donald Berwick describes what will, ideas, and execution means:
"Providing **will** refers to the tasks of fostering discomfort with the status quo and attractiveness for the as-yet-unrealized future. Providing **ideas** means assuring access to alternative designs and ideas worth testing,as opposed to continuing legacy systems. And **execution** was his term for embedding *learning* activities and change in the day-to-day work of everyone, beginning with leaders." Milbank Quarterly, August, 2019

The Partnership Executive Team and Board are committed to making a profound and deep link between the necessities of using a learning health plan framework to best serve our members and our communities.

The fundamental tenets of a Learning Health Plan are:

1. Using the scientific method to optimize implementation of quality improvement initiatives
   a. Building on prior research/experiences
   b. Rigorous and widespread testing of change on a small scale (using the model for improvement framework)
   c. Tracking of information gleaned from small tests of change so others can retrieve this information and build upon it.
   d. Use of control groups (where appropriate)
   e. Careful data and statistical analysis

f. Using a combination of classic project management methodology with the ConsolidatedFramework for Advancing Implementation Science[1] to have a systematic effective approach to program implementation and building internal expertise in these approaches.

2. Having the leadership and staff to support this approach
   a. Communicate effectively about quality and change, through a mixture of data and stories. "No data without a story, no story without data."

A Learning Health Plan avoids widespread implementations of any unproven projects, without measurement of what the outcome is, performing weak or no evaluation of the project, and continuing theproject without knowing if it is effective. While such projects are often related to regulatory mandates, gathering data on their effectiveness or lack thereof can provide valuable evidence for advocating policy change.

Without using the term "learning organization" or "learning health plan," Partnership has been building the infrastructure and leadership to include most of these elements. For example, creating a Project Management/Operational Excellence Department and Team, creating a Health Analytics Team, doing internal trainings through the Learning Management System and external trainings, conducting efficient but meaningful Return on Investment analyses of several programs, and developing a system of storing lessons learned in small tests of change in the quality department are all examples.

By identifying the elements of a strong learning health organization and standardizing our communicationaround the core principles, we will solidify the cultural values around being a Learning Health Plan.

Process of Developing 5 Star Strategic Plan

Leaders in the Quality Improvement (QI) Department created this strategic plan with input from Partnership leadership and staff via the HEDIS® Score Improvement team and the Analytics, Care Coordination, Population Health, Information Technology (IT), Member Services, Pharmacy and QI departments.

The scope of this strategic plan is rooted in the emerging field of population health management. Population health management, in the context of a health plan, requires assessment and analysis of member needs, stratifying the population into risk tiers and defining segments for targeted interventions. Once population segments are identified, the health plan engages available resources to improve the health and wellbeing of the plan's assigned membership on both an individual and aggregate level. This is distinct from approaching population health with a public health approach – which would encompass coordinated and multi-sector efforts to improve the quality of health for an entire community or communities – an approach which is beyond the scope of this strategic plan.

The Quality Improvement department will lead the implementation of this strategic plan, collaboratively and in partnership with other departments and providers, respecting capacities and competing priorities.

Evaluation

Partnership is committed to testing new approaches and scaling up when new approaches are successful. The QI department will lead efforts to support processes and systems for learning and monitoring progress on the implementation of the NCQA 5-Star Strategic Initiative Plan, and sharing evaluations with Partnership leaders and our community partners.

---

[1] Keith, R.E., Crosson, J.C., O'Malley, A.S. *et al.* Using the Consolidated Framework for Implementation Research (CFIR) to produce actionable findings: a rapid-cycle evaluation approach to improving implementation. *Implementation Sci* **12,** 15 (2017)

Environmental Factors

The following strengths and weaknesses within the organization and opportunities and threats external to the organization were taken into consideration when drafting this strategic plan.

Strengths	Weaknesses
• NCQA Interim Accreditation status attainted - many standards (notably the Population Health Management standards) directly support improved HEDIS® scores. • Significant programming and ability to offer technical assistance to bolster primary care capacity for quality and clinical improvement • Robust pay-for-performance program and commitment to value-based processes. • Supportive data systems including eReports and Partnership Quality Dashboard • Increasing cross-department collaboration • Strong HEDIS® Medical Record ReviewProject processes • New member portal building an infrastructure to outreach to members • Growing internal analytic capacity and standardized data sets support population health analysis • Recent assignment of largest direct member categories to PCPs so that PCP QIP applies	• Competing priorities: major system implementations, multiple goal teams, efforts to comply with NCQA standards, new benefits, new regulatory mandates • Many databases still not integrated or standardized • Data governance processes not deeply institutionalized • Preventive or coordination services Partnership offers are not widely understood or utilized by members • Member input not deeply integrated into member-facing improvement efforts • Limited Partnership experience in outreaching to members to close HEDIS® gaps • Collaboration across Partnership departments sometimes not prioritized over core departmental work. • Confined "single views" of member; gaps in care not visible across health plan data systems • Regional disparities in access and health risk factors
External Opportunities	**External Threats**
• NCQA First Survey Accreditation (11/2020) – roadmap to becoming higher quality plan • Provider network and communities support improved clinical performance and are willing to partner (e.g., Joint Leadership Initiative) • Provider partner bright spots with best practices and excellent quality scores • Pilot programs to enable greater accuracy of member contact information. • Preparation for MediCare Duals Special Needs Plan (D-SNP) • MCHC for all: Enhanced Care Management and In Lieu of Services proposals • Aligned Proposition 56 incentive funding	• Judicial threats to the Affordable Care Act (risk aversion) • Lethargic CMS response to DHCS proposals impact scope and speed of DHCS policy changes • Changing regulatory environment with increasing risk of financial sanctions and other penalties • Proposed changes to public charge policy (decreased enrollment) • Primary care site staff turnover (providers, nurses, medical assistants) • Member access to PCPs for care • PCP capacity for outreach • PPS providers (provider primary care for over 75% of members): PPS system reimburses based on volume, not services provided (removes some options for incentivizing quality activities) • Natural disasters and power outages • Pharmacy Carve Out

HEDIS® Score Improvement Aim Statement

The Partnership Five Star Quality Strategic Plan Aims to achieve the following:

1. A weighted average of all accountable DHCS MCAS measures >50th percentile (in year 1) with yearly improvement afterwards in three years, all individual measures performance will be above the 50th percentile.
2. ≥25th percentile in all adult and pediatric CAHPS® measures year 1; with yearly improvement afterwards
3. 80% of applicable points earned in each standard category of NCQA accreditation standards, including Must Pass elements

These are ambitious goals and will require a significant amount of investment, collaboration, and focus. The Managed Care Accountability Set (MCAS) will grow from 19 measures for measurement year (MY) 2018 to 36 for MY 2020. With the new MCAS measures, the minimum performance level increased from the 25th to the 50th national Medicaid percentile.

See Appendix E for HEDIS® performance in measurement year 2018.

Focus Areas, Goals and Objectives

This strategic plan is centered on five key focus areas: 1) Engaging Clinical Practices 2) Engaging Members 3) Data Infrastructure 4) Accreditation Standards and 5) Access. Specific activities, timelines, resources, and evaluation benchmarks will be developed in an operational plan. See Appendix A for a visual depiction(process map) of Partnership's Achieving Five Star Quality focus areas and goals.

Focus Area 1: Primary Care Practice Ability to Deliver High Quality Health Care

Partnership recognizes the critical role PCPs play in improving clinical quality performance, as well as optimizing utilization, maximizing access to care and enhancing the patient experience. A central theme within this focus area is to better equip PCPs to provide recommended high quality care through provision of information, technical assistance, improvement tools and financial incentives.

Focus Area 1: PCP Delivery of High Quality Care

Goals	Objectives
A. Supply Actionable Care Gap Data to PCPs	• Optimize: eReports • Optimize: Partnership Quality Dashboard (PQD) • Study: Integrate ePrompts into Provider OnlineServices • Expand: Unblinded quality data sharing • Promote: Electronic Health Record (EHR) workflow optimization, including integration with CAIR
B. Technical Assistance to Support Provider QI Capacity	• Optimize: Mandated PDSA/PIPs/Site Reviews/Prop56 • Expand: Technical assistance offerings, provider education and coaching for large and medium sizedpractices • Sustain: General QI training: ABCs of QI • Adapt: Measure-specific trainings and webinars • Evaluate: PCP leadership development • Study: Partnership leverage for promoting health equity through providers
C. Optimize Pay for Performance Programs	• Optimize: PCP QIP • Optimize: Perinatal QIP • Optimize: Hospital QIP

Focus Area 2: Partnership Engaging Members to Improve Quality Metrics

There is a significant opportunity for Partnership to expand direct-to-member engagement activities to improve MCAS and HEDIS® scores. The goals within this focus area will require Partnership to take on new initiatives and/or expand current initiatives that provide actionable data to Partnership staff, leverage contacts with members through in-reach and outreach, and increase Partnership's presence in communities. Direct health plan contact with members complements the outreach conducted by providers. Partnership Network providers are diverse in size, staffing and resources and may be limited in outreach capabilities for a variety reasons, including competing priorities or absence of supportive technology or workflows. In other instances, members are not assigned to or directly managed by a PCP (e.g., direct members) or the member may have considerablemovement across PCPs during the HEDIS® measurement year.

Focus Area 2: Partnership Engaging Members to Improve Quality

Goals	Objectives
A. Supply Actionable Care Gap Data to Partnership Staff and Members	•Integrate: Prompts into Essette •Integrate: ePrompts into Call Center •Integrate: ePrompts into Member Portal
B. Increase Partnership Member Engagement Capacity	•Pilot: Reminders into Care Coordination workflow •Study: Integration of reminders into Member Services workflow •Expand: Train Partnership staff on targeted qualitymeasures •Study: New and updated member incentives •Increase: Member input into engagement process •Expand: Partnership Outbound engagement activities •Develop: Digital Engagement Solutions
C. Other Strategies for Member Engagement	•Test: Leverage Community Health Workers/CareManagers on Quality Measures •Study: ED and inpatient settings •Test: Outreach to direct members •Expand: Outreach through identification and participation in grassroots community activities

Focus Area 3: Data, Analytics, and Knowledge Management

A critical element to improving MCAS and HEDIS® quality scores lies in Partnership's ability to strengthen data and analytics infrastructure. Additionally, in order to function under the Learning Health Plan framework, foundational systems and processes need to be developed and established to strengthen how data and improvement study results are evaluated and used in decision-making to further optimize the rate of qualityimprovement. Four goals will help improve the organization's infrastructure needed to support and assessprimary care and member interventions.

Focus Area 3: Data, Analytics, and Knowledge Management

Goals	Objectives
A. Actionable CareGap Data to PCPs, Partnership staff and members	• Objectives in Focus Area 1, Goal 1 • Objectives in Focus Area 2, Goal 2 • Expand: Pilots on improving member contact information • Align: Health education tools on Member Portal with quality measures
B. Data Quality, Timely Access and Completeness	• Optimize: Configuration of new core claims system • Implement: Provider Master Data Management • Expand: Data Dictionaries • Operationalize: Data Stewardship Program • Expand: Health Information Exchange (HIE) • Expand: Clinical Data Repository (CDR) • Operationalize: Partnership Data Governance structure
C. Supportive Analytics	• Expand: Well-constructed Data Marts • Build: Comprehensive member data (Member 360) • Optimize: Analysis and presentation of annual quality measure results • Optimize: Leverage rolling-year monthly HEDIS® data • Integrate: Equity analysis with improvement activities
D. Learning HealthPlan Framework	• Expand: Knowledge Management infrastructure • Develop: Standardized scientific approach to small tests of change • Study: Standardized approach to scaling up/implementation

Focus Area 4: Achieving Health Plan NCQA Accreditation

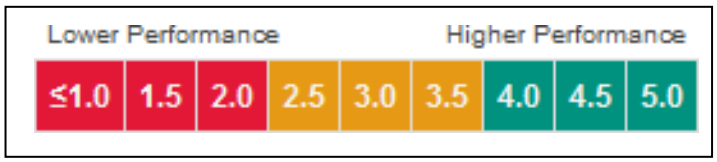
The provision of high quality healthcare to our members is fundamental to Partnership's vision and mission. Wewant to be one of the highest quality health plans in California. NCQA Health Plan Accreditation supportsthis goal by:

- Providing a framework to guide our operational and quality improvement activities. (Many of the activities outlined in the standards are best practices that should be pursued regardlessof our accreditation goals.)
- Providing a nationally recognized standard and definition for a high quality health plan, performance against which will allow Partnership to compare ourselves objectively against other high quality plans.
- Offering the only widely available health plan assessment that bases results on clinical performance (HEDIS®) and member experience (CAHPS®).

In the summer of 2019, Partnership received formal Interim Accreditation Status, receiving 50 out of 50 total possible points. Interim Accreditation ensures organizations have a basic structure in place to meet expectations for consumer protection and quality improvement. Interim Accreditation status indicates a strong position and readiness of an organization to move forward with formal First Survey Accreditation, which covers the full scope of the standards and requirements, including HEDIS® and CAHPS® reporting.

First Survey Accreditation is planned for late 2020-early 2021. As noted earlier, two years after that the HEDIS® and CAHPS® scores will be integrated to give a star rating from 0 to 5.

5-Star Scale



As part of the process for setting appropriate goals and areas of focus, the NCQA Project Management Team reviews the accreditation scoring methodology on an annual basis to appropriately apply updates, changes or modifications. Broadly, here are the categories in which we have extracted as areas of focus,which are resource intensive and have significant cross-departmental impact, expressed as goals:

Focus Area 4: Achieving NCQA Accreditation

Goals	Objectives
A. Pass all "MustPass" Elements	• Optimize: Internal file review • Optimize: Delegated file review • Optimize: Delegates following NCQA Standards • Align: Department Goals
B. Strengthen "Grand Analysis" Improvement Activities	• Optimize: Utilization Management • Improve: Member Experience • Optimize: Network Adequacy and Availability • Implement: Population Health Management • Implement: Continuity and Coordinationof Care • Non-Behavioral • Behavioral
C. Prepare for Medicare	• Measure: Baseline MediCare HEDIS®Measures • Address: MediCare HEDIS® Gaps • Evaluate: MediCare incentive programoptions for patients and providers • Plan: Support for overall quality oversight

Focus Area 5: Improving Member Experience through Improved PCP Access

Background: In the 2019 Partnership CAHPS® survey, the areas below the 25th percentile for adult and children werealmost exclusively in the area of perceived access to services. Since the CAHPS® survey will account for about one-third of our accreditation score and is also slated to become an MCAS measure, it is imperative that Partnership explore additional activities to improve PCP access. While the access composite scores in CAHPS® include questions related to specialty access, only PCP access will be included in Focus Area 5. Activities related to increasing specialty access will be covered in the Access and Availability Grand Analysis required as part of NCQA accreditation.

From July-October, 2019 multiple stakeholders[2] were asked to give feedback and suggestions for increasing access to PCPs in the Partnership service area.

> The 54 ideas that were generated were categorized by the degree of control the Clinical Practice has overthe factor, the degree of control the Health Plan has over the factor, as well as a categorization of the cost, effort and effectiveness of each suggestion. See Appendix D for the details.

Prioritization Process:
We eliminated those suggested interventions that were high cost (3-4) and low estimated effectiveness (1). Additional changes were made, based on feedback from Executive Committee. This leads to these 17 objectives, grouped into four goals.

[2] Nine Joint Leadership Initiatives, Physicians Advisory Committee, Strategic Planning Committee, Medical Directors of Partnership, Board Advisory Group on Quality, Executive Committee at Partnership, Operations Committee at Partnership

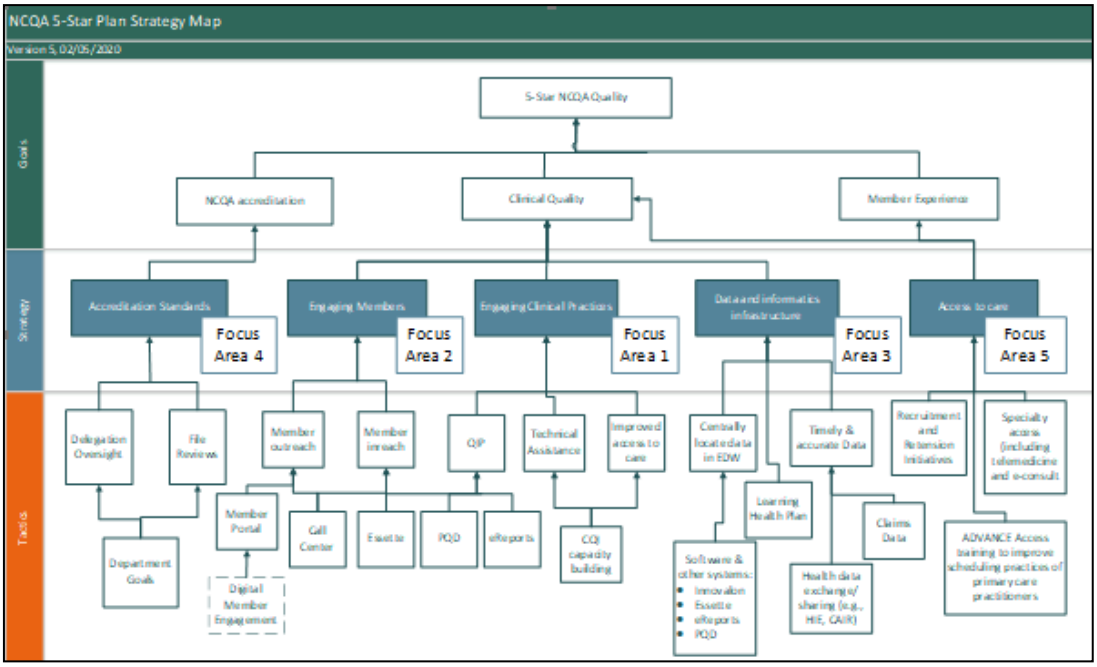
Focus Area 5: Improving Member Experience through PCP Access

Goals	Objectives
A. Recruitment	•Implement: Marketing to Residents within Partnership region •Implement: Marketing to Residents outside Partnership region •Implement: Marketing to out-of-state primary care Residents originally from Partnership counties •Explore: Support partner job search •Study: Support J-1 visa process
B. Retention	•Test: Optimize HPSA scores in shortage areas •Implement: Support providers in completing application/processfor loan repayment •Study: Increase PCP organization reimbursement for sites with greatest challenge via adjustment of PCP QIP by recruitment difficulty factor •Study: Coordination among local agencies providing supplemental dollars for loan repayment, signing bonus, etc. •Implement: Advocacy for new and larger loan repaymentprograms by state/federal government. •Test: Vetted Locum Tenens providers to provide vacationcoverage •Planning: Proposal for structure for providing social support to providers
C. Alternative Access Options	•Implement: Promoting the leveraging Phone/Video visits toincrease access •Implement: On demand video visits for urgent care •Promote: Advanced Access methodology
D. Learning	•Implement: Exit Interviews of Clinicians leaving the region •Implement: Interview practices that are very successful inrecruiting strong staff

~~Conclusion~~

~~This Partnership Strategic Plan for Achieving Five Star Quality provides a roadmap for using the overall structureand framework of NCQA, modified by requirements of DHCS, to substantially improve quality and ultimately achieve a 5-star rating by NCQA by 2025.~~

~~Appendix A: Partnership Strategic Quality Plan~~



Pathway to Excellence

Partnership Framework for Continuous Learning

~~Final Workgroup Report~~ June, 2021

~~Workgroup Members:~~
~~Robert Moore, MD MPH~~
~~Mark Netherda, MD~~
~~Erika Robinson~~
~~Nancy Steffen~~
~~Caron Lee~~
~~James Devan~~
~~Naresh Vemparala~~
~~Farashta Zainal~~

~~**From Quality Measure Score Improvement Team Goal #4:**~~

~~SMART goal #6:~~

~~Partnership's transformation as a Learning Health Plan: Define a framework/plan for expanding knowledge management infrastructure relative to best practices in quality measure improvement and operationalizing standardized approaches to small tests of change through scaling and wide-spread implementation.~~

~~**Milestones**:~~

~~Final report presented to the executive HEDIS® Measure Score Improvement team by June 30, 2021~~

Table of Contents

Executive Summary 8171
Framework Development 8474
Original Pathway to Excellence Whitepaper and Plan (2021) 8575
Continuous Learning as a Quality Framework 8575
Roots in Partnership Culture 8575
Definitions of Learning 8676
Learning Organization and Quality Improvement 8676
Pathway to Excellence Framework Overview 8878
Knowledge Management 9181
Background Concepts 9181
Categories of Knowledge 9282
Essentials of Strategic Knowledge Management 9282
Strategic Initiatives to Bridge Gaps 9383
Information Technology Resources for Knowledge Management 9484
Supportive Leadership Activities for Knowledge Management 9585
Small Tests of Change 9585
Framework Options 9585
Considerations when Planning a Pilot/Small Test of Change 9787
Data and Statistical Analysis 9989
Analytics Strategic Plan 9989
Project Purpose/Business Justification 9989
Structure of Analytics Strategic Planning 10191
Standards for Evaluation 10292
Optimizing Spread: Application of Implementation Science 10292
Organizational Factors 10595
Plan for Nurturing Organizational Culture 10595
Plan for Maturing the Framework 10797
Overall Plan 10797
Year 2 Activities 10797
Bibliography 10898

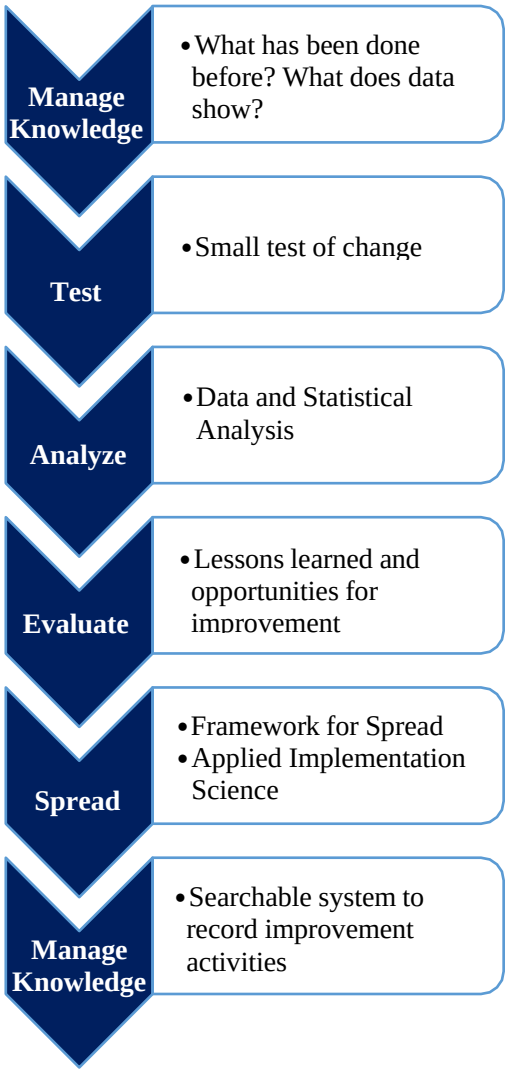
Executive Summary

For years, Partnership's QI Program Description (and DHCS itself) has highlighted the Model for Improvement, whichincludes the well-known PDSA (Plan-Do-Study-Act) cycle as a guiding framework for improving the quality of health are of our members. Yet, as we accumulated positive experience with many small tests of change, Partnership'soverall health plan ranking (comparing a subset of HEDIS® scores with the scores of other health plans) was improving slowly. Recent reports on relative performance on Pediatric Health measures has highlighted lower performance in Partnership's northern regions, which could have an impact Partnership's success with absorbing additional rural counties. While small tests of change (PDSAs) are a key framework in improvement activities, they are not sufficient to achieve larger scale long lasting improvement.

Partnership updated its 5-star Strategic Plan in 2020, and is executing a comprehensive tactical plan related to this plan. A central goal was NCQA accreditation, achieved in January 2021. HEDIS® scores for measurement year 2021 will be the baseline year for rating the health plan on NCQA's 5-star HEDIS® scoring. The COVID pandemic and the Health Edge core claims processing implementation have had a notable negative impact on energy that can be spent by Partnership and our providers on improving health care quality measures. As we move into late 2021 and 2022, we must be ready to re-energize our provider network to improve clinical outcomes.

In 1990, Peter Senge outlined the components of what he called a "learning organization," in his book *The Fifth Discipline: The Art and Practice of the Learning Organization*. The highest performing organizations are the strongest learning organizations, he argues, and they have specific disciplines that characterize being a learning organization. About a decade ago, the term "learning organization" was expropriated by a variety of Health Care Organizations to become a "learning health system." Different organizations and authors had different ideas of what the "system" was, ranging from a geographic system to an integrated delivery system to the entirehealth care delivery system in the United States.

Over the past year, a workgroup of Partnership's HEDIS® score improvement team explored how these concepts of a "learning organization" and a "learning health care system" could be applied to a health plan. The resulting framework is composed of five elements, shown in the diagram below (knowledge management has a role at the beginning and end of the process, so is presented twice):



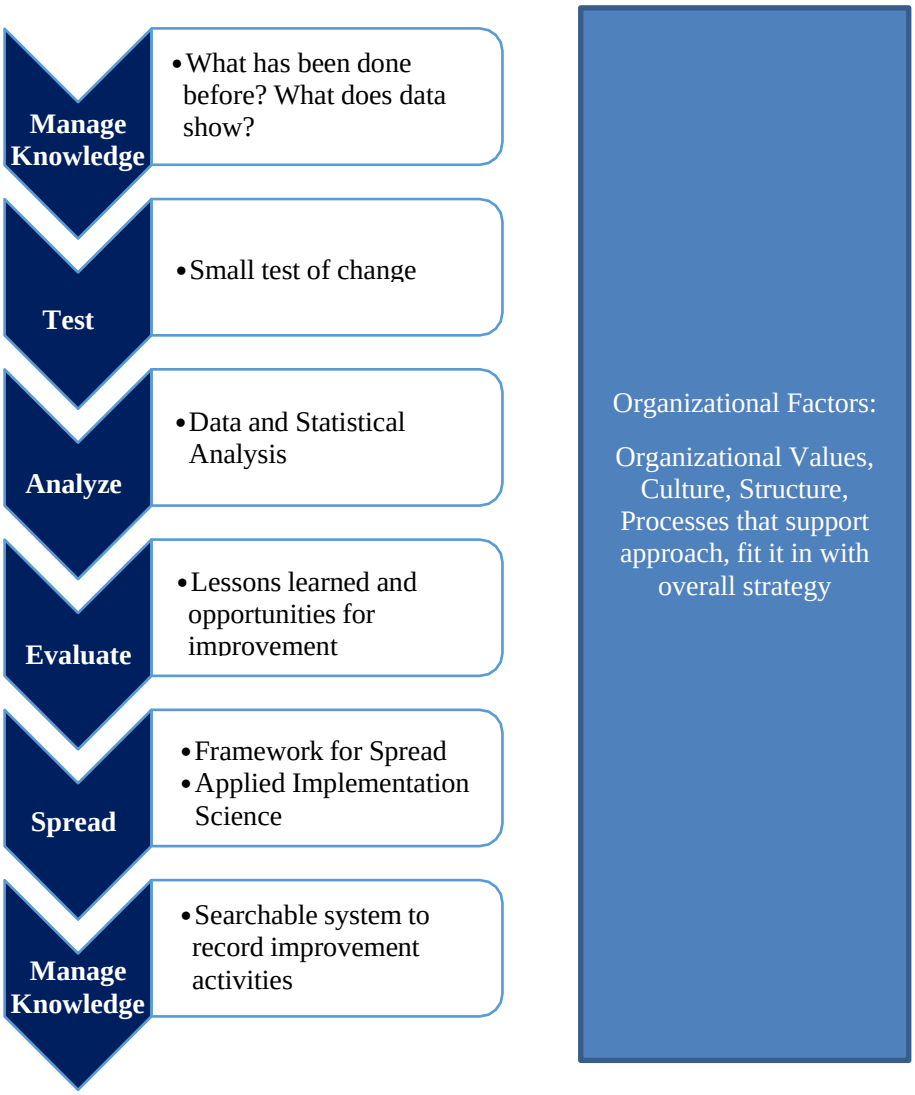
~~This document provides an overview of each of these key elements, including current activities at Partnership as well as a summary of the academic literature on each topic. Next, several leadership activities and overarching activities are described as critical elements to optimize the successful use of these five elements. We end with a plan for further developing our framework in the 2021-2022 fiscal year and beyond. We believe that adoption of this framework will provide critical support for our NCQA stars status, and contribute to our vision, to be themost highly regarded health plan in California.~~

~~A detailed description of the Pathway to Excellence framework can be found after the 2022 update activities section below.~~

2022 Update and Activities Related to the Pathway to Excellence Framework

Background:

Traditional QI frameworks are missing several key components essential for optimal testing of new ideas and implementation of successful tests. In 2020 to 2021, Partnership researched frameworks and ideas that were missing from traditional QI frameworks into one overarching framework, called the Pathway to Excellence. Major components are summarized here:



A detailed white paper with references is available on Partnership's internal website (Partnership4Me), along with a number of recorded presentations on each of the topics above.

Activities of 2022-23

During 2022, Partnership steadily worked on rolling out the Pathway to Excellence (P2E) Framework, building on an implementation plan created in 2021. Major activities of 2022 and planned activities for 2023 are listed here:

1. Creating in internal website to make P2E materials easily available to Partnership staff.
2. Formal presentations on each of the major topics:
   a. Overall Pathway to Excellence Framework, including coverage of theory of knowledge and learning.
   b. Knowledge Management
   c. Small Tests of Change
   d. Data and Statistical Analysis, including a sub presentation on Using the Data We Have (Health analytics and Data Governance work to continue into 2023).
   e. Evaluation methods
   f. Using Applied Implementation Science to Optimize Spread of Tested Ideas
3. These presentations were given internally:
   a. Operations Leaders

b. Medical Directors
c. Health Services Directors and Managers
d. Recorded for others to review (new staff, new leaders, etc.)
e. Board Quality Advisory Workgroup

4. Externally, the overall framework was adapted and presented to:
   a. Partnership's Hospital Quality Symposium
   b. The California Hospital Quality Council's annual Quality Forum
   c. Additional forums planned for 2023: CPCA Quality meeting in March.
5. Incorporating the major principles of the P2E framework in thinking about our everyday work. (Will continue in 2023)
6. Special focus on Strategic Knowledge Management (KM) Activities (all ongoing, continuing in 2023)
   a. Shared Drive Cleanup by HS departments
   b. SharePoint site cleanup
   c. Use of One-Note for Knowledge Management
   d. Master list of abbreviations updated and posted to SharePoint
   e. Principles for updating external website for KM created.
   f. Use of PowerDMS for Knowledge Management (Plan to implement after fall 2023)
   g. Microsoft 365 and its role in updating KM infrastructure (including external website). Planned for 2023.
   h. IT backup of KM materials on shared drive (2023 topic)

Framework Development

The Pathway to Excellence: Partnership's Framework for Continuous Learning was developed by a workgroup of the HEDIS® Score Improvement Goal Group. The workgroup met monthly to discuss and flesh out different aspectsof this framework and to systematically review the academic literature related to the different elements. A review of pre-existing activities that contribute to these elements was tabulated. Interviews of external organizations working on this framework were initiated, and will continue as our understanding of the framework elements expands.

~~Original Pathway to Excellence Whitepaper and Plan (2021)~~

~~Initially, the workgroup was named "Learning Health Plan" as an extension of the "Learning Health System" concept, but with feedback from the executive team and Partnership's board advisory committee on quality, the framework is renamed "Pathway to Excellence: Partnership's Framework for Continuous Learning."~~

~~Workgroup Members:~~

~~Robert Moore, MD MPH~~
~~Mark Netherda, MD~~
~~Erika Robinson~~
~~Nancy Steffen~~
~~Caron Lee~~
~~James Devan~~
~~Naresh Vemparala~~
~~Farashta Zainal~~

~~The workgroup developed this document, an annotated bibliography, several PowerPoint presentations summarizing the key concepts, and notes summarizing the monthly meetings.~~

Continuous Learning as a Quality Framework

Roots in Partnership Culture

The Mindset of Continuous Learning is rooted in Partnership's organizational culture.
Several of Partnership's organizational values (listed on the Partnership website) support different aspects of quality:

1. Partnerships: Fostering strong partnerships with members, providers, and community leaders to collectively improve health outcomes. "Putting our members first."
2. Overall focus on Quality: Focusing on continuous quality improvement in every aspect of the organization and in collaboration with our partners. "Doing the right thing right, the first time and every time. Excellence is achievable! Striving for perfection, but embracing the opportunity to learn from imperfection."
3. Integrity: Set a standard of professionalism, integrity, and accountability. "Willingness to challenge the status quo, and insist on change when needed."
4. Innovation: Seeking creative solutions. Apply knowledge in new ways.

In addition, two key organizational principles specifically support aspects of being a learning organization:

1. Balancing Compliance and Performance: Balancing rigid attention to regulatory requirements with flexibility and innovation needed to drive improvement. "Not all change is improvement, but all improvement requires change."
2. Continuous Learning: "Making decisions based on rigorous data analysis whenever possible (instead of based on hope or wishful thinking)." "Creating an atmosphere where new ideas can be explored and where strong, independent teams can test these ideas"

The mindset of continuous learning can be expressed in these three credos:

1. We are all very proud of Partnership, the work we do and the systems we have developed. Nonetheless, werecognize that we as individuals and as a company can do better.
2. We strive as individuals to be curious and continuously learn.
3. We also strive as an organization to learn and grow.

While these are organization-wide values, this document will focus on the applications of continuous learning to our work to support our strategic goal of becoming a 5-Star NCQA recognized health plan. This includes work related to improving quality and performance in these Partnership departments: quality, pharmacy, care coordination, utilization management, health analytics, and population health. Of note, some parallel activities in Partnership's operational departments are being organized by the OpEx/PMO department.

Organizational leadership activities are critical for applying this work. This includes ensuring that activities are related to organizational priorities, that staff are supported and motivated, that staff work well cross-departmentally, and that the overall organizational culture is supported.

Knowing is not enough; we must apply. Willing is not enough; we must do.
- Johann Wolfgang von Goethe

Definitions of Learning

Two useful definitions of learning are:
Learning (noun):

1. Process of acquiring information, knowledge or understanding/wisdom
2. The process by which (tacit) knowledge is *created* through the transformation of experience

Note that these definitions are very different from the concept of Machine Learning, a form of Artificial Intelligence (AI), defined as the use and development of computer systems able to learn and adapt without following explicit instructions. We will *not* be addressing machine learning in this report.

Another important distinction is the difference between Learning, Innovation, and Invention. In contrast to learning, innovation and invention are defined as follows:

Innovation (noun): The creation, development, *and implementation* of a new product, process or service, withthe aim of improving efficiency, effectiveness or competitive advantage.

Invention (noun): brand new concept or idea which may not be completely defined/fleshed out/proven.

Learning Organization and Quality Improvement

The idea of a learning organization was defined and popularized in Peter Senge's 1990 book, *The Fifth Discipline: the Art and Practice of the Learning Organization*. His definition of a

Learning Organization (noun): An organization that facilitates the learning of its members and continuously transforms itself.

In the book, Senge details the Five Disciplines of a Learning Organization:

1. Personal Mastery
2. Mental Models
3. Shared Vision
4. Team Learning
5. Systems Thinking

In this context, learning is used as an adjective, modifying organization.

Early reference to the importance of learning in Quality Improvement work also uses learning as an adjective, modifying activities. This is summarized by Don Berwick's analysis of a quote by Tom Nolan, the creator ofthe Model for Improvement:

> "What are necessary and sufficient conditions for improvement in large systems? **Will, ideas, andexecution**!"
>
> - Tom Nolan, creator of the Model for Improvement

> "Providing **will** refers to the tasks of fostering discomfort with the status quo and attractiveness for theas-yet-unrealized future. Providing **ideas** means assuring access to alternative designs and ideas worthtesting, as opposed to continuing legacy systems. And **execution** was (Nolan's) term for embedding *learning* activities and change in the day-to-day work of everyone, beginning with leaders."
>
> - Don Berwick, founder of the Institute for Healthcare Improvement

Learning Health System: Another use of learning as an adjective is Learning Health System, first used by the National Institute of Medicine in 2007, to mean that evidence based medicine would be applied reliably throughout the health care delivery system:

> "A learning healthcare system is designed to generate and apply the best evidence for the collaborative healthcare choices of each patient and provider; to drive the process of discovery as a natural outgrowthof patient care; and to ensure innovation, quality, safety, and value in health care."

Evidence based medicine is given a broader definition:

> "to the greatest extent possible, the decisions that shape the health and health care of Americans—by patients, providers, payers, and policy makers alike—will be grounded on a reliable evidence base, willaccount appropriately for individual variation in patient needs, and will support the generation of new insights on clinical effectiveness."

Immediately after this, a subsequent explanation drives back to "information from clinical experience" andclinical effectiveness of interventions.

The Institute of Medicine considers learning as building a knowledge base and translation of this knowledge regularly in the course of patient care.

In the decade that followed, the term learning health system was used in many different senses, depending onhow the author thought about the word "system":

1. U.S. Healthcare Delivery **System**
2. Academic Medical Center as a **System**
3. **System** of translating research into practice
4. Integrated Healthcare Delivery **System**
5. Local or Regional Healthcare Eco-**system**
6. Data Management or Health Information Exchange **System**

We bring this diversity of views to your attention so the reader will be aware that this term is fraught, not tochoose one concept of a Learning Health System over another.

Pathway to Excellence Framework Overview

What does the Pathway to Excellence look like?

1. Decisions and conclusions are based on rigorous data analysis whenever possible (instead of based on hope or wishful thinking), while creating an atmosphere where new ideas can be explored.
2. Within this framework, strong independent teams test these ideas, quantitative and qualitative evaluation is performed, knowledge gained is organized for future retrieval, and successful practices are spread effectively.

How does this work fit in with other Quality Frameworks?

The Pathway to Excellence Framework shares some themes with two other major quality frameworks: The National Baldrige Award for Quality criteria and the Shingo Model of lean management.

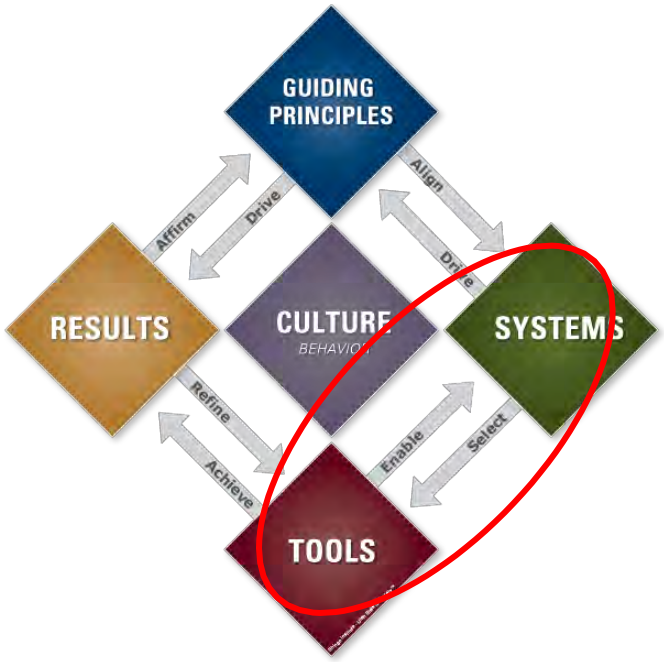
Baldrige Criteria: Four of underpinnings of the Baldrige criteria relate to the *Pathway to Excellence* Framework:

1. Organizational learning
2. Focus on Success and Innovation
3. Management by Fact
4. Delivering Value and Results.

The Organizational Profile of the Baldrige Criteria are shown on the figure below. Of special note, the overarching concepts of measurement, analysis and knowledge management identify three of the elements shared with the *Pathway to Excellence* framework. Also shared is the idea that organizational core values andconcepts underpin the effectiveness of the quality framework.

From Baldrige Performance Excellence Program. [illegible] *Improving Your Organization's Performance*. Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology. https://www.nist.gov/baldrige.

Shingo Model: The **Shingo model** of operational excellence asserts that successful organizational transformation occurs when leaders understand and take personal responsibility for architecting a deep and abiding culture of continuous improvement. Leaders lead culture; nurturing the organizational culture is at thecenter of the model. The Shingo Model includes an improvement system, improvement tools, a work system and a management system. While the Shingo model focuses on Purpose, Process, and People, the learning framework described in this paper at Partnership focuses on Process. Process values/principles/behaviours include: continuous improvement, seeking perfection, embracing scientific thinking, and focusing on the process.



Partnership Strategic Plan: The Pathway to Excellence framework will be applied to the first area of emphasis in thecurrent Partnership strategic plan (see below): Access to High Quality Care.

Pathway to Excellence Framework:

After consolidating our information on the Pathway to Excellence Framework, we can summarize this Partnership Framework for Continuous Learning as:

1. Using the scientific method to optimize implementation of quality improvement initiatives
   - Learn from the past: Building on prior research/experiences
   - Small Tests of Change: Rigorous and widespread testing of change on a small scale (using themodel for improvement framework)

- Knowledge Management: Tracking of information gleaned from small tests of change so otherscan retrieve this information and build upon it.
- Careful data and statistical analysis with use of control groups, where appropriate
- Implementation and Spread: Using a combination of classic project management methodologywith the Consolidated Framework for Advancing Implementation Science while having the leadership and staff to support this approach

2. Communicate effectively about quality and change, through a mixture of data and stories. "Nodata without a story, no story without data."

The following sections will summarize each element in greater detail.

Knowledge Management

Background Concepts

Knowledge Management as a field of study has a rather limited literature in relation to health care. There are several journals (including The Journal of Knowledge Management Practice and the Journal of Knowledge Management) and a few books that focus on this area (one is *Strategic Knowledge Management: Driving Business Results by Making Tacit Knowledge Explicit* by Arun Hariharan published in 2015).

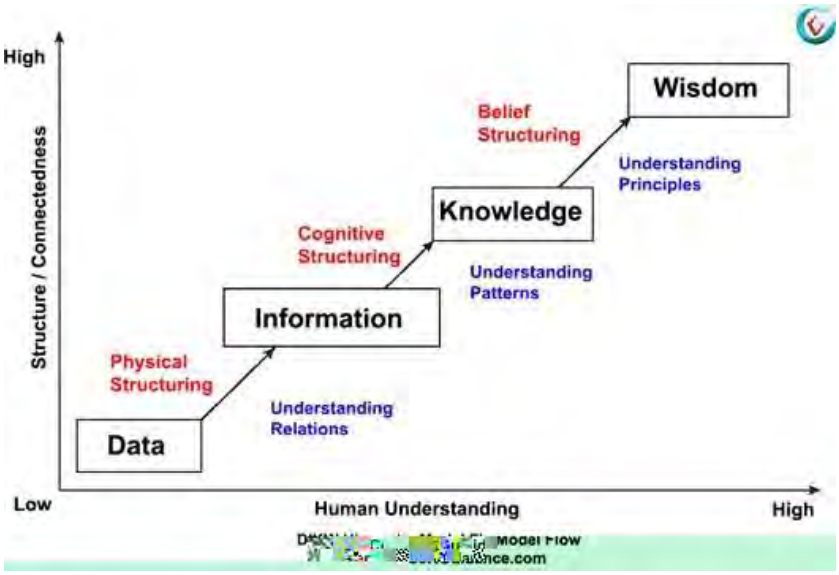
We begin with a brief overview of definitions and philosophy of knowledge.

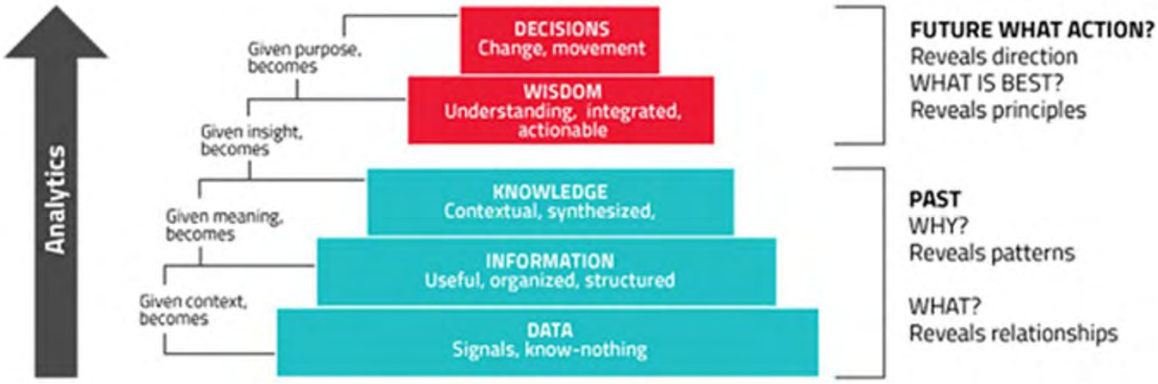
Definitions: Two useful definitions of knowledge are:

1. True belief or understanding of the relations which things and ideas bear to each other and to themselves (Originally from Greek philosophers)
2. Processed information (see below)

DIKW Framework: A key conceptual framework for related knowledge and learning is the Data Information Knowledge Wisdom (or DIKW) Framework, illustrated both as a graph and a pyramid, below. Each level is part of a hierarchy:

a. Data, which is physically structured and related to make
b. Information, which is cognitively structured and pattern recognition to make
c. Knowledge, which with belief structuring and principle definition makes
d. Wisdom, which can be used to prospectively make decisions about future courses of action.





Categories of Knowledge

Categories of Knowledge within an organization can be divided us as follows:

- Individual knowledge: within the brain of an individual, based on their experience, learning or analysis = ***tacit knowledge.*** This tacit knowledge may be possessed by an **expert within** an organization, or by a known **outside expert** who is consulted when needed.
- Individual knowledge: written down or recorded for reference by one person = ***explicit individual knowledge.*** Converting tacit knowledge to explicit knowledge is a central goal in the field of knowledge management.
- Group knowledge: written, recorded or programmed processed information for use by multiple individuals in an organization = ***explicit group knowledge.*** Explicit group knowledge may be derived from either internal sources or from systematic review of external sources. Explicit knowledge is storedin some sort of **knowledge base**, written down on paper or in an electronic format.

Essentials of Strategic Knowledge Management

The overall aim of Knowledge Management is to ensure that knowledge that is relevant to the business, fromany source internal or external, is available at the right place at the right time to enable the right person in thecompany to make the right decisions and implement them so they you achieve the organization's strategic business objectives.

There are three core goals of Knowledge Management

a. Easy and effective application of knowledge/reuse of knowledge. "Use the knowledge you have available."
b. Avoid reinventing knowledge (instead: build on prior knowledge). Don't "reinvent the wheel"
c. Create new knowledge. Apply what has been learned previously to try out new ideas/processes, and measure how well they work.

To robustly apply the principles of Knowledge Management to an organizations two levels of analysis and workmust be conducted:

1. Organizing knowledge and filling gaps (every few years, strategic work)
   a. Identify knowledge capabilities critical to business success (start with 3-5 processes)
   b. Identify a knowledge champion and community of experts for each process to ownknowledge repository of that process.
   c. Conduct knowledge inventory and infrastructure inventory to describe knowledge assetsand map knowledge, divided into internal, external, explicit and tacit. Research should include customer, data, business, market and regulatory framework
   d. Identify knowledge gaps and infrastructure gaps
   e. Define **strategic initiatives to bridge gaps**

2. Applying knowledge to spread or generate new knowledge (ongoing tactical activity)
   a. Storing, vetting, categorizing and transmitting knowledge
   b. Implementing initiatives using knowledge (AKA knowledge translation)
   c. Measuring business results (against benchmarks along with non KM based interventions)

Strategic Initiatives to Bridge Gaps

Broadly, there are three major **categories** of Strategic Knowledge Management Activities:

1. Organizing Explicit Knowledge
2. Organizing Tacit Knowledge
3. Application of existing Knowledge

Major activities in each category are described:

Organizing Explicit Knowledge:

1. Develop a process for gathering knowledge systematically from external sources
2. Develop a standard process for knowledge contribution
   a. Succinct high level summary
   b. Best practices funnel/vetting
3. Establish standardized processes for content management
4. Establish documentation standards for best practices/case studies/lessons learned when project fails

Organizing Tacit Knowledge:

1. Establish communities of practice with knowledge manager (AKA moderator)
2. Organize and define subject matter experts, with the best mechanism to consult them
   a. Pull: mechanism to look for expert in the topic at hand and reaching out to them for input.
   b. Push: experts reach out with information (newsletters, articles, emails etc.)
   c. Combination of Push-Pull: intermediary for contact with experts

Application of Existing Knowledge:

1. Systematic mine knowledge (pull)
a. Gathering information from high performers in a structured way.
b. Review current operational data daily: what needs to be done today? "Use the data we have"
2. Content dissemination (push) (Don't leave it to "chance or choice")
a. Knowledge sharing seminars
b. Publication/dissemination of best practices (newsletter, email)
3. Develop "closed loop processes" to ensure regular review of knowledge for possibility of spread.
4. Determine scope for process for spreading: small scale vs. company-wide
5. Ensure a process is developed for capturing result of knowledge replication/spread, including new knowledge.

Examples of strategic initiatives to bridge gaps that may be selected include:

a. Implementing supportive technology tools
b. Formation of communities of practice
c. Sharing best practices, case studies, lessons learned, both internal and external.
d. Define processes for knowledge sharing (contribution) and knowledge reuse (implementation)
e. HR activities to change culture
f. Corporate learning programs
g. Creating access to experts
ii. Hiring
iii. Consulting
iv. Trainers

Information Technology Resources for Knowledge Management

Features: Here are some features of knowledge management that need IT support:

1. Tools for collaboration and communication between team members
2. Mechanism for storing list of experts with areas of expertise
3. Potential support for other Knowledge Management processes
4. Support of leadership activities promoting Knowledge Management
5. Managing the programs selected to be the organization's **Knowledge Base**: Storing internal and external explicit knowledge contribution, with ability to search and find easily, as well as push certaincontent. This includes knowledge replication and business results.

Contents: Information to be organized within the Knowledge Base includes:

1. Best practices
2. Case Studies
3. Lessons learned
4. Standard documented processes
5. QI projects
6. Innovative ideas
7. FAQs
8. Internal benchmarking
9. e-learning modules
10. Other training material
11. External reports on markets, customers, competitors, regulatory environment, technology trends.

A review of Partnership IT tools that are currently used for some sort of Knowledge Management (and which could beleveraged to better manage additional knowledge) include:

1. Shared drives (baseline data, many other documents)
2. Outlook: email
3. SharePoint: Partnership4Me (document organization)
4. Public Website posting of knowledge for sharing with external partners
5. Microsoft office tools: Excel, Word, PowerPoint, Visio
6. Workfront: has review process and project management functions.
7. PowerDMS: review process for submitted documents. Note that PMO has selected this to be used for capturing end of project write-ups.
8. Prezi (entire 360-degree view)

Supportive Leadership Activities for Knowledge Management

Three key elements of a supportive leadership culture are

1. Sharing of ideas (Interpersonal relationships, professional trust)
2. Willingness to build on others' ideas
3. Giving credit for origination of knowledge

Some techniques that can included to achieve these are:

1. Link Knowledge Management to formal recognition (awards), incentives and/or performance evaluation system
2. Capturing measured results: process and outcome measures
3. Capturing and spreading narratives/survey results
4. Senior leadership attention to Knowledge Management and inclusion in strategic planning and organizational dashboards.
5. Designating resources to maintain/curate Knowledge Base over time to assure ease of access andlocation at the right place/time

Small Tests of Change

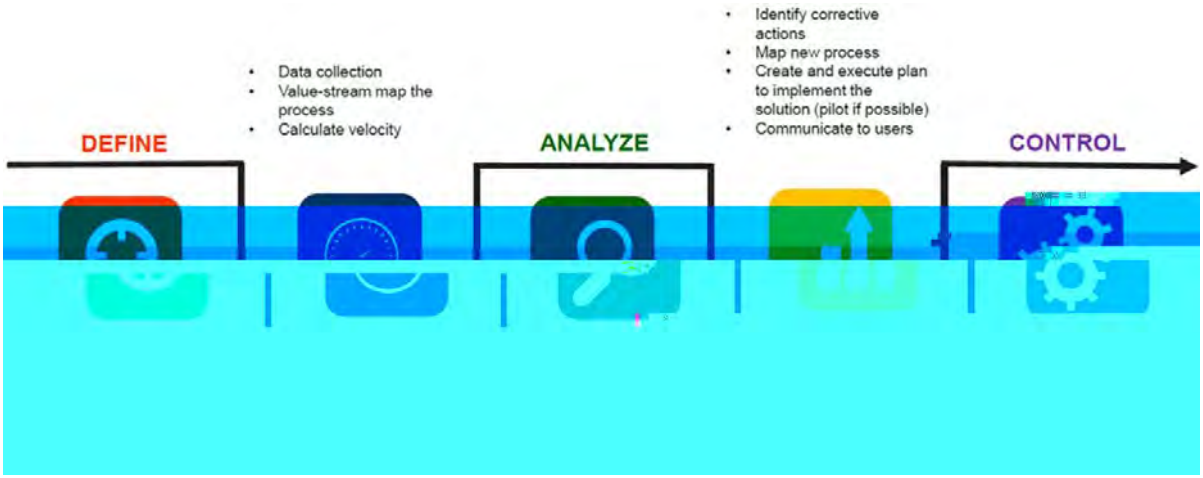
Framework Options

Broadly, when considering a small test of change, we start with a problem and a process.

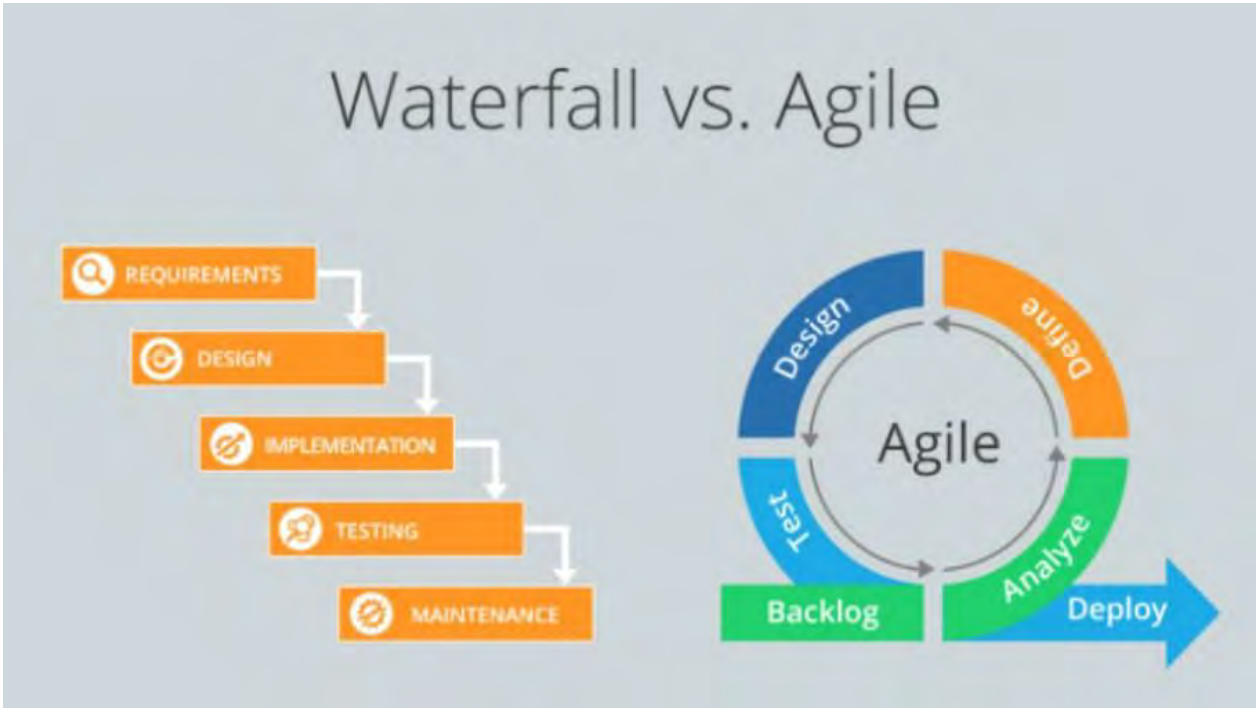
The model for improvement (includes the PDSA cycle is a problem oriented small test of change: In the Partnership run training *ABCs of QI*, the focus is on the basic concepts of Quality Improvement using the Model for Improvement. The Model for Improvement represents a focus on quality improvement, as opposed to using DMAIC or Lean Six sigma for process optimization or Agile for IT implementations that include doing tests of change.

For reference only, we briefly describe DMAIC and Agile; they are not the focus of this document.

Define, Measure, Analyze, Improve, and Control (DMAIC) is a standard process, which often includesapplication of lean/six sigma principles, for process oriented change and optimization.



Agile is a method of implementation that combines pilots/tests with scaled implementation, and is contrasted with the Waterfall method of implementation:



Considerations when Planning a Pilot/Small Test of Change

What size test? Is a test of change big enough for outcome to have meaning? There are three factors to consider: *cost of failure, confidence in intervention, resistance to change* as shown in the following graphic:

Are We Ready to Implement?

Appropriate Scope for a PDSA Cycle

Current Situation		Staff/Clinicians Readiness to Make Change: Resistant	Indifferent	Ready
Low Confidence that change idea will lead to Improvement	Cost of failure large	Very Small Scale Test	Very Small Scale Test	Very Small Scale Test
	Cost of failure small	Very Small Scale Test	Very Small Scale Test	Small Scale Test
High Confidence that change idea will lead to Improvement	Cost of failure large	Very Small Scale Test	Small Scale Test	Large Scale Test
	Cost of failure small	Small Scale Test	Large Scale Test	Implement

The Improvement Guide, Second Edition, Jossey-Bass, April, 2009

API 4

Here are other key factors to consider when designing a pilot in a way that will inform future implementation/scale-up activities. (Al-Ubaydli, List, & Suskind, 2019):

1. Do the research/pilot results scale to larger markets and settings?
2. When we scale the intervention to broader and larger populations, should we expect the same level of efficacy that we observed in the small-scale setting?
3. If not, what are the important threats to scalability? (Al-Ubaydli, List, & Suskind, 2019)
    a. Statistically underpowered (sample size needed)
    b. Difference in population
    c. Negative economies of scale
    d. Program structure difficult to scale
    e. Dosage of intervention will be less with larger scale
    f. Incentives will be different with larger scale
    g. Inputs (staffing training for example) will be different between pilot and spread
    h. Scaling likely to cause substitution effect that wasn't present in pilot
4. What can the researcher do from the beginning of their scholarly pursuit to ensure eventualscalability?

Data and Statistical Analysis

Analytics Strategic Plan

Partnership is has begun the process of building on a Strategic Data Plan to develop a Strategic Analytics Plan. A Charter has been created and initial work has begun, but the need to convert current analytic reports to draw data from Health Edge, and to validate these mappings, has led to this strategic analytic process to be put on hold.

The charter outlines many excellent definitions, aims and purposes, and so is extracted here:

Project Purpose/Business Justification

Definitions of Data and Analytics

Raw Data: discrete pieces of information that flow into the organization

Processed Data: organized and consolidated raw data, the result of which is more easily manipulated through analysis to generate information.

Data Literacy: Competencies to promote the ability to read, understand, create and communicate data as information.

Data Information Knowledge Wisdom Pyramid: A hierarchy of class of models for representing functional relationships between data, information, knowledge and wisdom

Analytics: Systematic computational analysis of data or statistics, used for the discovery, interpretation and communication of meaningful patterns in data.

Project Purpose

To create a framework for an enterprise-wide analytics strategy to achieve the following value/advantage:

- To be more efficient in how we analyze data, eliminating redundancies, and optimizing teams
- To be confident in the processed data we use and share
- To prioritize and evaluate processed data/analytics project needs efficiently and ensure capacity
- To be prepared to respond to processed data/analytics requests in urgent situations
- To make processed data management and analytics processes more transparent
- To standardize quality assurance, presentation, and documentation of processed data products
- To streamline intake processed data and analytics requests
- To conduct data analysis and program evaluations using sound scientific methods
- To make processed data available for self-service review and analysis by different business units
- To develop innovative solutions for systematic data discovery of opportunities, gaps, or risks thatwould improve financial and/or health outcomes
- To operationalize advanced analytics (prediction models, machine learning, time series, statisticaltesting, data mining, etc.)

Aim Statement
In a 5-year period, to develop an enterprise-wide framework to maximize use of data to generate information, knowledge and wisdom to improve health outcomes, enhance the member experience of care,and reduce or maintain the cost of care by optimizing utilization of resources, including data, technology and staff. The focus of the effort include: • Define analytic needs for the business • Strengthen or develop policies and procedures for prioritization, management, access, and documentation of processed data products • Review existing data architecture and identify opportunities to optimize structure • Expand self-service analytics tools • Operationalize/integrate advanced analytics • Increase data literacy
Scope
Draft: **In scope:** any data project that involves data analysis or the creation of a report or a specialized dataset to be used for regulatory reporting, operations, or measuring performance, either for financial or health care purposes. **Not in scope:** projects involved in acquiring, processing, or warehousing raw data from main sources (DHCS, providers, other)
Deliverables
Outcome 1: Identify an analytics governance body Outcome 2: Decide on an analytics team structure and role definitions Outcome 3: Develop standards for data products Outcome 4: Develop a comprehensive strategic plan for the next 5 years

Structure of Analytics Strategic Planning

Data Governance Council

- Final decision making body in the data governance structure
- Sets overall direction on health analytics strategy and initiatives
- Advises and empowers the Analytics Strategy Committee to implement an enterprise-wide analytics program

Analytics Strategy Committee

- Prioritizes and communicates efforts between Data Governance Council, workgroups and stakeholders
- Ensures the analytics strategy efforts align with the priorities from the Data Governance Council
- Provides recommendations (including resource allocation recommendations) to the Data Governance Council
- Sponsors, approves and manages plans that support analytics strategy efforts and projects
- Forms work groups and defines their scope, based on area of expertise and responsibility

The Pathway to Excellence Workgroup identified a number of specific opportunities in the data and analytics realm that would be part of the Framework for Continuous Learning:

Partnership should consider documenting and standardizing:

1. Review of **commonly used variables** used in outcomes analysis: sources of bias/confounding; how variables are inter-related
2. Description of **data currently available** for retrospective analysis
3. Major **types of statistical analysis** that applies to health plan level work.
4. Selecting **appropriate test for statistical significance**.
5. **Presentation of data**: best practices/Partnership standards in presentation of data

Partnership should standardize and train staff on the process of taking a data need and formulate a data request withjustification. Four key purposes of reporting on data:

1. Looking for trends and outliers. Trends over time, by year, month. Standard stratification approaches include: Geography, Provider site (and parent organization if PCP), Race/Ethnicity, Aidcode, Homeless status, Presence of major mental health disorder. Results should be shared by number and percentage of total (rates); Ideally with Tableau dashboard.
2. Evaluating the impact of a specified intervention (may be part of rough evaluation or formal evaluation). Report using data from data warehouse or other sources, with citation of data sources clearly indicated.
3. Define a detailed list of either members or sub-population for a particular intervention (the requester should be able to define planned intervention, as this determines the fields of the output). Depending on nature of date needed, raw or aggregate data can be generated from pharmacy, claims configuration (Essette), Claims or Finance.
4. Define a list of providers for a particular intervention (the requester should be able to define planned intervention, as this determines the fields of the output).

What are the data and analytic areas do we need to build internal expertise?

1. Communicating analysis to our provider partners, in a way that is not too complex.
2. More advanced database skills, programming (python, R), google colab

For what areas should we seek outside help?

1. Biostatistics/epidemiology
2. Data scientist (study design)
3. Economics/social science to determine methodologies, creative randomization or alternatives
4. Advanced database and programming expertise

Standards for Evaluation

General approach to Evaluation. We should systematically plan evaluation and analytic approach ahead of time and then iteratively. Some questions to answer:

1. Is it possible to prove something?
2. How scientifically sound is the evaluation? What size of intervention is needed?
3. Since the evaluation plan impacts study design, how will the study change?

On a regular basis in reviewing scientific literature we need to seek out and save evaluation methods done by others researchers, for possible future use. This knowledge should be managed logically.

What are major areas of evaluation methods, which Partnership should consider document and standardize?

1. Options for **randomization**, with explanation of factors to consider in choosing one (include ABtesting as option)
2. Options for **control groups**, with explanation of factors to consider in choosing one
3. Description of **ethical framework**: when is consent needed; when an Institutional Review Boardreview is needed (is publication planned).
4. **Standard template for study design**, including: problem analysis, strategy to manage change, proposed interventions, target population, definition of outcomes and potential unintended consequences, baseline outcome rate, anticipated observations/week, unit of randomization, blinding,and implementation of the randomization strategy
5. **List of options for study design** (See Horwitz reference for options)
6. **Overall evaluation framework** options to consider, with explanation of factors to consider inchoosing one.

Optimizing Spread: Application of Implementation Science

Overview: (Dubner, 2020) gives a definition of Implementation Science: Definition of ImplementationScience:

> *It's the study of how programs get implemented into practice and how the quality of that implementation may affect how well that program works or doesn't work.*

Factors to consider, at least once, when making the decision to do a large scale implementation based on resultsof a successful pilot.

The Consolidated Framework on Implementation (Damschroder, et al., 2009) is a Social science construct that seeks to organize the theoretical frameworks and factors that influence the success of an implementation. For a *larger* implementation, it is probably worth spending some time going through the list to consider strategies for improving the success of this particular implementation. For smaller implementations, it is rarely very helpful.In addition, (Al-Ubaydli, List, & Suskind, 2019) notes these reasons for failure of pilots to spread successfully:

1. Spillover and administration quality impacts direct treatment effects.
2. The participant(s) being unrepresentative of the population in terms of direct treatment effect.
3. The statistical estimation error.
4. Economies/diseconomies of scale in participation costs.
5. The participant(s) being unrepresentative of the population in terms of participation cost. (really asubset of number 2)
6. Economies/diseconomies of scale in implementation costs. (4 and 6 go together).

The Science of Using Science: Towards an Understanding of the Threats to Scaling Experiments (Al-Ubaydli, List, & Suskind, 2019) is a more practical consideration of this topic. Some highlights:

1. Consider the myriad of factors that lead results of pilots to not be generalizable with spread, when designing the pilot or small test of change. Initial backward induction to understand, up-front, potential problems with scaling; think like a policy maker when doing the initial study. ("What could possibly go wrong") (See section on PDSA for a list of these)

2. Due to these characteristics of pilots, which make generalizability problematic, the following are recommended:
   a. More precise statistical summaries of the pilots to assess if they actually worked
   b. More frequent replication before attempting spread: If goal is demonstrating 95% confidencethat small scale pilots will scale, may need about 4 independent studies to show the same thingto overcome the possibility of these biases being present.

3. Once decision to spread has been made: the following are recommended to <u>increase chance of success/fidelity:</u>
   a. Detailing the core elements or "non-negotiables" of the intervention
   b. Ensure the facilitators/project managers/staff understand the "whys" or the mechanism behind the intervention effect.
   c. Look for technology to standardize processes and to check fidelity: Upload data of spread sites in a way that can do fidelity testing as data entered. (see Dubner, below)
   d. Original scientist or pilot person also should play an important role in actual role out of program
   e. Carefully measuring program efficacy when program is scaled: (generation of new knowledge.)

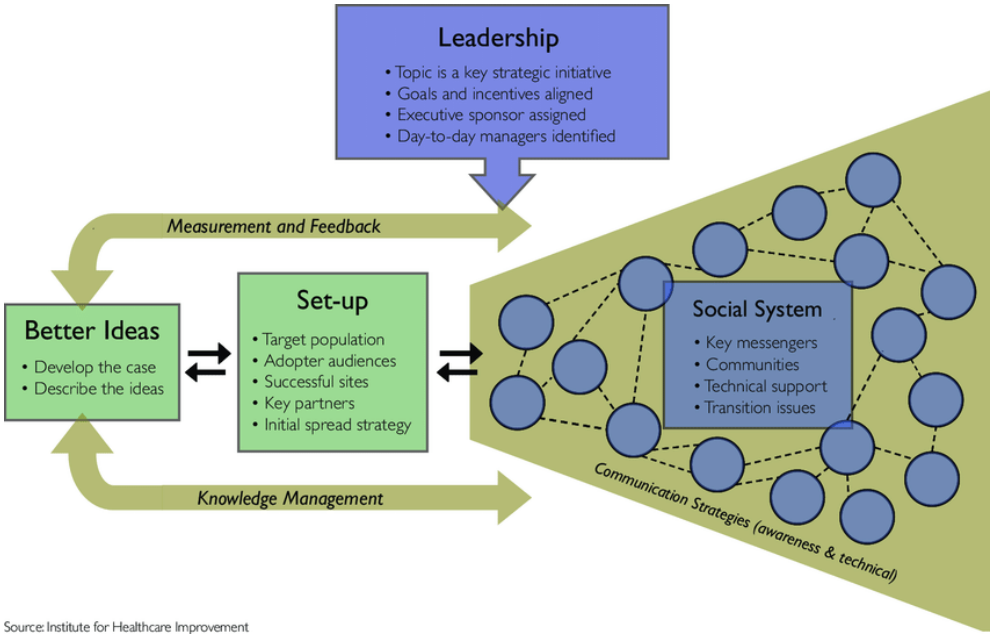
<u>Why spread fails</u>: (Dubner, 2020) summarizes the main five reasons spread/implementation fails:

1. Evidence not there to support scaling in first place
2. Wrong people were studied in the pilot compared to the larger population.
3. Wrong situation was used: voltage drop with change of situation: avoid by preserving "fidelity" oforiginal test. One solution: Upload data of spread sites in a way that can do fidelity testing as dataentered.
4. (Infrastructure/Delivery system of spread very different from system of academic testing.)
5. Need to look at both the supply and demand for the intervention

<u>Elements of successful transitions from projects to programs</u> (Savinsky & Stadelhofer, 2011?) describeselements of successful spread with important pitfalls to avoid.

1. Solidify leadership support
2. Understand current state
3. Define future state
4. Confirm and monitor operational metrics
5. Enlist expertise and appoint a transition leader
6. Engage affected personnel
7. Determine staffing
8. Develop team charters
9. Create and execute transition plans
10. Establish post-transition processes for documentation and evaluation

Framework for Spread (from the Improvement Guide):



Other factors to integrate (from workgroup discussion):

1. For implementations, standard should be a transparency of timeline and milestones
2. Ideally, there would be agreement of what constitutes thorough analysis of animplementation/spread.
3. To manage knowledge of optimal implementations, Partnership should capture examples of case studies towrite up to document best practices in spread, for example: birthday club, Palliative care, MPS, IOPCM
4. Future examples where framework will be helpful include implementation of ECM and Collective Medical Technology's Collective Plan.

Partnership approach to Scale-up and Implementation (Sustainability)

Current Status: Project Review Board (PRB) is the major mechanism for larger, multidepartment projects, for prioritization, estimation of resources and scope. Many, but not all major implementations go through PRB; the trend has been to ensure all do. Considerations: Project management approach, but not always done equally rigorously for every project. Implementations need to be integrated with department and organizational goals. As project becomes a program, there is a transition to Program Management approach to blending into other existing operations—this involves a different skill set than project management.

Organizational Factors

Organizational Factors:
Organizational Values, Culture, Structure, Processes that support approach, fit it in withoverall strategy

In addition to the organization factors listed under the Knowledge Management section, above, the workgroup collected other leadership and organizational activities that would we needed to support the success of the Pathway to Excellence framework.

1. **Nurture Values**: Current Status: Link to communication channels and other activities. Leadersmentoring and demonstrating them. Developing staff expertise. Supportive organizational and management culture. (See separate document)
2. **Systematically review the work we are currently doing,** categorizing by need for knowledge documentation, evaluation, nature of the work, budget, relationship to regulation/quality
3. **Promulgate a Partnership approach** to systematically consider each tactic.

Another view of overall organization framework to support continuous learning activities is from (Bellin Health Case Study, 2015):

1. Cascading structure of Planning, with the 120-day planning cycle forming the core timeline.
   a. 100 days of work, 20 days of evaluating results from last cycle, planning and prioritizing activities/plans for the next cycle. Steps:
      ii. Diagnostic Journey
      iii. Prioritization and Focus
      iv. Organizing the Work
      v. Work Period
      vi. Recalibration
   b. Major systems feeding into this process:
      i. Information gathering: marketing, customer service, strategic analysis, strategicplanning
      ii. System of production/optimization
      iii. System of measurement
      iv. System of improvement
      v. Managed Spread of successful improvements
      vi. System of evaluation
      vii. Building expertise/capturing knowledge (Improvement IQ)
      viii. Strategy room documenting all aspects of this system

Plan for Nurturing Organizational Culture

The workgroup crafted a plan to support supporting the organizational culture towards the principles of the Pathway to Excellence. It is presented here:

What to Share more widely and regularly to promote culture: Key Concepts (see draft PowerPoint)

- Overarching statements of values
- 5 key steps (skip the leadership step for presenting to organization)
- Brief Description of each step

- Key sayings/slogans to represent key ideas in each step: what to do and what not do to
- Use stories to illustrate

Sharing Knowledge about P2E:

- Presentations (Internal and potentially external)
  - Topics:
    - Overview of elements of P2E
    - Knowledge Management
    - Data Analysis/Statistics/Evaluation
    - Small tests of change/scaling up
  - Presentation to leadership teams; record for future.
- Showcased examples
  - Internal: capture, publish, publicize
  - External: lessons learned, capture information
- Smaller Key Message
  - Derived from Larger Presentation
- Slogans
  - Start with those already identified
  - Potential graphics associated with some?

Marketing Paths: Needs timeline and work plan

- Milestones
  - New name selected
  - Plan completed
  - Playbook draft/update
  - Presentations given/saved
  - Awards (Internal and external)
  - External presentations
- Internal communications paths; especially good for smaller key message and slogan
  - Emails
  - Partnership4me
  - Office Hours/VEB
  - Campaign
  - IQI, EQMSI, Ops, Exec
- Durable materials that use name of initiative
  - Trivets
  - Graphics
- Calendar to drip out the slogans etc.
- External communication paths, once core presentation refined
  - PAC
  - Board
  - Board Quality Committee
  - Strategic Planning
  - Clinic Consortia
  - CIN
  - CHCF Leadership
  - CAHP

- LHPC Medical Directors
- State quality convening 2022
- Poster presentation at IHI

Building Leadership Understanding and Commitment

- Incorporate into HS leadership meeting
- After leaders learn about aspects of the LHP, have them give talks to staff

Building Front Line Staff Understanding and Commitment

- LMS training
- Sample Interview questions for staff interviews that demonstrate LHP and ask about traits that would support it
- QI department training (NR and SR)
- Involving staff with aspects of Pathway to Excellence activities that are interesting and outside theirusual work
- Other department trainings/engagement: PMO, pharmacy, medical directors
- Awards for demonstrating aspects of P2E: examples
  - Best graphical presentation of data
  - Evaluation of the year
  - Best case study write-up
  - PDSA of the year
  - Spread process of the year (most likely to be sustained)
  - Project manager of the year
  - Analyst of the year
  - Best meeting facilitator of the year

Plan for Maturing the Framework

Overall Plan

Components of this Framework for Continuous Learning will be divided up and additional detailed documentation based on the recommendation in this document will be generated each year for the next severalyears.
In particular, the work of the Health Analytics Strategy Workgroup will resume in 2022, and may move beyondthe initial focus on analytics to tackle some of the data standardization and evaluation template needs describedabove.

Year 2 Activities

The current plan for activities in year 2 of the Pathway to Excellence are:

1. To spread key concepts in this framework to leadership within the Health Services leadershipteam.
2. To focus on the Knowledge Management section to develop a Strategic Knowledge Management plan and associated action plan, by June 30, 2022. A special area of focus withinthis work will be on regularly reviewing and using data we already have access to.

These will be incorporated into the Quality Measure Score Improvement team goal.

Bibliography

Al-Ubaydli, O., List, J. A., & Suskind, D. (2019). The Science of Using Science: Towards an Understanding ofthe Threats to Scaling Experiments. *National Bureau of Economic Research, Inc. Working Papers.* National Bureau of Economic Research. Retrieved from https://ideas.repec.org/p/feb/artefa/00670.htmlBellin

Health Case Study. (2015).

Berwick, D. M. (1996, March 9). A primer on leading the improvement of systems. *BMJ, 312*, 619-622.

Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009, August 7). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science, 4*(50). Retrieved from https://doi.org/10.1186/1748-5908-4-50

Dubner, S. (2020, February 12). Policymaking Is Not a Science (Yet). *Episode 405*. Retrieved from https://freakonomics.com/podcast/scalability/

Etheredge, L. M. (2007, January 26). A Rapid-Learning Health System. *Health Affairs*, w107-w118. Finkelstein, A.

(2020, April 16). A Strategy for Improving U.S. Health Care Delivery -- Conducting More Randomized, Controlled Trials. *New England Journal of Medicine, 382*(16), 1485-1488.

Firestone, J. M., & McElroy, M. W. (2003, November). *Corporate Epistemology: Competing Philosophies of Truth in Business and How They Influence Knowledge Management.* Retrieved from MKCI.org: https://www.kmci.org/media/Corporate_Epistemology.pdf

Hariharan, A. (2015). The Strategic Knowledge Management Handbook.

Horwitz, L. I., Kuznetsova, M., & Jones, S. A. (2019, September 19). Creating a Learning Health System through Rapid-Cycle, Randomized Testing. *New England Journal of Medicine, 381*(12), 1175-1179.

Institute of Medicine. (2007). The Learning Healthcare System: Workshop Summary. Washington D.C.: The National Academies Press.

Keith, R. E., Crosson, J. C., O'Malley, A. S., Cromp, D., & Taylor, E. F. (2017). *Using the Consolidated Framework for Implementation Research (CFIR) to produce actionable findings: a rapid-cycle evaluation approach to improving implementation.* Retrieved from Implementation Science Open Access 12:15: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5303301/

OpEx/PMO. (2020). DMAIC Process.

Platt, J. E., Wienroth, M., & Raj, M. (2020). An Analysis of the Learning Health System in Its First Decade in Practice: Scoping Review. *Journal of Medical Internet Research*, e17026.

Savinsky, C., & Stadelhofer, A. (2011?). Best practices for a smooth project-to-operations transition.

Simon, G. E., Platt, R., & Hernandez, A. F. (2020, April 16). Evidence from Pragmatic Trials during Routine Care -- Slouching toward a Learning Health System. *New England Journal of Medicine, 382*(16), 1488-1491.

Smoyer, W. E., Embi, P. J., & Moffatt-Bruce, S. (2016, December 20). Creating Local Learning Health Systems. *JAMA, 316*(23), 2481-2482.

Venkataramani, A. S., Underhill, K., & Volpp, K. G. (2020, January 7). Moving Toward Evidence-Based Policy: The Value of Randomization for Program and Policy Implementation. *JAMA, 323*(1), 21-22.

Weaver, P. (2010). Understanding programs and projects--oh, there's a difference! *PMI Global Congress 2010--Asia Pacific*. Melbourne, Victoria, Australia: Newtown Square, PA: Project Management Institute.

~~Annotated Bibliography Available on Request~~

Appendix ~~D~~C: Resumes for Key Leadership Roles Accountable for Implementing and Maintaining the QI/PI Program

The order of resumes corresponds to the sequence of key roles outlined in the Authority and Responsibility section of this document.

Chief Executive Officer

Sonja Bjork, JD

[redacted]

Medi-Cal Health Plan Senior Executive

Experienced and mission-driven Medi-Cal managed care Chief Executive Officer with excellent leadership, analytical and strategic planning skills. Engaging communicator and relationship builder with experience in geographic expansion to new service areas. Demonstrated record of success in complex provider contract negotiations. Supportive and hands-on leadership style with ability to motivate teams in achieving organizational excellence, including implementation of new benefits and initiatives that improve services for providers and members.

Areas of Expertise

- Strategic Planning & Execution
- Team Leadership & Development
- Organizational Design & Restructuring
- Budgeting & Fiscal Management
- Contracting & Negotiations
- Medi-Cal Policy Analysis & Implementation
- Employee Engagement
- Community Emergency Response

Select Career Highlights

- Selected as a commissioner on the national Medicaid and CHIP Payment and Access Commission (MACPAC), a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Service and states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP).
- Led expansion of health plan service area to multiple northern California counties. This included organizing network readiness requirements, memoranda of understanding with various agencies and providing expertise on required county board of supervisor enabling ordinances. Established additional regional offices and staffing models to ensure local presence and excellent customer service.
- Led operational departments in obtaining NCQA (National Committee for Quality Assurance) accreditation that required extensive policy and procedure development, reorganization of workflows and support of internal mock audits.
- Successfully implemented numerous Medi-Cal benefits and programs such as CalAIM enhanced case management and community supports, community-based adult services, autism and behavioral health services, including network development through community and provider outreach; oversaw internal operational readiness efforts such as claims configuration, member communication and provider education efforts.

Career Experience

Partnership HealthPlan of California
Chief Executive Officer
2023-Present

- Lead service area expansions, most recently adding ten counties to the health plan, resulting in a 38% increase in membership
- Ensures appropriate staffing levels to meet operational requirements, including a recent increase of almost 30%, while maintaining company culture and achieving a 92% overall employee satisfaction rate
- Guides strategic planning with stakeholders, including the Board of Commissioners, consumers and employees
- Oversees development of $5.9 billion annual budget
- Develops and maintains strong community partnerships in support of the health plan mission
- Identifies opportunities for new approaches to benefit administration
- Supports evaluation and adoption of new technologies to improve efficiency and service
- Lead focused initiatives to address health disparities identified through data analytics and support efforts to attain NCQA Health Equity Accreditation

Partnership HealthPlan of California
Deputy CEO/Chief Operating Officer
2022-2023
Chief Operating Officer
2015-2022

Executive management of multiple operational departments including claims, member services, grievance & appeals, health services (health equity, utilization management, care coordination and population health), provider relations, project management office, configuration department and multiple regional offices within a Medi-Cal managed care health plan.

- Oversight of multiple regional offices to assess and support local needs, community involvement and responsive service
- Led operational departments in establishing and maintaining performance standards to ensure DHCS contract compliance and excellent service to all stakeholders
- Worked with department heads to develop and implement annual administrative budget proposals
- Developed, sponsored and evaluated organizational and departmental goals in support of PHC's mission and vision
- Supported achievement & maintenance of NCQA Accreditation
- Developed and promoted health equity initiatives
- Supported & engaged with Plan's very active Consumer and Physician Advisory Committees
- Led provider recruitment and workforce development program, with focus on rural California
- Managed major benefit implementations within operational departments
- Served as liaison to consortia of Federally Qualified Health Centers, Tribal & Rural Health Centers
- Led health plan's Community Emergency Response Team, whose actions work to eliminate or reduce disruptions to accessibility of health care services to members in community-wide emergencies such as wildfires, flooding, planned public safety power shut-offs and the ongoing COVID-19 pandemic

Partnership HealthPlan of California
Deputy Chief Operating Officer
2014-2015

- Led implementation of new benefits, including coverage of mild to moderate mental health services
- Operationalized the transition of autism services from regional centers to PHC
- Led development of organization's multi-year strategic plan
- Led transition of low income health program (LIHP) into coverage through PHC Medi-Cal managed care
- Coordinated with stakeholders to support establishment of PACE in rural northern California
- Served as liaison to multiple community organizations in strategic grant award program

Partnership HealthPlan of California
Director of Policy & Program Development
Manager of Business Development
2011-2014

- Coordinated and evaluated multiple Requests for Proposals/Requests for Information for outsourcing opportunities
- Managed and implemented Medi-Cal Coverage Expansions for the health plan under the Affordable Care Act which included:

    1) Transition of indigent adults to Medi-Cal (Low Income Health Plan)
    2) Newly eligible to Medi-Cal under the Affordable Care Act
    3) Healthy Families – transition of children from subscriber-based coverage into Medi-Cal

- Led expansion of PHC to eight new rural northern California counties – PHC planning & developing team, educational activities and outreach in the northern region
- Managed the Intergovernmental Transfers (IGTs) process with multiple counties and district hospitals to bring matching federal Medicaid funds to our local communities
- Implemented Community Based Adult Services (CBAS) into Medi-Cal Managed Care

Stahnke & Associates Legal Services for Children
Attorney 2000-2010

As a Certified Child Welfare Specialist, provided high quality legal representation to children in abuse and neglect cases.

- Conducted trials involving complex legal and medical issues
- Performed legal research and analysis in preparing motions, trial briefs and writs of appeal
- Served on steering committee to develop and implement the Dependency Drug Court program which has improved access to substance abuse treatment and services for parents of dependent children
- Provided training to staff members, foster youth, foster parents and agency representatives on local implementation of state legislation affecting dependent children
- Served on advisory committees for various county initiatives including: Team Decision Making; Heart Gallery; Permanent Connections for Foster Youth

Solano Partnership HealthPlan (now Partnership HealthPlan of California)
Grievance Coordinator
1994-2000

Coordinated health plan response to member issues and complaints in order to address member concerns in a fair and timely manner:

- Worked closely with Member Services Director to develop and implement policies and procedures
- Prepared issue briefs and represented health plan at administrative hearings
- Established and facilitated the Consumer Advisory Committee whereby health plan members could provide input and feedback on various aspects of health plan operations
- Analyzed NCQA standards and requirements and ensured member grievance system compliance during mock audits
- Liaison with local legal aid advocacy groups to ensure smooth transition from traditional Medicaid program to managed care environment
- Represented the health plan on the Solano Community Services Task Force
- Served on the State Steering Committee of the California Connections Project

Solano County Legal Assistance
Staff Attorney 1993-1994

Legal services agency serving low-income residents of Solano County in the areas of housing, health care and government benefits. Received foundation grant funding to provide legal representation and advocacy to ensure low-income children's access to health care in Solano County.

- Represented low-income clients at administrative hearings on Medi-Cal and other public benefits issues
- Served on the steering committee of the Community Services Task Force on Managed Care to address health care access issues under the county's new Medi-Cal Managed Care Plan
- Created and coordinated distribution of Medi-Cal outreach material to pregnant teens in order to improve access and utilization of prenatal care services
- Supervised legal interns in providing advocacy to clients in the areas of domestic violence, housing and public benefits
- Served on the National Youth Law Center Statewide Youth/health Advocates Committee

Educational Background

Juris Doctorate
UC Berkeley School of Law, University of California, Berkeley

Bachelor of Arts, Sociology – Concentration in Analysis & Research (CARR)
University of Wisconsin, Madison

Professional & Personal Accomplishments

Commissioner – Medicaid and CHIP Payment and Access Commission (MACPAC) – Appointment Term; 2022-2025

Local Health Plans of California – Member and past chair of COO Committee (2015-present)

Volunteer, Soccer Without Borders – Oakland program for newcomer immigrant and refugee youth (2013-Present)

Statewide CAHP & County Behavioral Health Workgroup (2014)

Child Abuse Prevention Council Practitioner of the Year (2007)

National Association of Child Counsel- Child Welfare Law Specialist (certified in 2006)

Board Member & Board Chairperson, Solano Diversified Services (2006-2010)

Court Appointed Special Advocates (CASA) (2005-2010) Board Member

Solano County Women Lawyers (2000-2010)

Wendi Davis

Qualifications Summary

- *Dynamic healthcare leader offering 25+ years' comprehensive achievements with non-profit, rural, and integrated healthcare delivery and payer systems.*
- *Expertise in institutional, professional, LTC, Rehab, and Behavioral Health payment regulations and requirements, as well as Medi-Cal Managed Care and EDI technology.*
- *Proven ability to manage various specialties such as Admissions, Health Information Management, Care Coordination & Utilization Review, Physician Credentialing, Claim Adjudication, and Contract Negotiating.*
- *Exceptional strategic planning skills and a history of generating multimillion dollar improvements for multiple Northern California healthcare delivery systems while overseeing operations.*
- *Recognized for ability to incorporate innovative management techniques that result in exceptional employee engagement and retention rates, as well as cultivating strong collaborative relationships with government agencies, public officials and community groups.*

Professional Experience

Partnership Health Plan of California, Redding, CA Nov 2013-Present

Chief Operations Officer June 12, 2023 to present

Responsible for the oversight of operations and executive management of the Claims, Member Services, Configuration, Grievance and Appeals, Transportation, and the Regional Leadership Team. This position provides leadership in organizing the HealthPlan's operations, interdepartmental communication, and participates in goal setting and strategic organizational planning in the development of new business lines and programs.

- Oversight of the HealthPlan's operational departments and regional offices as described above to insure efficient and high quality administration of Medi-Cal Managed Care for 24 counties.
- Works with department directors to establish department goals, improve operational effectiveness, implement work plans and making corrective actions as needed.
- Oversee the provider network and contractual agreements including reimbursement and services.
- Monitors departments' performance and production through comprehensive reporting and progress against goals.
- Provides leadership in interdepartmental projects involving department operations to ensure quality outcomes. Participates in new business planning and program development.
- Participates with counterparts at local health plans throughout California.

Northern Region Executive Director July, 2017 to June, 2023

Oversee the operations of the Partnership HealthPlan of California's Northern Region. Represent the HealthPlan with community agencies, providers and elected officials. Manage staff in Redding and Eureka offices. Work with Plan leadership to assure awareness of the Region's needs and issues; work with Regional staff and communities to promote the interests and values of Partnership HealthPlan within the Region. The Northern Region employees over 175 staff, and provides support and services for the seven northern counties which account for approximately 175,000 members. Establish long range, strategic direction of the Northern Region and ensures departmental goals and objectives support that direction. Establish performance indicators, operating goals, process improvement initiatives, productivity improvements, and cost reduction programs that consistently improved production and quality, as well as provider and member satisfaction. Participate in community healthcare collaborative committees, and improvement projects.

Selected Achievements:

- *Successfully built and established a full service claims processing team and call center.*
- *Developed and implemented a Provider Scorecard program, providing quarterly claims, denial and payment data to providers resulting in a 21% decrease in denials.*
- *99.6% of all claims are processed within 30 days, and maintaining a 98.6% accuracy rate.*

Claims Director *Nov, 2013 to July, 2017*

Directed overall operations for Claims and Customer Service departments in the Northern Region. Established performance indicators, operating goals, process improvement initiatives, productivity improvements, and cost reduction programs that consistently improved production and quality, as well as provider and member satisfaction. Participates in community healthcare collaborative committees, and improvement projects.

Selected Achievements:

- *Successfully built and established a full service claims processing team and call center.*
- *Implemented a paperless work flow system, instituted real time inventory monitoring.*
- *Developed and implemented a Provider Scorecard program, providing quarterly claims, denial and payment data to providers resulting in a 21% decrease in denials.*
- *99.6% of all claims are processed within 30 days, and maintaining a 98.6% accuracy rate.*

Adventist Health System, Santa Rosa, CA Oct 2012-Nov 2013

Regional Executive Director, Revenue Cycle

Responsibility for the Revenue Cycle and workflows region-wide, including Scheduling, Pre-Registration, Insurance Verification, Financial Counseling, Health Information Management, Case Management, Billing and Collections and Customer Service for 4 acute hospitals(including 1 Critical Access facility), 58 Clinics, and 1 Behavioral Health Facility. This includes the centralized pre-registration center as well as the patient access functions at all facilities in the Northern Cal Network, as well as the Centralized Billing Office.

Selected Achievements

- *Increased clean claim rate from 56% to 92%, and decreased denials by 40%.*
- *Consolidated 4 Local Business Offices into one Central Office, while increasing the percent of accounts financially cleared from less than 50% to nearly 90% at all four sites.*
- *50+ Patient Access professionals obtained their CRCR certification through HFMA.*

Kaiser Permanente, Oakland, CA Aug 2007-Oct 2012

Nor Cal Exec Regional Director, Revenue Cycle (June 2010-Oct 2012)

Accountable for the accurate and compliant generation of over 2 million external claims annually, which equated to $2 Billion+ dollars a year for the Nor Cal Revenue Cycle. Outpatient and Physician visits exceeded 25 million encounters and inpatient stay days totaled 900,000 in 2011. Oversight and accountable for the management and ongoing remediation of Epic Resolute Systems, as well as ePremis Billing Systems. Partnered with KP Technology teams for various upgrades and enhancements.

The scope of responsibility included both professional and health system billing, as well as integration with Admissions/Registration, Physician Groups, Health Information Management, Professional Coding, Revenue Integrity, Case Management and Charge Capture. Claims were generated for 21 Acute Hospitals, 175+ clinics, Home Care and Hospice Services as well as professional claims for over 6300 physicians, representing all specialties.

Selected Achievements

- *Consolidated 21 Local Business Offices into one Central Office, and initiated Epic WQ's for all professional billing edits, while* simultaneously decreasing AR backlog by 45 Days.
- *Increased claim accuracy to 92% from a previous level of 47%.*
- *Collaborated with Union and labor leaders to establish productivity and accuracy standards for all staff*
- *Introduced process improvements in Case Management and Patient Financial Assistance to decrease Medi-Cal TAR denials by 83%.*

National Associate Vice President, Revenue Cycle Back End Processes (October 2007-June 2010)

Oversee the processes and procedures for billing and follow-up for Kaiser's 8 national regions. Develop the architecture and functional requirements for the national standard operating model for the back end functions of the revenue cycle, while assisting the local regions with regional projects and initiatives.

Selected Achievements

- *Led the design of the operating model for the BCR project (Billing/Collections HIM and Case Management Re-engineering), and successfully implemented the program in 6 regions.*
- *Co-Sponsored the development and implementation of NEVI-National Eligibility Verification Initiative (Integrated Insurance Verification) which resulted in a 31% decrease in claim rejections.*
- *Assisted in the coordinating and disbursement of $19 million in grant dollars given to aid in the support and expansion of 35+* federally qualified health centers (FQHCs) and 11 free clinics. This work increased and improved access to care for over 75,000 vulnerable and underserved individuals.

Catholic Healthcare West, North State Service Area, Redding, *CA* June 2003 - Aug 2007

Regional Exec Director of Revenue Cycle and Admissions

Manage and direct the Central Business Office and Admissions, for Catholic Healthcare West's North State Region. The Region includes three acute care facilities, 8 clinics, 3 rural health clinics, ground and air life support service, Home Care and Hospice and a SNF.

Selected Achievements

- *Gross AR days from 74 to 58, while decreasing bad debt from 3.2% to 1.5%, and increasing net revenue.*
- *Integrated insurance verification, and an ABN system, to enhance and expand the Pre-Registration System, while initiating an upfront cash collection process and collecting over 1.5 million in 2005.*
- *Increased patient and employee satisfaction scores to 5 star levels.*
- *Awarded the No. 1 CBO in CHW for percent over goal for cash collections in 2004 and 2005.*

Education

Masters of HealthCare Administration: *St. Joseph's College of Maine*
Bachelors of Science: *California State University, Chico 1992*
CHAM Certified-*Certified HealthCare Admissions Manager 2002*
QHC/RHC (Clinical Documentation, Billing and Coding Training) Certification *CPCA 2011*

Professional Associations/Awards

Healthcare Financial Management Association: *Affiliate,1997-Present*
CAHAM ~ Carl Satterfield Statewide Award of Professional Excellence: *1999*
California Association of HealthCare Admissions Management: Served as President, *2003-2012*

KATHERINE BARRESI, RN, BSN, PHN, NE-BC, CCM

Chief Health Services Officer

[redacted] • [redacted] • [redacted]

Healthcare Leadership Executive

Dynamic, results-driven healthcare leader with over a decade of executive experience in driving operational excellence and strategic growth within diverse healthcare settings, including managed care, case management, population health, and utilization management. Expert in policy development, cross-functional collaboration, and program transformation with a proven record of success at Partnership HealthPlan of California, impacting the lives of over 900,000 Northern California residents through sustainable health initiatives.

Qualifications

Executive Management: Oversight of multiple departments with 500+ budgeted employees across 6 regional offices, specializing in operational efficiency and interdepartmental alignment.

Regulatory & Compliance Expertise: In-depth knowledge of government sponsored health programs and standards, accreditation requirements, and healthcare policy for managed care.

Population Health & Case Management: Proven track record in directing programs across acute, outpatient, and community settings to enhance patient outcomes.

Data Analytics: Skilled in utilizing analytics for cost optimization and operational insights, supporting quality patient care and fiscal accountability.

Health Equity & Policy Development: Deep expertise in implementing initiatives addressing health disparities and inequities, social determinants of health and collaborating with non-traditional community-based groups.

Leadership & Mentorship: Adept at team building, talent development, and fostering a collaborative culture across diverse teams and stakeholders.

Experience

Partnership Health Plan of California — Fairfield, CA

Chief Health Services Officer — 10/2023 - Present

- Proudly served as a member of the Executive Team for Medicaid managed care plan that provided services and care to over 24 counties in Northern California.
- Responsible for the operational management and leadership for the following Health Services departments: Utilization Management (UM), Care Coordination (CC), Population Health Management (PHM), Health Equity, Behavioral Health, and CalAIM initiatives.
- Provided strategic leadership in organizing the health plan's operations, interdepartmental communication, and organizational goal planning and strategic direction.
- Served as a statewide expert on CalAIM and other various assorted initiatives related to government health care programs to promote solutions for health policy, population management, and clinical quality outcomes.

Partnership Health Plan of California — Fairfield, CA

Senior Director Health Services — 01/2023 - 10/2023

- Clinical and strategic leadership to assigned departments including planning, execution, growth and compliance of various benefits and services
- Dyad to Chief Medical Officer and associated Medical Directors at the Health Plan
- Responsible for providing direction to leaders in areas of health plan compliance and regulatory guidelines related to operations
- Created operational analytics to increase efficiencies, revenue optimization, and cost containment maintaining patient-centric quality expectations
- Change agent for transformation of services and benefits under CalAIM including Enhanced Care Management, Community Supports, Population Health Management, Health Equity, Housing and Homelessness Incentive Program and various other associated initiatives

Experience

Partnership Health Plan of California
Fairfield, CA

Director Care Coordination
02/2020 - 01/2023

- Responsible for the performance, quality and oversight of the various case management programs and services including Complex Case Management, Transitions of Care, California Children's Services Whole Child Model and other associated interventions
- Owned complex business and clinical proposals with executive communication and lead enterprise wide execution; requiring interdepartmental and external resources and teams
- Fostered a culture of collaboration and quality with external community partners and stakeholder to address shared goals and community needs

Partnership Health Plan of California
Fairfield, CA

Associate Director Care Coordination
06/2013 - 02/2020

- Responsible for day-to-day oversight for the operations and implementation of various case management programs and services in the Care Coordination Dept
- Worked collaboratively with others across the organization aligned the appropriate resources to maximize efficiencies and achieve goals
- Proactively identified potential gaps and enacted solutions to decrease organizational and operational risk
- Supported and monitored efforts to enhance staff support and training

Education

Sonoma State University
Sonoma CA

Bachelors of science nursing
01/2012 - 01/2013

- G.p.a. 3.66
- Juliana Johnson Memorial Scholarship Recipient
- Alliance Health Care Scholarship Recipient

Napa Valley College
Napa, CA

Associates degree in nursing
01/2010 - 01/2012

- Degree with honrs
- Nursing Class President
- 160 Nursing Preceptorship hours in Labor and Delivery
- Napa Valley College Foundation Scholarship Recipient
- Bra n Track Nursing Scholarship Recipient
- Elise M. Tarner Memorial Scholarship Recipient
- Geri Glover Scholarship Recipient
- Grant's Fund Scholarship Recipient

Active Licensures & Certifications

Registered Nurse (RN): License #825562 - California Board of Registered Nursing

Public Health Nurse (PHN): License #86817 - California Board of Nursing

Certified Case Manager (CCM): Certification #4215211 - Commission for Case Management

Certification Nurse Executive – Board Certified (NE-BC): Certification #2022003530 - American Nurses Association

Key Competencies

Managed Care Operations · Case Management · Public Speaking · Nursing · Program Development · Population Health Management · HEDIS · Leadership · Policy Analysis · Health Equity · Quality · Change Management · Public Health Nursing · Government Sponsored Health Programs · Regulatory Compliance · Finance · Employee Relations · Vendor Management · Utilization Management · Community Engagement · Team Development · NCQA · Data Technologies · Health Analytics

Volunteering

Registered Nurse (RN)

Napa County Medical Reserve Corps 2020 - Present

Registrant in the county's Disaster Healthcare Volunteers Program (DHV) to provide healthcare needs or supports, on a volunteer basis, during disasters and other emergencies.

Robert Moore, MD, MPH, MBA, FAAFP

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

Education

2014-17	Western Governors University Master's Degree in Business Administration (MBA) Healthcare Management, February, 2017
1986-92	University of California San Francisco School of Medicine: Doctor of Medicine (MD), May, 1992
1989-90	Columbia University, New York City School of Public Health, Division of Tropical Medicine Master's Degree in Public Health (MPH), February, 1991
1982-86	University of California Berkeley Bachelor of Arts in Biochemistry, May, 1986

Internship and Residency

1992-95	Family Medicine Residency Program Ventura County Medical Center

Post-graduate training

2007-2009	UCSF Center for Health Professionals: California Health Care Foundation Health Care leadership Fellowship, Cohort VII
2003-2008	Harvard School of Public Health, Boston Managing Ambulatory Care: A Program for Physicians in California Community Health Centers (Initial course: 2003, Alumni courses: 2004-2008)
2002	Intermountain Health Care, Salt Lake City Advanced Training Program in Health Care Delivery Improvement
2001	American Academy of Family Physicians, Kansas City Fundamentals of Management Course
2000	University of California, Davis Telemedicine Learning Center Training

Professional Experience and Training

2011-2024	Chief Medical Officer, Partnership HealthPlan of California. Includes professional oversight of grievances and appeals, quality, pharmacy, credentialing, health equity, care coordination, utilization management, behavioral health. Member of executive leadership team, with input on other aspects of health plan operations (claims, member services, provider relations, health analytics, IT, finance, HR). Active participation in Local Health Plans of California (co-facilitator of Medical Directors group) and the Association of Community Affiliated Plans. Advised the California Department of Health Services on assorted health policies.
1995-2023	Family Physician, Ole Health, Napa, California. Outpatient only since 2018.
1995-2018	Active on Medical Staff of Queen of the Valley Hospital, Napa, California
1998-2011	Medical Director, Community Health Clinic Ole (now Ole Health), Napa, California
2006-2011	Chief Medical Officer, Redwood Community Health Coalition (now Aliados Health)
2011	Chief Medical Officer, Redwood Community Health Network
2007-2008	Medical Director, Healthy Moms and Babies (now Ole Health Perinatal Services)
1995-2007	Private Practice in Obstetrics, Napa, CA
1994-99	Emergency Room Physician, Valley Emergency Physicians, several California sites
1994-95	Ventura Urgent Care, Physician
1993-95	Ventura County Emergency Department, Physician

Community Activities

2017-2024	Touro University Community Advisory Council, Member
2013-2020	Steering Committee, Honoring Choices Napa Valley
2013-2024	Board of Directors, Coalition of Compassionate Care for California
2012-2019	Board of Directors, Migrant Clinicians Network
2008-2023	Member of California Improvement Network, a program of the California Healthcare Foundation
2018-2024	Board of Directors, Sac Valley Med Share, a community health information exchange in northern California
2012-2018	Board of Directors, Connect HealthCare, a health information exchange in northern California. Served as Chair and Treasurer.
2009-2011	Chair of the Standardized Measures Group of the Tools for Quality Program, Tides Foundation and California Primary Care Association
2008-2011	Adjunct Assistant Professor of Family Practice, Touro University College of Osteopathic Medicine
2005-2017	Board of Directors, Western Clinicians Network
2009-2012	Medical Advisor to Board of Directors, Clinica Verde, Boaco, Nicaragua
2008-2009	Chair of Clinician's Committee, California Primary Care Association
2007-2008	Chair of Steering Committee, Accelerating Quality Improvement through Collaboration (California Primary Care Association program funded by California Health Care Foundation)
1996-2011	Teaching of Medical Students, Nurse Practitioner Students, Physician Assistant Students, Undergraduate Students at Community Health Clinic Olé
2012-2023	Teaching of Public Health Students at Partnership HealthPlan
1998-2007	Member of Board of Directors, Healthy Moms and Babies, Perinatal service provider

	for low-income women in Napa County (Served as Vice President, Secretary, Treasurer and currently President)
1998-2011	Member, Physician Advisory Committee, Partnership Health Plan of California
2003-2014	Chair of Community Health Committee of the Napa County Medical Society
1995-2003	Volunteer team physician for Napa and Vintage High School football teams
1999-2000	Member, Napa County Online Health Data Exchange Consortium

Research and Publications

2019	Chibber K, Tobey R, Moore R, and Rojasova S. Medicaid Managed Care Plan and Health Centers Advancing Value-Based Payment and Care. Robert Wood Johnson Foundation State Network Blog, November 2019.
2018	Liao J, Hodlofski A, Moore R, Navathe A. Partnership HealthPlan of California: Addressing Opioid Overuse with Behavioral Design Principles. Journal of Delivery Science and Innovation. Volume 6, Issue 1, March 2018, Pages 95-98.
2017	Barnato AE, Moore R, Moore CG, Kohatsu ND, Sudore RL. Financial incentives to increase advance care planning among Medicaid beneficiaries: Lessons learned from two pragmatic randomized trials. Journal of Pain and Symptom Management. Volume 54, Issue 1, July 2017, Pages 85-95.
2017	"EConsult Implementation Success Depends on Workflow" Health Affairs Letter, published March 13, 2017.
2013	"The Placebo Effect: the most powerful treatment we have." Marin Medicine 60 (1): 17-20
2012	"Conflicting national guidelines for mammography result in longer time intervals in between mammograms" Poster Presentation; 2012 Annual Meeting of APHA, Maria Fuchs, Robert Moore
2010	"Using Health Information Technology to Improve Quality" Information Bulletin #15, June 2010. Health Center Controlled Networks Series, National Association of Community Health Centers. Robert Moore, Fred Rachman, Michael Lardiere.
2008	"Cost Effective and Consistent TB screening and LTBI Care" Poster Presentation at Institute for Healthcare Improvement annual meeting, December 10, 2008 in Nashville, TN. Robert Moore, Carlos Avina.
2006	"Group treatment program of LTBI provides more efficient, higher quality care at a Community Health Clinic." Poster presentation at California TB Controllers Association Meeting, May 11, 2006. Luz Hernandez, Juan Martinez, and Robert Moore.
1991	"Chronic maternal morbidity in developing countries: data synthesis and policy suggestions." Presented at the 119th Annual Meeting of the American Public Health Association, Atlanta, Georgia, November 12, 1991.
1989-90	Laboratory investigations on the life cycle of *Trichinella spiralis*. Principle investigator: D. Despommier, Columbia University.
1985-86	"Identifying mutations in duplicated functions in *Saccharomyces cerevisiae*: Recessive mutations in HMG-CoA Reductase Genes," by Michael Basson, Robert Moore, Jules O'Rear and Jasper Rine. Genetics **117**:645-655 (December, 1987).

Professional Affiliations

1. American Academy of Family Physicians and California Association of Family Physicians, member since 1992
2. California Medical Association member since 1986
3. Napa Solano Medical Society member since 1995

Certification

October 2005	Fellow, American Academy of Family Physicians (FAAFP)
July 1995	Board Certified, American Board of Family Physicians; renewed 2002, 2009 and 2019
July 1993	Diplomate, National Board of Medical Examiners

Current Certification in Basic Life Support, Advanced Life Support in Obstetrics

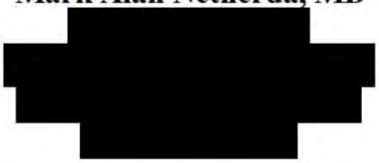
Honors and Awards

2011	Napa Hispanic Network Recognition for Contributions to the Community
2009	California Primary Care Association Hero Award
2008	Lifetime Achievement Award – Napa County Hispanic Network
2006	Values in Action Award for Justice – Queen of the Valley Hospital
2005	Award for Justice – Queen of the Valley Hospital Foundation
2000	Nominee-Values in Action Award for Service and Justice – Queen of the Valley Hospital
1998	Outstanding Physician of the Year – Napa County Medical Society
1997	Health Professional of the Year – Napa County Chamber of Commerce
1997	Nominee-Values in Action Award for Dignity – Queen of the Valley Hospital
1996	Recognition for service to America's underserved – National Health Service Corps
1986-92	Regents Scholar, University of California San Francisco
1986	Certificate of Distinction, University of California Berkeley -For Academic Excellence
1986	Departmental Citation, Biochemistry, University of California Berkeley -Outstanding Graduating Biochemistry Major
1986	Elected Phi Beta Kappa
1985	Robert Gordon and Ida W. Sproul Award, University of California Berkeley -Outstanding Scholarship, Leadership, and Service
1984	Elected to Order of the Golden Bear, University of California Berkeley

Other

Fluent in Spanish

Mark Alan Netherda, MD



CURRENT POSITIONS:
PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Medical Director for Quality 06/01/2022 - present
Associate Medical Director for Quality 08/01/2018 – 5/30/2022
Regional Medical Director for Solano and Yolo Counties 09/28/15 – 07/31/2018
Start date: 09/28/2015
4665 Business Center Drive
Fairfield, CA 94534
(707)863-4510

BOARD CERTIFICATION:
American Board of Family Medicine 1991, recertification 1998, 2005, 2012, currently in process

EDUCATION:
Pacific AIDS Education and Training Center
Designate "Key Physician" to be trained in educating and training other healthcare professionals in caring for people infected with HIV. 1992 – 1993

University of California, San Francisco – Fresno
San Joaquin Valley Medical Education Program, Department of Family Medicine
Valley Medical Center, Fresno, CA
Internship 1988 – 1989, Residency 1989 – 1991

George Washington University, School of Medicine and Health Sciences
Washington, DC
Degree – Doctor of Medicine 1988

Stanford University
Stanford, CA
Degrees – Master of Science, Biological Sciences 1984
Bachelor of Science, Biological Sciences 1983

EMPLOYMENT EXPERIENCE:
KAISER PERMANENTE
Family Medicine Primary Care Physician December 3, 2012 - September 7, 2015
401 Bicentennial Way
Santa Rosa, CA 95403
(707)393-4000

COUNTY OF SONOMA
Interim Public Health Officer May 2010 – April 2012
Interim Division Director May 2010 – February 2011
Department of Health Services
625 5th Street
Santa Rosa, CA 95404
(707) 565-4599

WEST COUNTY HEALTH CENTERS
Clinical Consultant providing HCV and HIV care. July 1999 – Aug 2011
6800 Palm Avenue
Sebastopol, CA
(707) 824-9333

COUNTY OF SONOMA
Deputy Public Health Officer
Department of Health Services
July 2008 – May 2010
April 2012 – December 2012
625 5th Street
Santa Rosa, CA 95404
(707) 565-4599

COUNTY OF SONOMA CENTER FOR HIV PREVENTION AND CARE
HIV Primary Care Physician. August 2007 – July 2008
Medical Director. September 18, 1995 – June 2006
499 Humboldt Street, Suite 104
Santa Rosa, CA 95404
(707) 565-7400

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
Associate Clinical Professor, Dept. of Family Medicine, December 1995 – March 2012
Santa Rosa Campus
3320 Chanate Road
Santa Rosa, CA 95404
(707) 576-4000

INTERNATIONAL TRAINING AND EDUCATION CENTER ON HIV
May 2003 – July 2008
University of Washington
901 Boren Avenue #1100
Seattle, WA 98104-3508
(206) 221-7372

Clinical Consultant and Senior Technical Advisor, US-CDC, Namibia
June 2006 - July 2007

Working with the Namibian Ministry of Health and Social Services and US-CDC to develop, implement and manage training programs for physicians, pharmacists and nurses on the use of antiretroviral medications in the public (government) health sector.

Additional in country projects in Namibia:
May 7 – June 7, 2003.
October 10 – 27, 2003.
May 25 – June 6, 2004.
November 10-20, 2005.

OUTPATIENT IMMUNOLOGY SERVICES
COMMUNITY HOSPITAL OF THE MONTEREY PENINSULA
Private Practice. HIV Primary Care. November 1991 – October 30, 1995
23845 Holman Highway, Suite 318
Monterey, CA 93940
(408) 625-4972

NATIVIDAD FAMILY HEALTH CENTER
NATIVIDAD MEDICAL CENTER OF MONTEREY COUNTY
Family Practice Physician. September 1993 – September 1995
945 Blanco Circle, Suite D
Salinas, CA 93901
(408) 422-7998

CUSTOM HEALTH PROGRAM, COUNTY OF MONTEREY
Medical Director – county employee health insurance program, December 1993 – September 18, 1995
1330 Natividad Road
Salinas, CA 93940

HEALTH FIRST CLINIC
Outpatient urgent care and occupational medicine. July 1993 – September 1993
846 Freedom Boulevard
Watsonville, CA 95076

PRIMUS CLINIC OF THE PRESIDIO OF MONTERY
Outpatient family medicine. August 1992 – August 1993
Monterey, CA Clinic closed.

WALK-IN MEDICAL CLINIC
Urgent care medicine. July 1991 – July 1992
Aptos, CA Clinic closed.

APPOINTMENTS:
North Coast Area AIDS Education Training Center
Sonoma County Academic Foundation for Excellence in Medicine
September 1995 – July 2008

Sonoma County Commission on AIDS
August 1997 – June 2006

Chair, Sonoma County Commission on AIDS
Treatment and Care Committee
August 1997- June 2006

Technical Advisory Committee on Medical Aspects of Marijuana
California Medical Association
January 1997 – December 2000

CURRENT PROFESSIONAL ORGANIZATION MEMBERSHIPS:
Sonoma County Medical Association
California Medical Association

Revised 10/2024

KJ

Kermit Jones

emailaddress@partnershiphp.org

Bold Profile

Professional Summary

Deputy Chief Medical Officer, regulatory attorney and Internal Medicine Physician with twenty years of practice experience and expertise in healthcare regulation and policy development

Work History

Partnership In Health - Deputy Chief Medical Officer
Fairfield, CA
08/2025 - Current

- Manage multidisciplinary teams to optimize patient care
- Oversee Utilization Management policy development
- Collaborate on oversight of Quality Improvement
- Work across departments to implement new Medicare-based lines of business
- Engage healthcare systems and providers on quality improvement programs and incentive programs
- Participate in Grievance and Appeals hearings, Quality and Utilization, Policy Review and Peer Review Committees

Partnership Healthplan of CA - Medical Director of Medicare Services
Fairfield, CA
04/2024 - Current

- Work with other organization departments to implement new Medicare-based line of business
- Engage healthcare systems and providers on quality improvement programs and incentive programs
- Participate in Grievance and Appeals hearings, Quality and Utilization, Policy Review and Peer Review Committees

The Permanente Medical Group, TPMG - Internal Medicine Physician
09/2017 - Current

- Implemented chronic disease management programs for high-risk communities
- Completed over 20,000 distinct clinical encounters

Skills

- Conversational language skills in Arabic and Hindi
- Experience in statistical modeling in R and using Python for Machine Learning and CNN
- Knowledge and expertise in healthcare regulation, Medicare quality programs and incentives
- Completed Master's Degree level course work in business associations, capital structure and finance

Education

04/2023
Massachusetts Institute of Technology
Cambridge, MA
Machine Learning And Data Science PE Program

05/2012
Columbia University School of International & Public Affairs
New York
M.P.A

05/2005
Duke University
Durham, NC
M.D., J.D

- Healthcare advisor for 2019 U.S. Presidential Campaign

United Health Group, Optum - Medical Director
San Francisco, CA
11/2023 - 03/2024

- Medical Claims Review, Utilization Management and Quality Review

U.S. House Of Representatives - U.S. Congressional Candidate
09/2021 - 11/2022

- Designing most comprehensive healthcare plan of any U.S. Congressional Candidate, available upon request
- Directing largest field operation in California with 20 staff members and 1,000 volunteers reaching 160,000 district residents

Rush University Medical Center - Residency Training, IM Resident
Chicago, Illinois
01/2015 - 01/2017

- Principal Investigator for military veteran's mental health research program for PTSD and other mental health interventions

Hyman, Phelps & McNamara - 2nd Year Associate
Washington, DC
09/2013 - 07/2014

- Drafted legal memos on HIPAA, ERISA, FDA regulations and DOJ-enforcement issues
- Advised large healthcare practices and systems on legal matters, compliance, and risk management

White House - Fellow
Washington, DC
08/2012 - 08/2013

- Senate appointment position for nation's premier mid-career leadership program with dual appointment in White House and Dept of Health and Human Services
- Led White House-level principal meeting on programs to secure veteran's benefits and military to civilian life transition program
- Led study group evaluating performance measures for new NIH institution – NCATS

US Navy - Medical Dept. Head
Camp Pendleton South, CA
04/2007 - 06/2009

- Medical Director of CASEVAC team for USMC 364 Squadron
- Medical Dept Head for joint U.S Marine Battalion of over 3,000 Marines at Camp Pendleton, Ca
- Collaborated with department personnel to coordinate multifaceted solutions to emerging military medicine problems.

National Naval Medical Center - Internal Medicine Intern

1997
Georgia Institute of Technology
Atlanta, GA
B.S
magna cum laude

KJ

Kermit Jones

Professional Summary

Medical Director focusing on Medicare line of business, regulatory attorney and Internal Medicine Physician with twenty years of practice experience and expertise in healthcare regulation and policy development

[redacted]
[redacted]
[redacted]
[redacted]

Work History

Partnership In Health - Medical Director of Medicare Services
Fairfield, CA
04/2024 - Current

- Manage multidisciplinary teams to optimize patient care
- Oversee Utilization Management policy development
- Work across departments to implement new Medicare-based lines of business
- Engage healthcare systems and providers on product lines, quality improvement programs and incentive programs
- Participate in Grievance and Appeals hearings, Quality and Utilization, Policy Review and Peer Review Committees
- Participate in contract design for network providers

The Permanente Medical Group, TPMG - Internal Medicine Physician
09/2017 - Current

- Implemented chronic disease management programs for high-risk communities
- Completed over 20,000 distinct clinical encounters
- Healthcare advisor for 2019 U.S. Presidential Campaign

United Health Group, Optum - Medical Director
San Francisco, CA
11/2023 - 03/2024

- Medical Claims Review, Utilization Management and Quality Review

U.S. House Of Representatives - U.S. Congressional Candidate
09/2021 - 11/2022

- Designing most comprehensive healthcare plan of any U.S. Congressional Candidate, available upon request

Skills

- Conversational language skills in Arabic and Hindi
- Experience in statistical modeling in R and using Python for Machine Learning and CNN
- Knowledge and expertise in healthcare regulation, Medicare quality programs and incentives
- Completed Master's Degree level course work in business associations, capital structure and finance

Education

04/2023
Massachusetts Institute of Technology
Cambridge, MA
Machine Learning And Data Science PE Program

05/2012
Columbia University School of International & Public Affairs
New York
M.P.A

05/2005
Duke University
Durham, NC

- Directing largest field operation in California with 20 staff members and 1,000 volunteers reaching 160,000 district residents

Rush University Medical Center - Residency Training, IM Resident
Chicago, Illinois
01/2015 - 01/2017

- Principal Investigator for military veteran's mental health research program for PTSD and other mental health interventions

Hyman, Phelps & McNamara - 2nd Year Associate
Washington, DC
09/2013 - 07/2014

- Drafted legal memos on HIPAA, ERISA, FDA regulations and DOJ-enforcement issues
- Advised large healthcare practices and systems on legal matters, compliance, and risk management

White House - Fellow
Washington, DC
08/2012 - 08/2013

- Senate appointment position for nation's premier mid-career leadership program with dual appointment in White House and Dept of Health and Human Services
- Led White House-level principal meeting on programs to secure veteran's benefits and military to civilian life transition program
- Led study group evaluating performance measures for new NIH institution – NCATS

US Navy - Medical Dept. Head
Camp Pendleton South, CA
04/2007 - 06/2009

- Medical Director of CASEVAC team for USMC 364 Squadron
- Medical Dept Head for joint U.S Marine Battalion of over 3,000 Marines at Camp Pendleton, Ca
- Collaborated with department personnel to coordinate multifaceted solutions to emerging military medicine problems.

National Naval Medical Center - Internal Medicine Intern
01/2005 - 01/2006

- Selected for prestiguous USN Flight Surgeon training program at NAS Pensacola, Florida

---

Affiliations & Select Publications

- Member, State Bar of California 2020
- American Board of Internal Medicine 2017
- Member of American Legion
- Member of the Council on Foreign Relations

M.D., J.D

1997
Georgia Institute of Technology
Atlanta, GA
B.S
magna cum laude

01/2005 - 01/2006

- Selected for prestiguous USN Flight Surgeon training program at NAS Pensacola, Florida

---

Affiliations & Select Publications

- Member, State Bar of California 2020
- American Board of Internal Medicine 2017
- Member of American Legion
- Member of the Council on Foreign Relations
- "Health Is Freedom," Diplomatic Courier, 12/2021
- "Stethoscope Diplomacy in the Middle East," Foreign Policy, 2/2021
- "Obesity is a major risk factor for dying of COVID-19. We need to take it more seriously," The Guardian, 6/2020

- "Health Is Freedom," Diplomatic Courier, 12/2021
- "Stethoscope Diplomacy in the Middle East," Foreign Policy, 2/2021
- "Obesity is a major risk factor for dying of COVID-19. We need to take it more seriously," The Guardian, 6/2020

Senior Director of Quality & Performance Improvement

ISAAC BROWN

Professional Profile

Healthcare and Business professional with strong analytical and problem solving skills. Certified Lean Six Sigma Master Black Belt with experience in Healthcare, Strategy, Customer Support, Supply Chain, Field Operations, Sales, Quality, and Project Management. Ability to think outside the box, generate innovative ideas and implement cross-functional improvements on both small and large scale projects. Proficient in:

- Process improvement
- Waste reduction
- Metrics and Dashboards
- Large data-set analysis
- Teaching improvement principles
- Coaching staff

Professional Experience

Partnership HealthPlan of CA, *Fairfield, CA* *2022-Present*

Senior Director of Quality Management

Senior Quality and Improvement Leadership role responsible for ensuring Quality Compliance of the organization as well as Quality Improvement of healthcare organizations within the Partnership footprint. Personnel responsibilities include growing and developing a group of leaders with responsibilities over Performance Improvement, Quality Incentives (P4P), Project and Program Management, Quality Investigations, CAHPS, Site Review, HEDIS, D-SNP, and Quality Data Analysis.

- Established a mechanism to align organizational measure priorities which reduced confusion and duplication of effort. It also improvement measure performance, leading to a reduction in performance related penalties.
- Supported the organanization through highly variable regulatory and budgetary challenges

Director of Quality Management

Quality and Improvement Leadership role responsible for ensuring Quality Compliance of the organization as well as Quality Improvement of healthcare organizations within the Partnership footprint. Personnel responsibilities include directing a group of leaders with responsibilities over Performance Improvement, Quality Incentives, Project and Program Management and Quality Data Analysis.

- Established work portfolio pipeline to facilitate movement of ideas into pilots, followed by scaling into programs.
- Supported the organanization through substantial growth and change, both internally and externally
- Provided vision and leadership regarding CAHPS (Member Experience) improvement

ISAAC BROWN

Northbay Healthcare, *Fairfield, CA* *2015-2022*

Quality and Process Improvement Leader

Improvement and Operations position responsible for ensuring the success of Strategic and Operational Excellence initiatives. This includes working with directors on action plans to address budget variances, managing projects, pulling KPIs and other performance data, as well as working with workstream owners to push for completion of Operational excellence goals.

- Pulled Axiom financial data and MIDAS performance KPIs to track project and division objectives
- Managed portfolios of projects related to Lab, Environmental Services, Nutritional services, Care Management, and helped with many others including the launch of a new Surgical Wing
- Worked with VPs and Directors on meeting their budget targets through analysis, mapping, and improvement efforts.

Performance Excellence Practitioner

Lean Six Sigma Master Black Belt position responsible for building out and growing the Lean capabilities of the NorthBay Hospital system. This includes creating a Lean curriculum, teaching classes, and coaching students at all levels of the organization. Responsibilities also include facilitation of large scale improvement events, problem de-construction, and RCA events.

- Helped create auto-approval process for referrals, reducing processing time by 20%
- Certified 100+ staff on Lean principles, and trained many more through JIT training
- Mentored all levels of staff through improvement projects, including frontline staff, physicians, and management
- Worked with leadership on aligning projects to the NorthBay Strategic Plan, resulting in greater focus and implementation of improvements
- Assisted staff with time-saving improvements to their individual work, enabling them to focus on broader improvement work across functions

(CONTINUED)

Vivint, *Provo, UT* *2013-2015*

Business Process Specialist

Lean Six Sigma Master Black Belt position responsible for mapping and analyzing business processes in order to create cross-functional value, improve company efficiency, and decrease waste; Work with process owners to help them better understand how their processes work; Drive improvement projects to completion.

- Collaborated with Directors on establishing meaningful metrics, important to the various levels of the organization
- Helped create cradle-to-launch process for new product offerings, decreasing post production support needs
- Decreased waste and cycle times within the Field Service product installation process
- Trained workforce on Lean and Six Sigma principles
- Mentored Green Belts on projects for certification
- Created Metric Action Plans for core metrics, decreasing the need for meetings to resolve metric related-issues

Skullcandy, *Park City UT* *2011-2013*

Customer Experience Engineer

Lean Six Sigma Position responsible for leading projects that create improved experiences for our

retailers and customers; Create positive change, improve service levels, and develop capabilities; Document processes; eliminate waste; invent solutions; Develop metrics, organize and summarize data, and perform root cause analysis on defects

- Led which improved our outbound email performance. This initiative brought down our cost per interaction by 30% and established a response time of less than 48 hours. These improvements were accomplished even while we had a 50% reduction in labor
- Increased service levels by over 40% by developing training for customer service agents and empowering the Agents with increased systems access and responsibilities. This allowed for quicker calls and emails. These steps also helped to decrease our number of escalations by 85%, eliminating the need for a large escalation group
- Eliminated 50% of inbound call volume YOY during period of double-digit revenue growth.
- Improved end-user refund process, decreasing process cycle time by over 60%. This improvement also helped decrease our number of charge-backs associated with longer cycle times
- Established data and information tracking around customer reviews, refunds, customer service interactions, warranties, and alternate sales channels. Helped test an improved order input process for retail clients, cutting cycles times by over 95%

Education and Professional Credentials

MBA/MHA, *Western Governor's University,* Salt Lake City, UT
BA, Business Administration, *Jon M. Huntsman School of Business*, Logan, UT
Portuguese Minor, *Utah State University*, Logan UT
Lean Six Sigma Master Black Belt, *Aveta Business Institute*

NANCY L. STEFFEN

[redacted]

Desire a senior leadership role in healthcare operations with emphasis in quality and continuous improvement. Passionate integrator of people, technology, and processes to achieve high quality patient care.

Education

BS Degree in Biomedical Engineering, Minor: Mechanical Engineering
Marquette University, Milwaukee, Wisconsin, 1997-Magna Cum Laude

Certifications

Six Sigma Black Belt – University of Wisconsin-Milwaukee
ASQ Quality Auditor

Summary of Experience

Twenty-seven years of experience leading cross-functional teams in quality assurance, quality improvement, analytics, and enterprise system integrations. Lead administrator of quality management systems and improvement initiatives within managed care, healthcare operations, diagnostic laboratories, and medical device manufacturing settings. Achieve sustainable results by developing effective processes/systems for healthcare teams to deliver value to patients.

Employment History

Partnership HealthPlan of California, Redding, California **July 2015 to present**
A non-profit community based health care organization that contracts with the State to administer Medi-Cal benefits through local care providers to ensure Medi-Cal recipients have access to high-quality comprehensive cost-effective health care. PHC serves over 600,000 people across 14 Northern California counties. Based in PHC's Northern Region.

Quality & Performance Improvement: Promoted May 2022 to Senior Director of Quality and Performance Improvement; responsible for plan-wide leadership of quality and performance improvement programs to substantially improve the quality of care provided to PHC members.

- In collaboration with the Chief Medical Officer (CMO), lead the strategic direction of PHC's quality goals and initiatives, including prioritization of efforts.
- Lead, develop, and coach the Quality staff in hiring, budgeting, training, performance appraisals, goal setting, and resource allocation.
- Oversee PHC's quality improvement program, ensuring all interventions are measured for effectiveness and efficiency, complete an annual review and update of the program, and write the annual plan. Prepare the organization for quality and performance improvement review, survey, and accreditation processes by external monitoring agencies, such as Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), CMS, and NCQA.

- In collaboration with executive leadership, oversee the administration of PHC's pay-for-performance programs.

- Direct performance improvement activities, including PHC's Performance Improvement Academy, DHCS mandated improvement work, and measure improvement and engagement activities done within the PHC provider network and service region.

- Oversee PHC's provider level quality data visualization and analysis program, the Partnership Quality Dashboard.

- Assure optimization of monitoring systems for collection and reporting of HEDIS and other quality measures.

- Ensure the Facility Site Review/Medical Record Review process and outcomes meet all regulatory and accreditation requirements. Demonstrate results are coordinated with peer review and credentialing processes.

Quality Improvement, Analytics, and Project Management: Joined as a manager and re-classified as an associate director in January 2016. Promoted February 2019, as Director of Quality and Performance Improvement, accountable for northern region efforts in quality measurement and improvement programs, analytics, and project management.

- Lead regional team in administering project management and performance improvement methodologies to ensure effective outcomes, partnerships, sustainability, and growth.

- Direct data collection and analyses, including medical record retrieval, to support quality performance reporting to the State, provider pay-for-performance programs, and regional improvements with local providers and community stakeholders.

- Responsible for work and staffing plans. Administer a $2.3 million operational budget.

BloodCenter of Wisconsin (*now* Versiti), Milwaukee, Wisconsin **July 2009 – July 2015**
A non-profit, healthcare organization committed to extending life and health by supplying blood to over 50 hospitals, conducting 70,000 diagnostic tests per year, recovering organs and tissues across SE WI, and leading research in innovative treatments for blood diseases and disorders.

Quality Support Services: As the Manager of Quality Management Systems, led cross-functional teams in simplifying, standardizing, and sustaining quality systems to reflect best practices in blood banking, medical device, and pharmaceutical industries.

- Administered all corporate computer systems used to demonstrate compliance to quality requirements in training/competency, error management, corrective/preventive action, audit, document control, and record retention.
- Led the successful implementation of the organization's first Learning Management System (LMS) in 2012. Integrated corporate-level training and job-specific competencies for laboratory, blood collection and corporate roles - approximately 1000 employees.

- Maintained corporate quality management systems plan, corresponding policies and

procedures, and fulfilled data analysis requests during onsite audits/inspections. Assessors included FDA, CMS, national accrediting bodies, and numerous state licensing boards.

- Achieved significant cycle time and waste reductions through cross-functional, continuous improvement activities in document control, record retention, training, and error management systems. Exceeded cost savings targets each year.

- Led integration of corporate quality systems upon acquisition of the Wisconsin Donor Network (OPO) and Wisconsin Tissue Bank in 2010. Developed and managed activities over a multi-year integration-plan involving corporate QA/RA, OPO nursing, and tissue bank recovery staff.

GE Healthcare, Milwaukee, Wisconsin **August 2007 - June 2009**
A General Electric Company providing a range of products, services, and expertise in medical imaging and information technologies, medical diagnostics, and patient monitoring systems.

Imaging Sub-Systems Quality Assurance: As a QA leader, responsible for leading implementation of a global quality initiative at five manufacturing sites worldwide.

- Successfully led implementation of global quality (QMS) initiative at Milwaukee manufacturing site in 2007-08. Assessed progress vs. global quality plan, conducted gap analyses, led gap closure activities, and executed training plans.

- Instrumental in coordination of global quality (QMS) initiative at two manufacturing sites in India. Served as key liaison between QA Site Managers and corporate QA team to troubleshoot systemic gaps and training issues.

- Led team at new manufacturing site in New York to implement GEHC global quality plan, obtain ISO 13485 certification, and FDA registration.

The Prairie School, Racine, Wisconsin **2002 to 2007 (Part-time)**
An independent, child-centered, college-preparatory day school, whose mission is to educate children, develop their individual talents, interests, and abilities.

Mathematics and Science Departments: As a faculty member, instructed pre-algebra, algebra, geometry, and science students in grades 6-10. Co-developed and taught an introductory algebra class for struggling middle school students.

Gyrus ACMI Corporation, Racine, Wisconsin **2005-06 (Part/Full-time), 2001-02 (Full-time)**
An industry-leading manufacturer of minimally invasive surgical instruments used in urology, gynecology, and laparoscopy.

Quality Assurance: As a quality engineer, responsible for supporting disposable and durable product lines manufactured and repaired at Racine plant. Supervised 8-10 Quality Control techs.

- Facilitated resolution of supplier and manufacturing related quality issues by working directly with raw component suppliers and manufacturing personnel.

- Developed Process Master Validation plans for disposable and durable product lines transferred from Wisconsin to Mexico and Minnesota in 2006.

- Reviewed complaint investigations completed by manufacturing engineers for proper root cause analysis and corrective actions.

Kimberly-Clark Corporation, Neenah, Wisconsin **1998 - 2001**
A multi-billion dollar global consumer products company with core businesses in personal care, health care, and tissue.

Child-Care Business Support: Responsible for implementing nonwoven qualifications, cost savings initiatives, quality improvements, and development to commercialization scale-ups.

Adult Care Research: Responsible for product development contributions and related competitive product analysis for incontinence products.

Amy Turnipseed

[redacted]

Accomplished Healthcare Executive with over 15 years of experience providing strategic vision and leadership in the health care delivery system. Currently responsible for the operations and executive management of five departments at Partnership HealthPlan of California, a Medicaid plan serving approximately 900,000 members in 24 counties.

Professional Experience

Partnership HealthPlan of California (PHC), Fairfield, CA

Chief Strategy and Government Affairs Officer	September 2021 - *Present*
Senior Director of External and Regulatory Affairs	February 2017- September 2021
Director of Policy and Program Development	July 2014- February 2017

- Executive team member, reporting directly to the CEO and Board of Commissioners since 2014
- Served as the Compliance Officer from 2017 to 2023, reporting to the full Board on compliance with federal and state regulations. Leads the development and maintenance of PHC's Compliance Plan and annual Risk Analysis
- Responsible for directly reporting to the Board of a variety of key initiatives, government affairs, and all areas of compliance
- Responsible for the executive oversight of five PHC operating departments including: Regulatory Affairs and Compliance, Communications, Legal, Network Services, and Project Management/Operational Excellence
- Develops the health plan's Strategic Plan and leads the Strategic Planning Committee, a subcommittee of the Board
- Leads PHC's California Advancing and Innovating Medi-Cal (CalAIM) implementation including:
    - Strategic planning to manage multi-year implementation of CalAIM initiatives
    - Leading cross-departmental operations for successful execution and operationalization of the new Enhanced Care Management benefit and Community Supports services. Departments include: Health Services, Provider Relations, Member Services, Claims, Configuration and Quality;
    - Representing PHC at state-level meetings with Department of Health Care Services (DHCS);
    - Meeting with county leaders and their local partners to collaborate on CalAIM;
    - Leading education sessions with county partners, providers, community-based organizations, and stakeholders on multiple aspects of implementation; and
    - Developing the Incentive Payment Program grants structure, a mechanism to financially support local organizations to develop CalAIM capacity and infrastructure
- Directly oversees the implementation of new benefits, program expansions, and regulatory changes, requiring cross-departmental management and participation including for: CalAIM, Whole Child Model transition, program eligibility expansions, 2024 DHCS Medi-Cal contract., and managed care model changes
- Leads the strategic efforts, planning and implementation for the expansion of PHC's county organized health system model (known as single plan model) into 10 additional counties in Northern California (Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama and Yuba) expected in 2024.
- Conduct implementation planning for new requirements for Duals Special Needs Plan (DSNP)
- Establishes and maintains productive relationships with key staff at DHCS and other regulatory agencies including the Department of Managed Care, Office of Inspector General, and Centers for Medicare & Medicaid Services (CMS)
- Oversees PHC's external community and government relations, including managing and monitoring of trade associations, outreach and legislative strategy and reporting directly to the Board
- Responsible for analysis and making recommendations on major policy and budgetary changes that may impact plan and updating the Board accordingly
- Responsible for the strategic development and contracting of PHC's provider network in consideration of market conditions and competitive activities

- Actively participate on behalf of PHC in various community and advocacy forums including meetings with our associations, regulators, legislative representatives, and provider partners and advise business leaders on positioning and engagement methods

Harbage Consulting, Sacramento, CA — October 2011- June 2014
Senior Consultant

- Advised and worked closely with senior management at DHCS on a multitude of complex initiatives, including the Coordinated Care Initiative (CCI). The CCI was launched by the state of California to provide better coordinated care to people with both Medicare and Medi-Cal
- Reported to the Director at DHCS on the progress of CCI
- Facilitated meetings between DHCS and health plan leaders on implementation of CCI
- Managed progress of projects and execution throughout DHCS, requiring coordination across numerous departments and external stakeholders
- Facilitated communication between DHCS and CMS on the CCI
- Coordinated information flow to a statewide communications team, as well as organizing large events with over 300 attendees.
- Represented DHCS at meetings with stakeholders, including advocacy organizations.

Office of the Secretary of Education, Sacramento, CA
Senior Communications Director — August 2010- February 2011
Policy Analyst — May 2009- February 2011

- Served as liaison between the Secretary of Education and the public, including communicating directly with media
- Developed communication strategy on education issues for the Governor and Secretary focusing on higher education issues and the California Master Plan
- Researched and tracked state and federal legislative bills and policy initiatives regarding higher education

Goddard Claussen, Sacramento, CA — August 2006- January 2009
Account Coordinator

- Coordinated qualitative and quantitative research programs for tax reform, water policy, healthcare, transportation and political reform
- Developed messaging and outreach materials for numerous ballot initiatives and issue advocacy campaigns

Leadership/Achievements

Association for Community Affiliated Plans (ACAP) — Washington D.C.
Leadership Academy, 2020-2021

Local Health Plans of California (LHPC) — Sacramento, CA
Compliance Officers Committee, Co-Chair, 2019- current

Education

University of Southern California, 2010 — Los Angeles, CA
Master of Public Administration

Gonzaga University, 2006, *cum laude* — Spokane, WA
Bachelor of Arts, Political Science
Bachelor of Arts, History

Danielle Ogren

[redacted]

Accomplished Healthcare Leader with over 15 years' experience in Medi-Cal Managed Care. Results-oriented, decisive leader with the ability to balance strategic decisions and financial stewardship with a hands on approach. Engaging communicator and relationship builder with proven success in improving regulatory compliance while spearheading improvements to ensure quality healthcare delivery for over 895,000 members in 24 Northern California counties. Excel in dynamic, demanding environments while remaining pragmatic and focused. Highly engaged leader with expertise in Compliance and team development with passion for the vision. *Core strengths include:*

- Compliance and Regulatory Affairs
- Culture Development and Refinement
- Health Care Operations
- Risk Management
- Contract Negotiations
- Team Building and Motivation
- Issue Analysis and Resolution
- Program Development

Professional Experience

Partnership HealthPlan of California, Fairfield, CA

Sr. Director of Regulatory Affairs and Contracting	May 2024-Present
Director of Compliance and Regulatory Affairs	September 2023-May 2024
Director of Regulatory Affairs and Program Development	May 2022- August 2023
Associate Director of Compliance and Program Strategy	October 2021-May 2022

- Leadership team member, reporting directly to the Chief Strategy and Government Affairs Officer, CEO and, Board of Commissioners
- Serves as Compliance and Privacy Officer, minimizing risk by ensuring development of policies, procedures and ensuring full compliance with federal and state regulations including Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health (HITECH) Act, and other rules as applicable. Immediately addressed issues though training and corrective actions.
- Responsible for conducting risk analyses, oversees PHC audits, and manages Fraud, Waste, and Abuse (FWA) and HIPAA Program and privacy reporting.
- Responsible for directly reporting to the Board of Commissioners on a variety of key initiatives, and areas of compliance.
- Facilitates Fraud Waste and Abuse and Physical, Administrative, Technical Safeguards, and Delegation Oversight Review committees, subcommittees of Compliance Committee
- Establishes and maintains productive relationships with key staff at the Department of Health Care Services (DHCS) and other regulatory agencies including the Department of Managed Care (DMHC), Office of Inspector General (OIG), Department of Justice (DOJ) and Centers for Medicare & Medicaid Services (CMS)
- Cultivated relationships with Federal Agencies serving as an expert witness as requested
- Responsible for ensuring compliance program incorporates critical compliance elements as identified by the U.S. Department of Health and Human Services (HHS), OIG, Code of Federal Regulations (CFR) related to Medicaid program integrity requirements, and DHCS. Responsibilities include:
    - Development and review of policies and procedures
    - Lead development and implementation of compliance training and education programs for all key stakeholders
    - Development of annual compliance risk assessment and internal work plans to monitor progress
    - Development of monitoring and audit work plan including internal, external, subcontractor, delegate audits. Ensure timely and accurate regulatory reporting, responses, and corrective actions.

    - Provider participation status review and background checks
    - Investigations and remediation
    - FWA detection and prevention
- Responsible for oversight of implementation of new benefits and regulatory changes, requiring cross-departmental participation. Programs include: CalAIM and 2024 DHCS Medi-Cal contract.
- Responsible for the operations and management of Regulatory Affairs and Compliance (RAC) and Legal Affairs and Provider Contracting Departments
- Responsible for the oversight of annual regulatory audits
- Responsible for analysis of major policy/regulatory changes that may impact plan, with particular attention to potential state and federal changes affecting Medi-Cal
- Responsible for drafting PHC's provider network templates in consideration of regulatory requirements. Participate in negotiations.

Associate Director of Cost Efficiency	October 2020- October 2021
Senior Manager of Cost Efficiency	December 2017- October 2020
Cost Avoidance Manager	December 2015-December 2017
Finance Contracting Analyst	July 2013-December 2015

- Leadership team member, reporting directly to the Chief Financial Officer (CFO) and Finance Committee
- Provided strategic support to legal for contract language related to the development and/or modification of contract templates to ensure compliance with all regulatory requirements and health plan initiatives
- Established and developed analytic reporting to Compliance Officer and Director of Legal Affairs related to fraud, waste, abuse and provider payment disputes
- Responsible for the oversight of compliance with network provider agreement provisions and reported outcomes, developed corrective action plans and ensured remediation of cited deficiencies to Compliance Officer.
- Cultivated relationships with DHCS including Capitated Rates Development Division and other state and federal regulatory agencies
- Developed and oversaw operational functions for recoveries, reinsurance, coordination of benefits, third party liability and overpayments
- Responsible for process improvement opportunities, recommendations and implementation of changes to maximize efficiency and quality of analytic work
- Completed an extensive analysis comparing PHC's healthcare spend to the Medi-Cal provider manual, resulting in significant configuration and contracting changes, which was positively received by the CFO and subsequently the PHC Board of Supervisors
- Responsible for contract fiscal negotiations for large network, all provider types
- Responsible for all value based provider rate development including new and innovative approaches to contracting using current and alternative reimbursement methodologies
- Provided CFO with rate development analytics and budgetary impact analysis
- Responsible for providing strategic direction to the Chief Financial Officer (CFO) and other C-Level Executives for rate development of innovative programs
- Ensures overall performance of network provider contracts aligns with quality and incentive programs
- Maintains knowledge of market rates in the service area
- Support CFO in completion, oversight and analysis of Supplemental Rate Development (SDR) and Rate Development Templates (RDT) to Department of Health Care Services (DHCS)
- Responsible for the Private Hospital Directed Payment and Enhanced Payment Program reconciliation and submission with network providers to DHCS
- Provide analysis and review of the annual health care cost budget, month end statements, and actual to budget variances
- Lead and managed the Cost Efficiency team to support PHC's strategic goal of fiscal stewardship and compliance

Certifications/Leadership

Certificate of Health Care Compliance (CHC): 2022

Local Health Plans of California (LHPC) — Sacramento, CA
Compliance Officers Committee, Chair, 2022- current

Affiliations

Health Care Compliance Association (HCCA) Member and Certified Health Care Compliance (CHC) Member

Education

University of California Davis — Davis, CA
Bachelor of Science

JEFFREY J. DEVIDO, M.D., M.T.S.

JDEVIDO@PARTNERSHIPHP.ORG

[redacted]

OVERVIEW

Specialist in mental health and addiction treatment. Administrative oversight of mental health and addiction treatment systems of care within Medicaid program in Northern California.

BOARD CERTIFICATIONS/LICENSURE

Adult Psychiatry
Addiction Psychiatry
Addiction Medicine
Active CA Medical Licensure

EXPERIENCE

CHIEF, ADDICTION SERVICES, MARIN COUNTY, CA, HHS
2016 - present
Responsible for grant management (over $4 million) aimed at expansion of SUD treatment system of care for Medicaid beneficiaries. Medical Director of co-occurring SMI-SUD outpatient clinic. System of care clinical education.

BEHAVIORAL HEALTH CLINICAL DIRECTOR, PARTNERSHIP HEALTHPLAN OF CA
2017 - present
Medical Director of DMC-ODS regional model SUD treatment system of care (7 counties). Quality management oversight and program expansion of/innovation in non-specialty mental health treatment system of care (24 counties). System of care education.

ASSISTANT CLINICAL PROFESSOR—VOLUNTEER; DEPT OF PSYCHIATRY AND BEHAVIORAL SCIENCES; WEILL INSTITUTE FOR NEUROSCIENCES AND UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
Full time consultation-liaison psychiatrist 2013-2016. Resident supervision and resident/fellow/medical student supervision/education.

EDUCATION

B.S. CHEMISTRY WITH SPECIALIZATION IN BIOCHEMISTRY
University of Virginia, 2000

MASTERS IN THEOLOGICAL STUDIES
Harvard Divinity School, 2003

MEDICAL DOCTOR
Columbia University College of Physicians and Surgeons, 2008

ADULT PSYCHIATRY RESIDENCY
Massachusetts General and McLean Hospitals, Harvard University, 2012

ADDICTION PSYCHIATRY FELLOWSHIP
Partners Health, Harvard University, 2013

Mark Bontrager

EDUCATION AND LICENSES

2011 Stanford Graduate School of Business, Executive Program for Nonprofit Leaders (EPNL)
2002 Indiana University School of Law, Doctor of Jurisprudence degree (J.D.)
1995 Indiana University School of Social Work, Master of Social Work degree (M.S.W.)
1993 Goshen College, Bachelor of Arts degree in Psychology (B.A.)
State Bar of Indiana, admitted 2002, Currently Inactive
Licensed Clinical Social Worker (LCSW), State of California 2006, State of Indiana 1997
Certified Healthcare Privacy Compliance (CHPC), Certified Healthcare Compliance (CHC)

PROFESSIONAL EXPERIENCE

Sr. Director of Behavioral Health **2021/Present**
Partnership HealthPlan of CA, Fairfield, California

- Oversee mental health and substance use disorder services for managed care plan
- Serve on the Executive Team for the managed care plan
- Represent the plan on external committees and stakeholder groups
- Support new programs and benefit implementations as needed and directed

Director of Regulatory Affairs & Program Development **2018/2021**
Partnership HealthPlan of CA, Fairfield, California

- Oversee Regulatory Affairs and Compliance department for managed care plan
- Serve as Privacy Officer for the health plan
- Manage staff in Regulatory Affairs and Compliance
- Support new programs and benefit implementations as needed and directed
- Participate in annual risk assessment, audits and the creation of compliance plan
- Participate as a member of the Operations and Emergency Response Teams

Executive Director **2007/2018**
Aldea Children & Family Services, Napa, California

- Oversaw operations for an agency of 160 staff and annual budget over $12 million
- Worked in conjunction with Board of Directors on mission and strategic planning
- Set organizational goals and objectives each year
- Led Development staff on fundraising, grant writing and strategy
- Created partnerships with public and private entities to better serve clients
- Managed senior program staff and administrative staff, setting annual goals
- Oversaw the purchase of properties and other assets
- Provided oversight to the CFO and fiscal operations of the agency
- Collaborated with other agencies in service development and implementation
- Identified new public and private funding opportunities for the agency and partners
- Participated in community-wide committees and advisory groups

- Oversaw the expansion of programming, services and staffing
- Participated in a successful $2 million dollar capital campaign
- Obtained National Accreditation

Deputy Director **2005/2007**
Aldea Children & Family Services, Napa, California

- Managed program directors overseeing eight programs
- Oversaw fiscal operations and agency Controller
- Developed new programs utilizing existing infrastructure
- Worked towards greater integration of programming and services
- Directed senior management in overall agency operations
- Directed mental health and child welfare service lines for the agency
- Developed contracts and expanded existing contracts for services
- Worked closely with local government to partner on specific projects
- Participated in Finance and Development Committees of the Board
- Partnered with Executive Director in planning and execution of services

Attorney **2002/2006**
Private Practice, Indianapolis, Indiana

- Represented clients in adoption and special education matters
- Conducted custody evaluations as directed by the court
- Performed mediations for parties in dispute
- Successfully advocated and passed laws promoting adoption from foster care
- Provided trainings to public social service / child welfare agencies
- Consulted with school districts over special education issues
- Represented clients in family law matters

Program Manager / Therapist / Social Worker **1996/2003**
The Villages of Indiana, Inc., Indianapolis, Indiana

- Used organizational skills to assist in establishing a residential program
- Conducted interviews and trained direct care staff in behavior management
- Directed staff meetings and weekly clinical team meetings
- Gave presentations to community groups to garner support
- Provided individual and family therapy with clients
- Completed foster care / adoption home studies
- Managed program staff of twelve members
- Created policy and procedures for program operations

Vitae

BOARD/COMMITTEE MEMBERSHIPS

Governors Appointment to Mental Health Services Act Oversight & Accountability Commission (2021 – Present)
Governors Appointment to Children's Justice Act Task Force (2015 – 2018)
Solano County Children's Alliance Executive Committee (2013 – 2018)
Napa County Child Abuse Prevention Council Steering Committee Member (2008 – 2018)
Foster Family-based Treatment Association (FFTA) (2010 – 2012)
Napa County Children's Health Initiative Board Member – Treasurer (2007 – 2012)
Napa Valley Coalition of Non-Profits Behavioral Health Committee – Co-Chair (2008 – 2010)
Napa County Workforce Investment Board Member – Vice Chair (2005 – 2010, 2015 - present)
Pacific Union College Social Work Advisory Board Member (2006 – 2009)
Napa County Mental Health Services Act – PEI Advisory Board Member (2007 – 2009)
Adoption in Child Time, Inc. Board Member (2003 – 2009)
Indiana Juvenile Justice Task Force, Inc. (2004 – 2006)

PUBLICATIONS & TRAININGS PROVIDED

Bontrager, Mark & Peter Kenny (2004). Foster Parent Journal. School Datebooks Publication, Lafayette, Indiana.

Kenny, Peter & Mark Bontrager (2004). Adopting a Foster Child. ACT Publications, Rensselaer, Indiana.

Bontrager, Mark & Jim Kenny (July/August 2004 issue). "Pseudo-Bonding and Other Myths." *Foster Families Today*. Louis & Company Publishing, Windsor, Colorado.

Bontrager, Mark & Jim Kenny (May/June 2004 issue). "Appellate Courts Choose Bonding." *Foster Families Today*. Louis & Company Publishing, Windsor, Colorado.

Bontrager, Mark (2003). "New Tax Credits a Boon to Parents Adopting Special Needs Kids." ACT ONE. 5 (1), pg. 3.

Bontrager, Mark (2003). "Do I Have to be Rich to Adopt?" ACT ONE. 5 (2), 2-3.

"Legal Issues for Mental Health Professionals: Responding to Requests for Disclosures, What does HIPAA Allow?" (Training 3 hours of continuing education credit, 2009)

Professional/Educational/Volunteer Experience

University of California at Berkeley Haas School of Management – Executive training programs: Leading for Performance, Leader as Coach, Leadership Training
Victim/Offender Mediator, Certified Civil Mediator state of Indiana (2002)
Court Appointed Special Advocate (CASA)
North American Council on Adoptable Children: Indiana State Subsidy Representative (2004)

MOHAMED ALIEU JALLOH, PHARM.D.

[redacted]

CURRENT EMPLOYMENT

2023-Present **HEALTH EQUITY OFFICER (DIRECTOR OF HEALTH EQUITY)**
Partnership Health Plan of California, Fairfield, CA

2016-Present **ASSISTANT PROFESSOR IN CLINICAL SCIENCES**
Touro University California College of Pharmacy, Vallejo, CA
- Lecture at least 25+ hours of pharmacotherapy lecture material in family medicine, evidence based medicine, health equity, and digital health-related topics each year
- Over 92% of 120+ students rated " very agreed" or "agreed" that my lectures are presented in a clear and understandable manner

2018-Present **GUEST LECTURER**
Stanford University College of Medicine, Stanford, CA
- Lecture at least 6+ hours of pharmacotherapy lecture material in family medicine topics each year
- Over 95% of 50+ students rated lectures "excellent" or "very good"

2020-2021 **PER-DIEM COVID-19 VACCINATION PHARMACIST**
CVS Pharmacy, Vallejo, CA

2016-2021 **SPOKESMAN FOR THE AMERICAN PHARMACISTS ASSOCIATION (APhA)**
American Pharmacists Association | Washington, DC
- Quoted and interviewed by 20+ leading journalists from *Time Magazine*, *WebMD*, *Men's Health*, *Washington Post*, *NPR*, *AccuWeather*, and *USA Today*

2014-2016 **PER-DIEM COMMUNITY PHARMACIST**
Walgreens | Omaha, NE

HONORS AND AWARDS

2021 Touro University College of Pharmacy "Clinical Professor of the Year" Award Winner

2021 Touro University College of Pharmacy "Most Engaging Professor of the Year" Award Winner

2019 Touro University College of Pharmacy "Most Entertaining Professor of the Year" Award Winner

2019 Touro University College of Pharmacy "IPhO Preceptor of the Year" Award Winner

2018 The Doctors Company **and** Napa Valley Community Foundation Second Responder Recognition

2018 ASHP CEO National Courageous Service Award Winner

2014 Natural Medicines Comprehensive Database Recognition Award Winner

2013 Walgreens National Diversity Scholarship Recipient

2013 Wilkes Multicultural Global Scholar and Citizen Award Winner

2012 Who's Who Among Students in American Universities and Colleges

EDUCATION

2008- 2014	**DOCTOR OF PHARMACY (PHARM.D.)** *Pharmacy Spanish Concentration Certificate* Wilkes University, Nesbitt School of Pharmacy, Wilkes-Barre, PA
2014- 2016	**GRADUATE CERTIFICATE IN CLINICAL AND TRANSLATIONAL SCIENCES (BIOSTATISTICS)** Creighton University School of Medicine, Omaha, NE

INTERNATIONAL EDUCATION

SPANISH LANGUAGE

Summer 2012	University of Malaga, Malaga, Spain
Summer 2011	Colegio Mayor Mara, Madrid, Spain

LICENSURES AND BOARD CERTIFICATIONS

Licenses	**PHARMACIST**
Expires 2025	California License#: RPH76770
Expires 2024	Nebraska License#: 14659
Certifications	
Expires 2026	**BOARD CERTIFIED PHARMACOTHERAPY SPECIALIST (BCPS)** Board of Pharmacy Specialties, # 3160131

CERTIFICATES

Certificates	
Jan 2022	**DIVERSITY, HEALTH EQUITY, INCLUSION, AND ANTI-RACISM** American Association of Colleges of Pharmacy (AACP)
Jan 2021	**BASIC LIFE SUPPORT (BLS) PROVIDER** ACLS Certification Institute
Apr 2019	**PHARMACY-BASED TRAVEL HEALTH SERVICES** American Pharmacists Association, Washington, DC
Mar 2017	**LIFESTYLE AND WELLNESS COACH** National Diabetes Prevention Program (DPP) Vallejo, CA
Jun 2016	**MEDICATION THERAPY MANAGEMENT** American Pharmacists Association, Washington, DC
Jun 2016	**EVIDENCE-BASED PRACTICE** Creighton University School of Pharmacy & Health Professions, Omaha, NE
May 2015	**TEACHING CERTIFICATE PROGRAM FOR PHARMACY RESIDENTS** Creighton University School of Pharmacy & Health Professions, Omaha, NE

May 2013 **PHARMACY BASED IMMUNIZATION DELIVERY**
American Pharmacists Association, Washington, DC

POST-DOCTORAL TRAINING

Jul 2014-Jun 2016 **DRUG INFORMATION AND EVIDENCE BASED MEDICINE RESEARCH FELLOWSHIP**
Center for Drug Information & Evidence-Based Practice
Creighton University, Omaha, NE
Program Preceptor(s): Darren Hein, PharmD; Zara Risoldi-Cochrane, PharmD, MS; Amy Wilson, PharmD

- Provided pharmacotherapeutic recommendations in a medication therapy management center and volunteer ambulatory care and acute care clinic.
- Managed an academic drug information consultation service that provides over 1000 clinical consultation annually to health care professionals.
- Supervised over 50+ Pharm.D. advanced pharmacy practice experience (APPE) rotation students during an academic drug information consultation service and medication therapy management (MTM) center.
- Provided regional and national medication policy and P&T support for Catholic Health Initiatives (CHI), PharMerica, and McKesson.
- Provided medical content and editorial expertise for Medscape and Healthline.com.
- Served as an investigator and co-investigator on 3+ research projects.

TEACHING EXPERIENCE

Fall 2016 to Present **STANFORD UNIVERSITY SCHOOL OF MEDICINE**
Didactic Lectures

- Men's Health (BPH and ED) (2 hours)
- Headache and Migraines (2 hours)
- Sexually Transmitted Diseases and HIV (2 Hours)
- Osteoarthritis Management (2 hours)

Fall 2016 to Present **TOURO UNIVERSITY CALIFORNIA COLLEGE OF PHARMACY PROGRAM**
Didactic Lectures

- Introduction to Drug Information (3 hours)
- Drug Literature Evaluation (3 hours)
- Reviewing and Applying Systematic Reviews and Meta-Analyses (1.5 hours)
- Ophthalmic, Otic, and Oral Agents Part 1 (3 hours)
- Constipation and Diarrhea Management (3 hours)
- Atopic Dermatitis and Contact Dermatitis Management (3 hours)
- Medication Therapy Management and Reimbursement (3 hours)
- Osteoarthritis Management (3 hours)
- Gout (3 hours)
- Headache and Migraines (3 hours)
- Men's Health (BPH and ED) (3 hours)
- Travel Health (8 hours)

Clinical Rotations Teaching/Experiential Teaching

- Ambulatory Care Rotation (1 PGY1 resident and 2 students every 6 weeks)

CREIGHTON UNIVERSITY SCHOOL OF PHARMACY AND HEALTH PROFESSIONALS

Fall 2014 to Spring 2016

Didactic Lectures

- PHA 458 Literature Evaluation and Evidence Based Practice (15 hour)
- PHA 469 Case Studies and Case Discussion (15 Hours)
- PHA 319 Pharmaceutics Skills Lab (8 hours)

Clinical Rotations Teaching/Experiential Teaching

- PHA 515, Drug Information Rotation (8 students every 5 weeks)
- PHA 534, Medication Therapy Management (MTM) (2 students every 5 weeks)
- PHA 528, Dominican Republic International Medical Mission (2 students every 4 weeks)

GRANT WRITING AND CONSULTANT EXPERIENCE

Contracts

Jul 2014-present **PROJECT MANAGER OR CONTRIBUTOR**

- Provided key project management for Mckesson, PharMerica, and Healthline.com that resulted in over $2000 in billable services.

Grants Submitted

Sep 2021 **Children's Book Intervention to Address Parent Knowledge and Motivation in Childhood Vaccinations: A Cross-Sectional Study** Touro University California, Vallejo, CA

- $2,326.16 (Funded)

May 2021 **Barber Motivation for Conducting Mental Health Screening In African American Barbershops: A Cross-Sectional Study**
Touro University California, Vallejo, CA

- $2, 000 (Funded)

Feb 2015 **"ASSESSING DRUG INFORMATION NEEDS OF RURAL NEBRASKA PHARMACISTS"**
Nebraska Pharmacists Association, Lincoln, NE

- $2, 500.00 (Not Funded)

PUBLICATIONS

Peer-Reviewed Journals

Sep 2022 ***Jalloh MA***, Stompanato J, Nguyen JQ, Barnett MJ, Ip EJ, Doroudgar S. Barber Motivation for Conducting Mental Health Screening and Receiving Mental Health Education in Barbershops That Primarily Serve African Americans: a Cross-sectional Study. *J Racial Ethn Health Disparities*. 2022;10.1007/s40615-022-01420-5.

May 2022 ***Jalloh MA,*** Chung K, Doroudgar S. Severity of visual hallucinations worsened with lisinopril despite receiving sedative hypnotic therapy or antipsychotic therapy: First case report. *Res Social Adm Pharm*. 2022;18(11):4009-4011.

Mar 2020 ***Jalloh MA,*** Barnett M, Ip EJ. Men's Health Related Magazines—what they recommend and the evidence to support their recommendations: A retrospective study. *Am J Mens Health.* 2020 May-Jun; 14(3): 1557988320936900

Mar 2020 ***Jalloh MA.*** Esketamine (Spravato) for Treatment-Resistant Depression. *Am Fam Physician*. 2020 Mar 15;101(6):339-340.

May 2018 ***Jalloh MA***, Doroudgar S, Ip EJ. What is the impact of the 2017 cochrane systematic review and meta-analysis that evaluated the use of PCSK9 inhibitors for lowering cardiovascular disease and mortality? Expert Opin Pharmacother. 2018 May;19(7):739-741.

May 2016 ***Jalloh MA***, Gregory PJ, Hein DJ, Risoldi-Cochrane Z, Rodriguez A. Dietary supplement interactions with antiretrovirals: A systematic review. *Int J STD AIDS*. 2017;28(1):4-15.

May 2016 Gregory PJ, Bird AS, Hein DJ, Abe A, Risoldi-Cochrane Z, ***Jalloh MA***, Wilson AF. Assessment of the value of an academic drug information service to the healthcare community. *J Am Pharm Assoc* [Currently in review]

May 2015 Schreck Bird A, Gregory PJ, ***Jalloh MA***, Risoldi Cochrane Z, Hein DJ. Probiotics for the Treatment of Infantile Colic: A Systematic Review. *J Pharm Pract*. 2016. [Epub ahead of print].

May 2015 Gregory PJ, ***Jalloh MA***, Abe AM, Hu J, Hein D. Characterization of Complementary and Alternative Medicine-Related Consultations in an Academic Drug Information Service. *J Pharm Pract*. 2015. [Epub ahead of print].

Continued Education

Jalloh M. Itching to Find a Solution: The Community Pharmacist's Role in Ocular Allergy Treatment. https://www.powerpak.com/course/preamble/121944

PRESENTATIONS

Invited Podium Presentations

ADDRESSING VACCINE HESITANCY (VH) AND HEALTH DISPARITIES IN MINORITY COMMUNITIES: ALTERNATIVE APPROACHES AND LEVERAGING COMMUNITY PARTNERSHIPS
March 2023 2023 NACCHO Preparedness Summit Conference, Atlanta, GA

March 2019 **"COORDINATING WITH PHARMACIES DURING STATE AND NATIONAL EMERGENCIES"**
2019 NACCHO Preparedness Summit Conference, St. Louis, MO

May 2018 **"PRESCRIBING MEDICATION RELATED APPS"**
California Pharmacists Association (CPhA) Western Pharmacy Exchange Conference, San Diego, CA

May 2015 **"ARE RECOMMENDATIONS IN MENS HEALTH-RELATED MAGAZINES TRULY EVIDENCE-BASED: A RETROSPECTIVE STUDY-PRELIMINARY RESULTS"**
Midwestern Pharmacy Residency Conference, Omaha, NE

Dec 2014 **"GOOGLE POWER SEARCHING FOR PHARMACISTS: HOW TO APPLY THE HIDDEN TOOLS OF GOOGLE FOR DRUG INFORMATION"**
American Society of Health System Pharmacists (ASHP) Midyear, Orlando, FL

Leadership Related

Nov 2013 **"A #SCRIPT FOR SOCIAL MEDIA"**
Audience: 600+ APhA-ASP Region 1 & 2 Midyear Meeting attendees, Washington, DC

LEADERSHIP AND PROFESSIONAL SERVICE

University

Jul 2022- Present	**CHAIR-FACULTY DEVELOPMENT COMMITTEE** Touro University California College of Pharmacy
Aug 2019- Jul 2022	**CHAIR-ADMISSIONS COMMITTEE** Touro University California College of Pharmacy
Aug 2019- Jul 2022	**COP MEMBER-ENROLLMENT MANAGEMENT COMMITTEE** Touro University California College of Pharmacy
Aug 2019- Jul 2022	**COP MEMBER-ENROLLMENT LEADERSHIP COMMITTEE** Touro University California College of Pharmacy
Health Plan/PBM	
	VOTING MEMBER OF P&T COMMITTEE Partnership Health Plan
Editorial Advisory Board	
	EDITORIAL ADVISORY BOARD MEMBER
Mar 2018- Present	*Drug Topics: Voice of the Pharmacist* Modern Medicine Network
May 2018-Present	*British Medical Journal (BMJ) Evidence Based Medicine*
Mar 2015-Mar 2016	*Transitions* American Pharmacists Association- New Practitioner Network
Mar 2012-Mar 2014	*Student Pharmacist Magazine,* American Pharmacists Association-Academy of Student Pharmacists
Peer Reviewer	
	MEDICAL JOURNALS
May 2020-Present	*American Journal of Men's Health*
Jan 2018-Present	*British Medical Journal (BMJ) Evidence Based Medicine*
Oct 2014- Present	*Journal of Medical Internet Research*
Oct 2014-Present	*Journal of Evidence-Based Complementary and Alternative Health*
National Student Leadership	
Jul 2013-Aug 2014	**NATIONAL STUDENT ADVISORY COMMITTEE MEMBER-AT-LARGE** American College of Clinical Pharmacy (ACCP)
Jun2013-Aug 2014	**NATIONAL LIAISON TO REGION I** Phi Lambda Sigma (PLS) Pharmacy Leadership Society
Mar 2013-Mar 2014	**NATIONAL STANDING COMMITTEE MEMBER OF COMMUNICATIONS** American Pharmacists Association-Academy of Student Pharmacists
Mar 2013-Mar 2014	**NATIONAL STRATEGIC PLANNING COMMITTEE** American Pharmacists Association-Academy of Student Pharmacists

EXPERT COMMENTARY EXPERIENCE

DeLorean Ruffin, DrPH, MPH

Education

- **Doctor of Public Health (DrPH)** – Health Education and Promotion, Loma Linda University (2022)
- **Master of Public Health (MPH)** – Argosy University (2016)
- **Bachelor of Science Biology** – Barry University (2013)

Core Competencies

- Program Monitoring & Evaluation
- Data Synthesis/Decision Making
- Strategic Leadership and Planning
- Grant and Budget Management
- Cross-Functional Leadership
- Program and Policy Development
- Organizational Learning Advocacy
- Resource Allocation Strategy
- Change Management
- Good Clinical Practices
- Project Management
- Stakeholder Communication
- Population Health Management

Technical Competencies

- MS Office Suites, Visio, Statistical Analysis Software (SAS), SPSS, Proficiency in Process Mapping, Six Sigma & Lean
- PowerBI Dashboards, Tableau
- Qualitative Data Analysis-NVivO, EDC (Veeva)
- EMR (Epic, eCW, Athena)
- Salesforce (CalConnect)
- Cloud Based Repository

Professional Affiliates

- Black Doctoral Network (BDN), Member, Conference Workshop Presenter **2020-Present**
- American Public Health Association Member, Peer Reviewer (HIV/AIDS, MCH) **2019-Present**
- Society of Public Health Education Member, **2019-Present**
- Institute of Health Care Improvement (IHI), Member, **2021-Present**
- CA Primary Care Association (CPCA), Member, **2021-Present**

Additional Work Experience

- Clinical Research Coordinator-

Summary of Qualifications:

Dynamic and results-driven Population Health Management executive with over 10 years of experience in strategic healthcare leadership. Proven track record of developing and implementing comprehensive population health strategies that drive quality patient outcomes and operational excellence. Adept at leveraging data analytics to inform decision-making and improve health equity across diverse patient populations. Skilled in fostering cross-functional collaboration and building strategic partnerships with community organizations to enhance care delivery and access. Demonstrated success in maintaining and achieving HPA and HEA NCQA accreditation and maintaining regulatory compliance with CMS, DHCS, and CDPH standards.

Professional Experience

Partnership HealthPlan of California — April 2024 – Present
Director of Population Health Management — **40 hours/week**

Key Responsibilities and Achievements:

- Spearheaded data-driven Population Health Management strategies, collaborating closely with the Health Analytics team to leverage data for measurable improvements in patient health outcomes and real-time program adjustments.
- Developed innovative, patient-centered interventions to address care gaps and health equity issues in Solano County, partnering with the Director of Health Equity to create sustainable activities with tangible impact on patient outcomes.
- Implemented proactive approach to community engagement by strategically utilizing Community Health Liaisons to transform the department's participation from reactive to strategic, aligning activities with organizational goals and community partnerships.
- Led comprehensive reviews of Population Health Management Program Description and Evaluation, ensuring high-quality work and timely project completion to drive better member outcomes.
- Fostered strong interdepartmental collaboration and positive team dynamics, setting a tone of accountability and professionalism while building key partnerships with internal and external stakeholders.

Accomplishments and Impact:

- Spearheaded the development of innovative, patient-centered interventions for Solano County, addressing critical care gaps and health equity issues, resulting in a comprehensive suite of sustainable activities poised to make a tangible difference in patient outcomes.

West Oakland Health Council (now Baywell Health) — August 2021 – March 2024
Director Of Research, Evaluation, and Community Health — **40 hours/week**

Key Responsibilities and Achievements:

As the driving force behind West Oakland Health's strategic endeavors in community health, research, and evaluation, my role encompasses steering the organization's direction in population health management. I am deeply engaged in crafting and implementing research strategies, enhancing quality improvement initiatives, and leading community health programs, all while ensuring alignment with the requirements and regulations set forth by CMS, DHCS, NCQA, CDPH, and other regulatory bodies.

- Spearhead West Oakland Health's strategic initiatives in community health, research, and evaluation, aligning with CMS, DHCS, NCQA, and CDPH regulations.
- Ensure regulatory compliance (TJC, NCQA-PCMH, HRSA-UDS, FTCA) and actively participate in certification and audit processes.
- Cultivate strategic partnerships with community organizations and stakeholders to enhance population health management activities.
- Develop innovative programs for specialized patient populations, improving quality, health equity, and patient outcomes leveraging continuous quality improvement methodologies and tools (PDSA, Lean Six Sigma, and DMAIC.)

PMI Health, Atlanta, GA | June 2014- Aug. 2016, 2 years, 2 months

- Analyze large datasets using quantitative and qualitative methods to drive quality outcomes and evaluation.
- Oversee grant applications and direct funds toward key quality improvement, prevention, and treatment initiatives.

Accomplishments and Impact:

- Advanced from Director of Quality Assurance, implementing population health management tactics that reduced service delivery disparities by 50% within six months.
- Led development of strategic objectives supporting quality improvement initiatives while ensuring compliance with federal and state regulations.
- Expanded leadership role from managing three data analysts to overseeing four key departments: WIC, Community Health, and Maternal Child Health.

Contra Costa County Health Services, Concord, CA — November 2020 - August 2021
PUBLIC HEALTH PROGRAM MANAGER — 40 Hours/week

Key Responsibilities and Achievements:

- Developed, coordinated, and implemented, evidenced-based audience-centric health education programs across a range of county and state health education, prevention, or public health services programs inclusive of non-clinical sites, residential care facilities, and co-leads state level quality strategy for Community of Practice (CoP) sessions.
- Built, fostered, and maintained collaborative partnerships to strengthen resources available for extending the reach of CCHS awareness and education programs and broad-based education initiatives to improve public health in the communities serviced.
- Delivered culturally competent communications leveraging specialty techniques, and methods to provide data and educational public health information and strategic communication plans inclusive of reports, presentations, fact sheets, articles for publication, and responses to individuals or groups to improve overall health literacy.
- Monitored action items within the organization focused on PMO efficiency and ensured timely responses, and appropriate progress to remedy problems that required interim and long-term solutions.
- Consolidated data and research information for presentation to executive leadership and other facility leadership and staff for use in the planning, development, and operation of new and existing managed care programs
- Provided subject matter expertise in response to day-to-day business issues; researched applicable subject matter practices; and remained aware of latest epidemiological disease management learning agendas.

Accomplishments and Impact:

- Created public health messaging and content and coordinated website maintenance, engaging over 5000 views that led to program sustainability and additional state funding for site management to reconcile and resolve budgetary matters.
- Managed external client facing relationships and partners with corporate and regional business areas advised undergraduate and graduate epidemiology interns and delegated tasks that supported the goals of the COVID-19 Vaccination Program staff and volunteers.

Interface Children & Family Services, Camarillo, CA — December 2020 – April 2021
EVALUATION MANAGER — 40 Hours/week

Key Responsibilities and Achievements:

- Successfully built and maintained systems and programs to assess and increase the impact of ICFS core program areas including justice services; domestic violence; mental health; human trafficking; runaway and homeless youth; early child and family development; and child abuse prevention.
- Ensured program sustainability by working collaboratively with Program Coordinators to obtain $1.5 Million in grant funding. Developed and tracked sound initiative goals and objectives ensuring partner engagement and commitment to agency objectives utilizing business intelligence tools for trauma-informed Mental and Behavioral Health programs.
- Led designing, developing, and executing critical complex projects supporting system migration, change control, and archival activities for data management systems.
- Extracted and compiled data from databases using query language to generate reports and presentations on collected data, interpreting the data, and drawing conclusions.

- Collaborated with Justice Services teams to facilitate performance improvement activities for quality of care, process improvement, regulatory compliance, and patient experience using evidence-based tools, techniques, and methodologies.
- Leveraged business intelligence tools to analyze reports and create solutions that would maximize the financial performance of the business unit.

Accomplishments and Impact:

- Successfully awarded $1.5 Million in grant funding (Medically Assisted Treatment (MAT), Phoenix Project, CCVI) following thorough evaluation and leadership recommendations for improvements to technology that would enhance continuous monitoring and compliance of privacy data and mature the management governance, practices, processes, and tools used.
- Leveraged business intelligence tools to analyze reports and create solutions that would maximize the financial performance of the business unit which led to generating agency and departmental fact sheet through Power BI.
- Developed roadmap for the modernization of processes, policies, and systems and other technological advancements with implementable milestones and sustainable outcomes. This included authoring proposals, reviews, and ratings of RFP from competing vendors, and final selection processes.

IQVIA (contracted), Long Beach, CA — June 2020 – November 2020
Clinical Research Coordinator — 40 Hours/week

Key Responsibilities and Achievements:

- Worked closely with the Director of Operations at Long Beach Clinical Trials site with collection and tracking of critical study documents, including preparation and approval of essential document packages.
- Facilitated successfully completed 3 eTMF reviews, including data management utilizing EDC for clinical trials to ensure compliance with study protocols and IRB, GCP, ICH, and FDA regulations and guidelines.
- Day- to-day data management and administration for 3 clinical studies simultaneously.
- Participated in the selection of Contract Research Organizations (CROs) for small budget sponsored clinical investigation.

Accomplishments and Impact:

- Provided strategic oversight to the Clinical Operations Director in our vendor and CRO relationships and provides clinical input into their governance committees.
- Reviewed start-up documentation, including site initiation, interim monitoring, and close-out materials.
- Conducted subject recruitment, eligibility screenings, informed consent (1678), and outpatient logistics to ensure accurate study tracking metrics, including study milestones, site/subject payments, vendor relations, etc.

Good Samaritan Health Center, Atlanta, GA — August 2016 – August 2018
Health Outcomes Manager — 40 Hours/week

Key Responsibilities and Achievements:

- Instrumental in identifying steps necessary to effectively communicate with outside organizations such as IPA's, health plans, and government agencies to serve as an internal SME for relevant programs and tracking performances, including HRSA Site Visit Protocol, HEDIS, PCMH, UDS, MU, FTCA, and Joint Commission guidelines.
- Fulfil research requests using inferential statistical techniques to interpret data from various sources such as surveys, automated reports, online programs, and published literature.
- Optimized administrative OPX budget and accelerated productivity of operations team following the execution of successful cost analysis and gaining sponsor approval and stakeholder buy-in for my recommendation to replace the outdated dental EHR with a cloud-based system.
- Provided strategic and practical support to develop, submit and maintain large-scale sponsored research projects and enhance community impact.
- Change agent and project management partner for the transformation and inaugural rollout of grant writing for QI/QA-related funding opportunities.
- Managed grants administration activities including development and management of contracts and subcontracts and ongoing post-award compliance matters by introducing the practice and coordination of PDSA Cycles.

Accomplishments and Impact:

- Successfully championed at-risk health programs, leading to NCQA accreditation by spearheading the development of the PCMH (Patient-Centered Medical Home) care delivery model within a healthcare facility of 45-50-personnel.
- Oversaw the re-branding of several CBO partners with social media content creation.
- Successfully developed and executed a pilot program aimed at revising an outdated QI/QA program, work plan, and annual evaluation process.
- Fostered a high-performance culture by motivating teams and developing member relationships and engagement.

Professional References

Professional, Academic, or Personal References
Available Upon Request

Synopsis of Changes to MQPD1001

Below is an overview of the policies that will be discussed at the Aug. 19, 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: Quality Improvement – *Presenter: Isaac Brown, Senior Director, Quality & Performance Improvement*			
MPQD1001- Quality and Performance Program Description – *CLEAN copy begins on p. 981*	821 - 1096	**1) Program Scope & Strategic Direction** • Updated language to reflect removal of a committed D-SNP launch year, while retaining references to future Medicare/D-SNP integration to align with current organizational planning and leadership direction. • Updated language to reflect inclusion of dental services in quality oversight, acknowledging dental as a state-carved-out benefit with monitored quality components. • Updated language to reflect the planned transition/unwinding of the Wellness and Recovery Program, while retaining program content for 2026–2027 due to ongoing administrative and quality responsibilities. **2) Governance & Committee Structure** • Updated language to reflect removal of the Population Needs Assessment (PNA) Committee, following its formal disbandment in Q1 2026. • Updated language to reflect addition of the Quality D-SNP Sub-Committee, including defined purpose, membership, meeting cadence, and reporting structure to support future Medicare/D-SNP Model of Care and CMS/DHCS quality requirements. • Updated to reflect refined delegation oversight, explicitly removing credentialing from delegated activities and clarifying Carelon Behavioral Health as the sole delegated entity for quality improvement functions. • Updated language to reflect revised committee membership compositions, including removal of obsolete roles and alignment of attendance lists with current governance practices. • Updated to reflect standardized meeting frequency for the Credentials Committee, removing seasonal exceptions to align with current operational practice. **3) Leadership & Accountability** • Updated to reflect creation of the Deputy Chief Medical Officer role, including defined authority related to quality oversight, clinical leadership, and Medicare/D-SNP readiness. • Updated language to reflect continued designation of a Medical Director for Medicare Services, with clarified scope focused on future D-SNP implementation and Medicare quality oversight.	

Synopsis of Changes to MQPD1001

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)
		• Updated language to reflect revised organizational chart and leadership accountability, including alignment of role titles and updates to Appendix D resumes to address prior audit expectations. **4) Health Equity & Accreditation Alignment** • Updated language to reflect NCQA's renaming of Health Equity Accreditation to Health Outcomes Accreditation, effective January 15, 2026. • Updated language to reflect removal of DEI committee survey requirements as an accreditation expectation, while clarifying that such activities may continue as discretionary business practices rather than compliance obligations. **5) Behavioral Health Oversight & Delegation** • Updated language to reflect de-delegation of Behavioral Health member-facing functions from Carelon Behavioral Health, including access line, grievances and appeals, and care coordination. • Updated language to reflect Carelon Behavioral Health's retained responsibilities, limited to network administration, claims processing, and delegated behavioral health quality activities. • Updated language to reflect current DHCS regulatory guidance, including revised citations to APL 26-002 and BHIN 26-002. **6) Value-Based Payment Programs** • Updated to reflect re-establishment of the Extended Care Center (EXT) Quality Incentive Program effective January 2026, following sunset of the state Skilled Nursing Facility Workforce QIP. • Updated to reflect completion of the Behavioral Health Quality Incentive Program, revising tense and placement to avoid mischaracterization as an active program. **7) Pathway to Excellence (P2E)** • Updated to reflect substantial expansion of the Pathway to Excellence framework, transitioning from a high-level description to a detailed model for continuous learning, implementation science, and spread of quality improvement interventions. • Updated language to reflect enhanced emphasis on organizational learning, knowledge management, leadership accountability, and sustainability of improvement efforts, with corresponding expansion of Appendix content.	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPQP1048				**Lead Department: Health Services** Business Unit: Quality Improvement	
Policy/Procedure Title: Reporting Communicable Diseases				☒**External Policy** ☐ **Internal Policy**	
Original Date: 06/17/2009			**Next Review Date: ~~09/10/2026~~09/09/2027** **Last Review Date: ~~09/10/2025~~09/09/2026**		
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~~09/09/2026**	

I. RELATED POLICIES:
A. MCCP2035 – Local Health Department (LHD) Coordination
B. MPUP3047 – Tuberculosis Related Treatment

II. IMPACTED DEPTS:
A. Health Services

III. DEFINITIONS:
A. N/A

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
To specify reporting requirements for communicable diseases and conditions that California health care providers are required to report to local public health authorities pursuant to ~~mandated by California state law (~~Title 17, California Code of Regulations, ~~Title 17,~~ § 2500).

VI. POLICY / PROCEDURE:
A. Requirement
1. California ~~state~~ law requires ~~that~~ health care providers to report designated diseases and conditions of public health importance to the applicable local ~~public~~ health department. *Health care provider* is defined as "a physician or surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist" (CCR, Title 17, § 2500, (a)(15)).
2. An updated (March 2026) list of reportable diseases, reporting timeframes, and reporting method are available from the California Department of Public Health (CDPH) website at: https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/ReportableDiseases.pdf

B. Where to Report
1. California Local Health Department (LHD) Contact Information (updated March 27, 2026) for Health Care Providers/Labs To Report Communicable Diseases and Submit Confidential Morbidity Report (CMR) forms can be accessed at https://www.cdph.ca.gov/Programs/CCLHO/Pages/LHD-Communicable-Disease-Contact-List.aspx#
~~1.~~2. If unable to reach the LHD, healthcare providers may contact the CDPH Duty Officer at (916) 328-3605.

Policy/Procedure Number: MPQP1048			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Reporting Communicable Diseases			☒ **External Policy** ☐ **Internal Policy**
Original Date: 06/17/2009		**Next Review Date:** ~~08/10/2026~~09/09/2027 **Last Review Date:** ~~09/10/2025~~09/09/2026	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒**Partnership Advantage**

VII. REFERENCES:

A. Title 17, ~~of the~~ California Code of Regulations (CCR), § 2500, Reporting to the Local Health Authority (revised March 2026)
B. California Department of Public Health (CDPH) CCLHO Health Officer Directory ~~July 9, 2025~~(revised June 11, 2026)
C. California Department of Public Health (CDPH) Local Health Department (LHD) Communicable Disease Contact List ~~Jan. 27, 2025~~(March 27, 2026)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

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

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:

Healthy-Kids - MPQP1048 (Healthy Kids program ended 12/01/2016)
05/19/10; 10/17/12; 10/16/13; 10/15/14: 10/21/15; 10/19/16 to 12/01/16

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3012 (previously UP100312)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Discharge Planning (Non-capitated Members)</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 05/27/1999</td><td colspan="4">Next Review Date: ~~11/12/2026~~09/09/2027
Last Review Date: ~~11/12/2025~~09/09/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~11/12/2025~~09/09/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3020 - Hospice Services Guidelines
B. MCUG3038 - Review Guidelines for Member Placement in Extended Care (Custodial/ Long Term Care, Skilled or Subacute) ~~(LTC)~~ Facilities
C. MP~~C~~CP2019 - Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services
D. MCUG3024 - Inpatient Utilization Management
E. MCCP2024 - Whole Child Model for California Children's Services (CCS)
F. MPUG3011 - Criteria for Home Health Services
G. MCCP2031 - Private Duty Nursing under EPSDT
H. MPCP2034 - Transitional Care Services (TCS)

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

Discharge Planning is the coordinated process that evaluates a patient's needs and ensures that each patient has an individualized plan for continuing care, follow-up and/or rehabilitation. It can also be defined as planning for the appropriate continuing care of the patient upon discharge from an acute care facility.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the process for Discharge Planning. Discharge Planning is part of admission certification and an integral part of daily inpatient utilization management.

VI. POLICY / PROCEDURE:

A. OBJECTIVES OF DISCHARGE PLANNING
   1. To identify prior to or on admission, "high risk" patients with medical, surgical, or psychosocial problems which have potential for increased lengths of stay or possible readmission.
      a. Examples of "high risk" patients include Seniors and Persons with Disabilities, children in the

California Children's Services (CCS) program, or other populations as identified by Partnership HealthPlan of California (Partnership).

2. To coordinate post-~~-~~discharge needs and alternative care
3. To ensure continuity of care throughout inpatient confinement and following discharge
4. To ensure appropriate utilization of inpatient facilities and services
5. To prevent iatrogenic complications that may require hospital readmission
6. To reduce length of stay by preventing unnecessary inpatient days

B. PROCESS

1. Assessment
   a. Discharge planning begins **prior** to admission by assessing the following areas:
      1) The patient's living arrangements prior to hospitalization
      2) The expected living arrangements post-discharge
      3) Any significant others who would be available to provide assistance at home
      4) The assessment of patient/family psychosocial status
      5) Family, support group status
      6) The patient's socio-economic status
      7) Available community resources and the estimated cost and benefits
      8) The patient's ability to perform activities of daily living
      9) Special nursing procedures, medication administration, other special ancillary care services required
   b. ~~Determination of T~~the need for discharge planning is also determined ~~through~~ usinge ~~of~~ goal-based criteria. Discharge planning should be considered for ~~all~~ every patient~~s~~ admitted to an acute care facility.
   c. Each ~~The need of all~~ patient's need for discharge planning should be identified, and discharge planning should ~~commence~~ begin at the time of admission.
2. Ongoing Assessment
   a. Throughout the patient's confinement, the Partnership Nurse Coordinator, facility discharge planner, and/or social worker assess the following:
      1) The patient/family psychosocial, and emotional status
      2) Any change in the patient's physical status that may affect post-discharge well-being (i.e., physical progress or deterioration, new diagnosis, disease or procedure)
   b. Once the alternate care setting has been selected and transfer has taken place, a request is made to the agency or provider for a written progress report when necessary.
3. Identification of Alternate Medical Services
   a. Home health care, pediatric private duty ~~day~~ nursing care, hospice, ~~or a~~ skilled nursing facility ~~is~~ services, subacute care facility services, long-term acute care ~~hospital~~ (LTAC~~H~~) hospital services, ~~inpatient~~acute rehabilitation services, or other medically appropriate post-acute services may be appropriate for patients who ~~may~~ require intermittent professional nursing care outside ~~the~~ of an acute care facility. ~~See~~Please refer to the following ~~-~~Partnership ~~HealthPlan of California's (Partnership's)~~ policies for more information regarding authorization of these services:
      1) MPUG3011 Criteria for Home Health Services~~,~~
      2) MP~~C~~CP2031 Private Duty Nursing under EPSDT~~,~~
      3) MCUP3020 Hospice Services Guidelines
      4) ~~and~~ MCUG3038 Review Guidelines for Member Placement in Extended Care (Custodial/ Long Term Care, Skilled or Subacute) Facilities ~~for authorization of these services.~~
      5) MCUG3024 Inpatient Utilization Management

~~a.1. For Members receiving pediatric subacute care services, discharge planning to an appropriate adult~~

Policy/Procedure Number: MCUP3012 (previously UP100312)		**Lead Department: Health Services** **Business Unit:** Utilization Management
Policy/Procedure Title: Discharge Planning (Non-capitated Members)		☒ **External Policy** ☐ **Internal Policy**
Original Date: 05/27/1999	**Next Review Date:** ~~11/12/2026~~09/09/2027 **Last Review Date:** ~~11/12/2025~~09/09/2026	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

~~level of care shall be completed at least two months prior to the Member's 21st birthday.~~

4. The a~~A~~ttending physician, ~~or~~ hospital discharge planner, or authorized treating provider shall ~~must~~ notify the Partnership Nurse Coordinator prior to the patient's discharge ~~for~~ to obtain precertification ~~of that~~for any service ~~as part of a~~included in the patient's discharge plan.

~~b. An alternate notification process is for the service provider to call and request pre-certification of services for the patient being discharged.~~

~~c.~~a. Approval for pediatric subacute care services ceases once the Member turns 21 years of age. Authorization requests for pediatric Members should not exceed the Member's 21st birthday; therefore, ~~For Members receiving pediatric subacute care services,~~ discharge planning to an appropriate adult level of care ~~shall~~must be completed at least two months prior to the Member's 21st birthday.

VII. REFERENCES:

A. Centers for Medicare & Medicaid Services (CMS) Standards
B. Medi-Cal Provider Manual/ Guidelines
C. Department of Health Care Services (DHCS) All Plan Letter (APL) 26-011~~,~~ Subacute Care Facilities – Long-Term Care Benefit Under Managed Care (06/10/2026)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES: 05/05/00; 05/16/01; 05/15/02; 10/20/04; 10/19/05; 10/17/07; 10/15/08; 11/18/09; 05/18/11; 10/15/14; 01/20/16; 08/17/16; 08/16/17; *09/12/18; 09/11/19; 09/09/20; 08/11/21; 08/10/22; 09/13/23; 09/11/24; 11/12/25; 09/09/26

*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

<table>
<tr><td colspan="5">Policy/Procedure Number: MCUP3050 (previously UP100350)</td><td colspan="2">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="5">Policy/Procedure Title: Medication Abortion in the First Trimester</td><td colspan="2">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 01/17/2001</td><td colspan="4">Next Review Date: ~~11/12/2026~~09/09/2027
Last Review Date: ~~11/12/2025~~09/09/2026</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="2">☐ Employees</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: ~~11/12/2025~~09/09/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUG3024 - Inpatient Utilization Management
B. MCUP3015 - Family Planning Bypass Services
~~B.~~C. MCRP4068 - Medical Benefit Medication TAR Policy
~~C.~~D. MPQP1016 - Potential Quality Issue Investigation and Resolution

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

Mifepristone REMS Program: The U.S. Food and Drug Administration (FDA) risk evaluation and mitigation strategy (REMS) for mifepristone for reproductive health indications. On January 3, 2023, the FDA permanently removed the in-person dispensing requirement and added a new pharmacy certification process, which will enable retail pharmacies that meet certain qualifications to dispense mifepristone directly to patients, in-person or by mail, who have a prescription from a certified prescriber. All other previous mifepristone REMS requirements remain in effect, including the need for prescriber certification and completion of Prescriber and Patient Agreement Forms.

IV. ATTACHMENTS:

A. Mifepristone Patient Agreement Form for Danco Laboratories
B. Mifepristone Patient Agreement Form for GenBioPro Inc.
C. Mifepristone Prescriber Agreement Form for Danco Laboratories
D. Mifepristone Prescriber Agreement Form for GenBioPro Inc.
E. Mifepristone Pharmacy Agreement Form for Danco Laboratories
F. Mifepristone Pharmacy Agreement Form for GenBioPro Inc.

V. PURPOSE:

~~To define the guidelines for appropriate management of medication abortions using mifepristone and/or misoprostol for first trimester medication abortions.~~ To define the guidelines for the provision and appropriate management of medication abortions using mifepristone and/or misoprostol for first trimester

medication abortions.

VI. POLICY / PROCEDURE:

A. Medication Regimens:

This policy describes Provider and Member considerations with regard to the medical management of abortion using mifepristone and/or misoprostol.

1. Effective January 1, 2022 with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 25-013 "Medi-Cal Rx Pharmacy Benefits, And Cell and Gene Therapy Coverage" and Executive Order N-01-19 . For pharmacy benefit administration and coverage requirements, p~~P~~lease refer to the ~~State~~ California Department of Health Care Services (DHCS) Medi-Cal Rx program and applicable guidance using the webpage which is found at https://medi-calrx.dhcs.ca.gov/home/
2. Mifepristone, an antiprogestin, has been approved by the U.S. Food and Drug Administration (FDA) for termination of intrauterine pregnancies through 70 days gestation. It is generally used with misoprostol, an E1 prostaglandin analog.
   a. The usual dose is oral mifepristone 200 mg followed by misoprostol 800 mcg buccal 24 to 48 hours later. This leads to complete abortion in 94% to 98% of patients up to 63 days gestation and in 93% of patients between days 64 – 70 gestation.
   b. For patients 9 to 11 weeks gestation, a second dose of misoprostol should be self-administered after 3 to 6 hours (see Reference VII.DE. It is noted that the FDA approval does not include usage after 10 weeks gestation or a second dose.
   c. The primary complications are vaginal bleeding and crampy abdominal pain, which may be severe. Curettage may be needed to control bleeding or, after treatment failure, to terminate the pregnancy.
3. Misoprostol alone is endorsed by the World Health Organization (WHO), the American College of Obstetrics and Gynecology (ACOG) and the Society of Family Planning for medical abortions at < 11 weeks gestational age.
   a. Dosing regimens include sublingual 800 mcg every 3 hours for 2-3 doses OR intravaginal or buccal 800 mcg every 3-12 hours 2-3 doses
   b. Complications that may need follow~~-~~up include heavy bleeding, pain or fever.
   c. Primary side effects include nausea, vomiting, diarrhea and fever.

B. Provider Requirements

1. Under Federal law, the FDA Mifepristone REMS Program requirements were updated on January 3, 2023 as follows:
   a. Mifepristone must be prescribed by a health care provider who meets certain qualifications and is certified under the Mifepristone REMS Program (see III. above).
   b. In order to become certified to prescribe mifepristone, health care providers must complete a Prescriber Agreement Form. (see Attachments C and D)
   c. The Patient Agreement Form (Attachment A or B as applicable) must be reviewed with, and signed by, the patient and the health care provider, and the risks of the mifepristone treatment regimen must be fully explained to the patient before mifepristone is prescribed.
   d. The Patient must be provided with a copy of the Patient Agreement Form (Attachment A or B as applicable) and Mifepristone Medication Guide (FDA~~-~~approved information for patients.
   e. Mifepristone may only be dispensed by, or under the supervision of, a certified prescriber, or by a certified pharmacy on a prescription issued by a certified prescriber.
   f. To become certified to dispense mifepristone, pharmacies must complete a Pharmacy Agreement Form. (see Attachments E and F)
   g. Certified pharmacies must be able to ship mifepristone using a shipping service that provides tracking information.

h. Certified pharmacies must ensure mifepristone is dispensed to the patient in a timely manner.

2. The following provider requirements must also be met for all medical abortions:
   a. The prescriber must have the ability to assess the duration of pregnancy accurately.
   b. The prescriber must have the ability to diagnose ectopic pregnancies.
   c. The prescriber must be able to provide surgical intervention in cases of incomplete abortion or severe bleeding, or has made arrangements to provide such care through other appropriately trained and credentialed practitioners, and is able to assure patient access to medical facilities equipped to provide blood transfusion and resuscitation, if necessary.
   d. When using Mifepristone, the prescriber has read and understood the prescribing information. Prescribing information is available on the manufacturers' websites as cited in References VII.B and C. below.
3. Providers of medication abortions must be available to patients receiving this care for consultation after office hours and must have arrangements with a suitable facility for emergency surgical intervention when necessary, including after office hours.
4. The prescriber must provide each patient with a Mifepristone Medication Guide. The prescriber must fully explain the procedure to each patient, provide the patient with a copy of the Mifepristone Medication Guide and Patient Agreement form (see Attachment A or B as applicable), give the patient an opportunity to read and discuss, obtain the patient's signature on the Patient Agreement form, and the prescriber must sign it.
5. The prescriber should educate the patient on the importance of follow-up between 5 to 14 days after use of mifepristone to confirm that a complete termination of pregnancy has occurred and to address any complications. The prescriber must ensure there is access to schedule a follow-up appointment after initiating treatment.
   a. Telephonic follow-up at 5 to 14 days for evaluation of patient experience and infection symptoms (cramping, vaginal bleeding, passage of tissue, fever or discharge) in combination with an in- home pregnancy test at 4 weeks can be considered adequate.
   b. The prescriber must notify the manufacturer in writing as discussed in the Package Insert under the heading Dosage and Administration in the event of an on-going pregnancy which is not terminated subsequent to the conclusion of the treatment procedure.
   c. While serious adverse events associated with the use of mifepristone are rare, the prescriber must report any hospitalization, transfusion, or other serious event to the manufacturer, identifying the patient solely by package serial number to ensure patient confidentiality.
6. The provider must keep on file a signed Mifepristone Patient Agreement Form (Attachment A or B as applicable).

C. Patient Requirements
   1. The patient must read carefully and understand the Mifepristone Medication Guide, which will help in understanding how the treatment works.
   2. The patient must sign the Patient Agreement Form.
   3. The patient should agree to see their provider between day 7 and day 14 after receiving the medication.

D. Partnership Requirements
   1. Partnership will reimburse enrolled and eligible Medi-Cal providers for covered services in accordance with DHCS requirements and applicable provider agreements~~the service~~.
   2. Partnership does not require prior authorization or medical justification for medication abortion services, but does require authorization for inpatient hospital services for complications arising from medication abortions when such services are medically necessary (in agreement with Partnership policy MCUG3024 Inpatient Utilization Management), consistent with DHCS APL 24-003.
   3. Abortions are considered sensitive services and as such are provided to Partnership Members in a timely manner through the Member's primary care provider (if appropriately qualified),

obstetrics/gynecology (OB/GYN) specialist, or providers of family planning bypass services.

E. Partnership monitors the quality of medical abortion services through the Member grievance and appeals process or through the Plan's Potential Quality Issue (PQI) process (see MPQP1016 Potential Quality Issue Investigation and Resolution policy).

VII. REFERENCES:

A. U.S. Food and Drug Administration (FDA) "Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation" website content updated ~~03/23/2023~~01/17/2025

B. Danco Mifeprex (mifepristone) manufacturer's website, "For Health Professionals" tab: https://www.earlyoptionpill.com/for-health-professionals/

~~B.~~C. GenBioPro Inc. Mifepristone manufacturer's website, "Prescriber Resources" tab: https://genbiopro.com/products/mifepristone/prescribers/abortion-resources/

~~C.~~D. UpToDate: "Medication Abortion"

~~D.~~E. UpToDate: Bartz D, Blumenthal P. Induced abortion in the f~~F~~irst ~~-~~trimester ~~pregnancy termination~~: Medications ~~abortion published online~~last updated: ~~27 June 2022~~May 19, 2026

~~E.~~F. American College of Obstetrics and Gynecology (ACOG), "Medication Abortion Up to 70 Days of Gestation" Practice Bulletin #225 Volume 136, No. 4, October 2020. https://www.acog.org/-/media/project/acog/acogorg/clinical/files/practice-bulletin/articles/2020/10/medication-abortion-up-to-70-days-gestation.pdf

G. Medi-Cal Provider Manual/ Guidelines: Abortions and Directly Related Medical Services and Supplies *(abort)*

H. World Health Organization (WHO) 2022 Abortion Care Guideline: https://apps.who.int/iris/handle/10665/349316

I. International Federation of Gynecology and Obstetrics: Morris JL, Winikoff B, Dabash R, et al. FIGO's updated recommendations for misoprostol used alone in gynecology and obstetrics. Int J Gynaecol Obstet 2017; 138:363.

J. Department of Health Care Services (DHCS) All Plan Letter APL 25-013 "Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage" (09/18/2025)

K. DHCS All Plan Letter APL 24-003 Abortions and Directly Related Medical Services and Supplies (03/28/2024)

VIII. DISTRIBUTION:

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

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

X. REVISION DATES:

02/14/01 (Physician Advisory Committee); 09/19/01; 10/16/02, 10/20/04; 10/19/05, 10/18/06, 08/20/08; 11/28/12; 02/18/15; 02/17/16; 02/15/17; 11/15/17; *02/13/19; 02/12/20; 11/11/20; 10/13/21; 10/12/22; 10/11/23; 10/09/24; 11/12/25; 09/09/26

*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

PATIENT AGREEMENT FORM

Mifepristone
Tablets, 200 mg

Healthcare Providers: *Counsel the patient on the risks of mifepristone. Both you and the patient must provide a written or electronic signature on this form.*

Patient Agreement:

1. I have decided to take mifepristone and misoprostol to end my pregnancy and will follow my healthcare provider's advice about when to take each drug and what to do in an emergency.

2. I understand:
- **a.** I will take mifepristone on Day 1.
- **b.** I will take the misoprostol tablets 24 to 48 hours after I take mifepristone.

3. My healthcare provider has talked with me about the risks, including:
- heavy bleeding
- infection

4. I will contact the clinic/office/provider right away if in the days after treatment I have:
- a fever of 100.4°F or higher that lasts for more than four hours
- heavy bleeding (soaking through two thick full-size sanitary pads per hour for two hours in a row)
- severe stomach area (abdominal) pain or discomfort, or I am "feeling sick," including weakness, nausea, vomiting, or diarrhea, more than 24 hours after taking misoprostol — these symptoms may be a sign of a serious infection or another problem (including an ectopic pregnancy, a pregnancy outside the womb).

My healthcare provider has told me that these symptoms could require emergency care. If I cannot reach the clinic or office right away my healthcare provider has told me who to call and what to do.

5. I should follow up with my healthcare provider about 7 to 14 days after I take mifepristone to be sure that my pregnancy has ended and that I am well.

6. I know that, in some cases, the treatment will not work. This happens in about 2 to 7 out of 100 women who use this treatment. If my pregnancy continues after treatment with mifepristone and misoprostol, I will talk with my provider about a surgical procedure to end my pregnancy.

7. If I need a surgical procedure because the medicines did not end my pregnancy or to stop heavy bleeding, my healthcare provider has told me whether they will do the procedure or refer me to another healthcare provider who will.

8. I have the MEDICATION GUIDE for mifepristone.

9. My healthcare provider has answered all my questions.

Patient Signature: _____ **Patient Name (print):** _____ **Date:** _____

Provider Signature: _____ **Provider Name (print):** _____ **Date:** _____

Patient Agreement Forms may be provided, completed, signed, and transmitted in paper or electronically.

1/2023

DANCO

PATIENT AGREEMENT FORM **Mifepristone Tablets, 200 mg**

Healthcare Providers: *Counsel the patient on the risks of mifepristone. Both you and the patient must provide a written or electronic signature on this form.*

Patient Agreement:

1. I have decided to take mifepristone and misoprostol to end my pregnancy and will follow my healthcare provider's advice about when to take each drug and what to do in an emergency.
2. I understand:
   a. I will take mifepristone on Day 1.
   b. I will take the misoprostol tablets 24 to 48 hours after I take mifepristone.
3. My healthcare provider has talked with me about the risks, including:
   - heavy bleeding
   - infection
4. I will contact the clinic/office/provider right away if in the days after treatment I have:
   - a fever of 100.4°F or higher that lasts for more than four hours
   - heavy bleeding (soaking through two thick full-size sanitary pads per hour for two hours in a row)
   - severe stomach area (abdominal) pain or discomfort, or I am "feeling sick," including weakness, nausea, vomiting, or diarrhea, more than 24 hours after taking misoprostol – these symptoms may be a sign of a serious infection or another problem (including an ectopic pregnancy, a pregnancy outside the womb).

   My healthcare provider has told me that these symptoms listed above could require emergency care. If I cannot reach the clinic/office/provider right away, my healthcare provider has told me who to call and what to do.
5. I should follow up with my healthcare provider about 7 to 14 days after I take mifepristone to be sure that my pregnancy has ended and that I am well.
6. I know that, in some cases, the treatment will not work. This happens in about 2 to 7 out of 100 women who use this treatment. If my pregnancy continues after treatment with mifepristone and misoprostol, I will talk with my provider about a surgical procedure to end my pregnancy.
7. If I need a surgical procedure because the medicines did not end my pregnancy or to stop heavy bleeding, my healthcare provider has told me whether they will do the procedure or refer me to another healthcare provider who will.
8. I have the MEDICATION GUIDE for mifepristone.
9. My healthcare provider has answered all my questions.

Patient Signature: _____ **Patient Name (print):** _____ **Date:** _____

Provider Signature: _____ **Provider Name (print):** _____ **Date:** _____

Patient Agreement Forms may be provided, completed, signed, and transmitted in paper or electronically.

GenBioPro
PUTTING ACCESS INTO PRACTICE

GenBioPro, Inc. - PO Box 32011 - Las Vegas, NV 89103
1-855-MIFE-INFO (1-855-643-3463) - www.MifeInfo.com

Mifeprex® (Mifepristone) Tablets, 200 mg

PRESCRIBER AGREEMENT FORM

Mifeprex* (Mifepristone) Tablets, 200 mg, is indicated, in a regimen with misoprostol, for the medical termination of intrauterine pregnancy through 70 days gestation. Please see Prescribing Information and Medication Guide for complete safety information.

TO *BECOME A CERTIFIED PRESCRIBER*, YOU MUST:

If you submit Mifeprex prescriptions for dispensing from certified pharmacies:

- Submit this form to each certified pharmacy to which you intend to submit Mifeprex prescriptions. The form must be received by the certified pharmacy before any prescriptions are dispensed by that pharmacy.

If you order Mifeprex for dispensing by you or healthcare providers under your supervision:

- Submit this form to the distributor. This form must be received by the distributor before the first order will be shipped to the healthcare setting.
- Healthcare settings, such as medical offices, clinics, and hospitals, where Mifeprex will be dispensed by or under the supervision of a certified prescriber in the Mifepristone REMS Program do not require pharmacy certification.

Prescriber Agreement: By signing this form, you agree that you meet the qualifications below and will follow the guidelines for use. You are responsible for overseeing implementation and compliance with the Mifepristone REMS Program. You also understand that if the guidelines below are not followed, the distributor may stop shipping mifepristone to the locations that you identify and certified pharmacies may stop accepting your mifepristone prescriptions.

Mifepristone must be provided by or under the supervision of a certified prescriber who meets the following qualifications:

- Ability to assess the duration of pregnancy accurately.
- Ability to diagnose ectopic pregnancies.
- Ability to provide surgical intervention in cases of incomplete abortion or severe bleeding, or have made plans to provide such care through others, and be able to assure patient access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary.
- Has read and understood the Prescribing Information for mifepristone. The Prescribing Information is available by calling 1-877-4 Early Option (1-877-432-7596), or by visiting **www.earlyoptionpill.com**.

In addition to having these qualifications, you also agree to follow these guidelines for use:

- Ensure that the *Patient Agreement Form* is reviewed with the patient and the risks of the mifepristone treatment regimen are fully explained. Ensure any questions the patient may have prior to receiving mifepristone are answered.
- Ensure the healthcare provider and patient sign the *Patient Agreement Form*.
- Ensure that the patient is provided with a copy of the *Patient Agreement Form* and Medication Guide.
- Ensure that the signed *Patient Agreement Form* is placed in the patient's medical record.
- Ensure that any deaths of patients who received Mifeprex are reported to Danco Laboratories, LLC, identifying the patient by a non-identifiable reference and including the NDC and lot number from the package of Mifeprex that was dispensed to the patient.

Ensure that healthcare providers under your supervision follow the guidelines listed above.

If Mifeprex will be dispensed through a certified pharmacy:

- Assess appropriateness of dispensing Mifeprex when contacted by a certified pharmacy about patients who will receive Mifeprex more than 4 calendar days after the prescription was received by the certified pharmacy.
- Obtain the NDC and lot number of the package of Mifeprex the patient received in the event the prescriber becomes aware of the death of a patient.

If Mifeprex will be dispensed by you or by healthcare providers under your supervision:

- Ensure the NDC and lot number from each package of Mifeprex are recorded in the patient's record.

I understand that a certified pharmacy may dispense mifepristone made by a different manufacturer than that stated on this Prescriber Agreement Form.

Print Name: _____ Title: _____

Signature: _____ Date: _____

Medical License # _____ State _____

NPI # _____

Practice Name(s): _____

Practice Setting Address: _____

Email: _____ Phone: _____ Preferred ☐ email ☐ phone

Return completed form to: Mifeprex@dancodistributor.com or fax to 1-866-227-3343.

Mifeprex®

(Mifepristone)

Tablets, 200 mg

THE ORIGINAL EARLY OPTION PILL.

DANCO

Support ● Progress ● Options

*MIFEPREX IS A REGISTERED TRADEMARK OF DANCO LABORATORIES, LLC.

P.O. BOX 4816 · NEW YORK, NY 10185 1-877-4-EARLY-OPTION · (1-877-432-7596)

WWW.EARLYOPTIONPILL.COM

Approved 09/2025

Mifepristone Tablets, 200 mg, is indicated, in a regimen with misoprostol, for the medical termination of intrauterine pregnancy through 70 days gestation. Please see Prescribing Information and Medication Guide for complete safety information.

To *become a certified prescriber*, you must:

- If you submit mifepristone prescriptions for dispensing from certified pharmacies:
    - Submit this form to each certified pharmacy to which you intend to submit mifepristone prescriptions. The form must be received by the certified pharmacy before any prescriptions are dispensed by that pharmacy.
- If you order mifepristone for dispensing by you or healthcare providers under your supervision:
    - Submit this form to the distributor. This form must be received by the distributor before the first order will be shipped to the healthcare setting.
    - Healthcare settings, such as medical offices, clinics, and hospitals, where mifepristone will be dispensed by or under the supervision of a certified prescriber in the Mifepristone REMS Program do not require pharmacy certification.

Prescriber Agreement: By signing this form, you agree that you meet the qualifications below and will follow the guidelines for use. You are responsible for overseeing implementation and compliance with the Mifepristone REMS Program. You also understand that if the guidelines below are not followed, the distributor may stop shipping mifepristone to the locations that you identify and certified pharmacies may stop accepting your mifepristone prescriptions.

Mifepristone must be provided by or under the supervision of a certified prescriber who meets the following qualifications:

- Ability to assess the duration of pregnancy accurately.
- Ability to diagnose ectopic pregnancies.
- Ability to provide surgical intervention in cases of incomplete abortion or severe bleeding, or have made plans to provide such care through others, and be able to assure patient access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary.
- Has read and understood the Prescribing Information for mifepristone. The Prescribing Information is available by calling 1-855-MIFE-INFO (1-855-643-3463 toll-free), or by visiting www.MifeInfo.com.

In addition to meeting these qualifications, you also agree to follow these guidelines for use:

- Ensure that the *Patient Agreement Form* is reviewed with the patient and the risks of the mifepristone treatment regimen are fully explained. Ensure any questions the patient may have prior to receiving mifepristone are answered.
- Ensure the healthcare provider and patient sign the *Patient Agreement Form*.
- Ensure that the patient is provided with a copy of the *Patient Agreement Form* and Medication Guide.
- Ensure that the signed *Patient Agreement Form* is placed in the patient's medical record.
- Ensure that any deaths of patients who received mifepristone are reported to GenBioPro, Inc., identifying the patient by a non-identifiable reference and including the NDC and lot number from the package of mifepristone that was dispensed to the patient.

Ensure that healthcare providers under your supervision follow the guidelines listed above.

- If mifepristone will be dispensed through a certified pharmacy:
    - Assess appropriateness of dispensing mifepristone when contacted by a certified pharmacy about patients who will receive mifepristone more than 4 calendar days after the prescription was received by the certified pharmacy.

- Obtain the NDC and lot number of the package of mifepristone the patient received in the event the prescriber becomes aware of the death of a patient.

- If mifepristone will be dispensed by you or by healthcare providers under your supervision:
  - Ensure the NDC and lot number from each package of mifepristone are recorded in the patient's record.

I understand that a certified pharmacy may dispense mifepristone made by a different manufacturer than that stated on this Prescriber Agreement Form.

Print Name: _____ Title: _____

Signature: _____ Date: _____

Medical License #: _____ State: _____

NPI #: _____

Practice Name(s): _____

Practice Setting Address: _____

_____

Email: _____ Phone _____ Preferred: ☐ Email ☐ Phone

Return completed form to RxAgreements@GenBioPro.com or fax to 1-877-239-8036.

PHARMACY AGREEMENT FORM

Mifeprex® (Mifepristone)
Tablets, 200 mg

Pharmacies must designate an authorized representative to carry out the certification process and oversee implementation and compliance with the Mifepristone REMS Program on behalf of the pharmacy.

Healthcare settings, such as medical offices, clinics, and hospitals, where mifepristone will be dispensed by or under the supervision of a certified prescriber in the Mifepristone REMS Program do not require pharmacy certification.

BY SIGNING THIS FORM, AS THE AUTHORIZED REPRESENTATIVE I CERTIFY THAT:

- Each location of my pharmacy that will dispense Mifeprex is able to receive *Prescriber Agreement Forms* by email and fax.
- Each location of my pharmacy that will dispense Mifeprex is able to ship Mifeprex using a shipping service that provides tracking information.
- I have read and understood the Prescribing Information for Mifeprex. The Prescribing Information is available by calling 1-877-4 EARLY OPTION (1-877-432-7596 toll-free) or online at www.earlyoptionpill.com; and **each location of my pharmacy that will dispense Mifeprex will put processes and procedures in place to ensure the following requirements are completed.** I also understand that if my pharmacy does not complete these requirements, the distributor may stop accepting Mifeprex orders.
    - Verify that the prescriber is certified in the Mifepristone REMS Program by confirming their completed *Prescriber Agreement Form* was received with the prescription or is on file with your pharmacy.
    - Dispense Mifeprex such that it is delivered to the patient within 4 calendar days of the date the pharmacy receives the prescription, except as provided in the following bullet.
    - Confirm with the prescriber the appropriateness of dispensing Mifeprex for patients who will receive the drug more than 4 calendar days after the date the pharmacy receives the prescription and document the prescriber's decision.
    - Record in the patient's record the NDC and lot number from each package of Mifeprex dispensed.
    - Track and verify receipt of each shipment of Mifeprex.
    - Dispense mifepristone in its package as supplied by Danco Laboratories, LLC.
    - Report any patient deaths to the prescriber, including the NDC and lot number from the package of Mifeprex dispensed to the patient, and remind the prescriber of their obligation to report the deaths to Danco Laboratories, LLC. Notify Danco that your pharmacy submitted a report of death to the prescriber, including the name and contact information for the prescriber and the NDC and lot number of the dispensed product.
    - Not distribute, transfer, loan or sell mifepristone except to certified prescribers or other locations of the pharmacy.

- Maintain records of *Prescriber Agreement Forms*, dispensing and shipping, and all processes and procedures including compliance with those processes and procedures.
- Maintain the identity of Mifeprex patients and prescribers as confidential and protected from disclosure except to the extent necessary for dispensing under this REMS or as necessary for payment and/or insurance.
- Train all relevant staff on the Mifepristone REMS Program requirements.
- Comply with audits carried out by the Mifepristone Sponsors or a third party acting on behalf of the Mifepristone Sponsors to ensure that all processes and procedures are in place and are being followed.

Any new authorized representative must complete and submit the Pharmacy Agreement Form.

Authorized Representative Name: _____ Title: _____

Signature: _____ Date: _____

Email: _____ Phone: _____ Preferred ☐ email ☐ phone

Pharmacy Name: _____

Pharmacy Address: _____

Return completed form to Mifeprex@dancodistributor.com or fax to 1-866-227-3343.

Mifeprex®
(Mifepristone) Tablets, 200 mg
THE ORIGINAL
EARLY OPTION PILL

DANCO

Danco Laboratories, LLC • P.O. Box 4816 • New York, NY 10185
1-877-4 Early Option (1-877-432-7596) • www.earlyoptionpill.com

*MIFEPREX is a registered trademark of Danco Laboratories, LLC.

09/2025

Pharmacies must designate an authorized representative to carry out the certification process and oversee implementation and compliance with the Mifepristone REMS Program on behalf of the pharmacy.

Healthcare settings, such as medical offices, clinics, and hospitals, where mifepristone will be dispensed by or under the supervision of a certified prescriber in the Mifepristone REMS Program do not require pharmacy certification.

By signing this form, as the Authorized Representative I certify that:

- Each location of my pharmacy that will dispense mifepristone is able to receive *Prescriber Agreement Forms* by email and fax;
- Each location of my pharmacy that will dispense mifepristone is able to ship mifepristone using a shipping service that provides tracking information;
- I have read and understood the Prescribing Information for mifepristone. The Prescribing Information is available by calling 1-855-MIFE-INFO (1-855-643-3463 toll-free) or online at www.MifeInfo.com; and
- Each location of my pharmacy that will dispense mifepristone will put processes and procedures in place to ensure the following requirements are completed. I also understand that if my pharmacy does not complete these requirements, the distributor may stop accepting mifepristone orders.
    - Verify that the prescriber is certified in the Mifepristone REMS Program by confirming their completed *Prescriber Agreement Form* was received with the prescription or is on file with your pharmacy.
    - Dispense mifepristone such that it is delivered to the patient within 4 calendar days of the date the pharmacy receives the prescription, except as provided in the following bullet.
    - Confirm with the prescriber the appropriateness of dispensing mifepristone for patients who will receive the drug more than 4 calendar days after the date the pharmacy receives the prescription and document the prescriber's decision.
    - Record in the patient's record the NDC and lot number from each package of mifepristone dispensed.
    - Track and verify receipt of each shipment of mifepristone.
    - Dispense mifepristone in its package as supplied by GenBioPro, Inc.
    - Report any patient deaths to the prescriber, including the NDC and lot number from the package of mifepristone dispensed to the patient, and remind the prescriber of their obligation to report the deaths to GenBioPro, Inc. Notify GenBioPro that your pharmacy submitted a report of death to the prescriber, including the name and contact information for the prescriber and the NDC and lot number of the dispensed product.
    - Not distribute, transfer, loan or sell mifepristone except to certified prescribers or other locations of the pharmacy.
    - Maintain records of *Prescriber Agreement Forms*, dispensing and shipping, all processes and procedures including compliance with those processes and procedures.
    - Maintain the identity of mifepristone patients and prescribers as confidential and protected from disclosure except to the extent necessary for dispensing under this REMS or as necessary for payment and/or insurance purposes.
    - Train all relevant staff on the Mifepristone REMS Program requirements.
    - Comply with audits carried out by the Mifepristone Sponsors or a third party acting on behalf of the Mifepristone Sponsors to ensure that all processes and procedures are in place and are being followed.

Any new authorized representative must complete and submit the Pharmacy Agreement Form.

Authorized Representative Name: _____ Title: _____

Signature: _____ Date: _____

Email: _____ Phone: _____ Preferred __ email __ phone

Pharmacy Name: _____

Pharmacy Address: _____

Return completed form to RxAgreements@GenBioPro.com or fax to 1-877-239-8036.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3052 (previously UP100352)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Medical Nutrition Therapy (MNT) Services</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 05/16/2001</td><td colspan="4">Next Review Date: ~~02/11/2027~~09/09/2027
Last Review Date: ~~02/11/2026~~09/09/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~02/11/2026~~09/09/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3113 - Telehealth Services
B. MPCP2026 - Diabetes Prevention Program
C. MPBP8013 - Eating Disorder Management Policy
D. MCUG3118 - Prenatal & Perinatal Care
~~D.~~E. MCUP3041 - Treatment Authorization Request (TAR) Review Process
~~E.~~F. MPAP7003 - CalAIM Community Supports (CS)

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Certified Diabetes Educator (CDE®): A health professional who possesses comprehensive knowledge of and experience in prediabetes, diabetes prevention, and management. The CDE® educates and supports people affected by diabetes to understand and manage the condition. A CDE® promotes self-management to achieve individualized behavioral and treatment goals that optimize health outcomes. The Certification Examination for Diabetes Educators (Examination) is designed and intended for health professionals who have responsibilities that include the direct provision of diabetes self-management education (DSME), as defined by National Certification Board for Diabetes Educators.

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

C. Medical Nutrition Therapy (MNT): An evidence-based application of the Nutrition Care Process. The provision of MNT (to a patient/client) may include one or more of the following: nutrition assessment/ re-assessment, nutrition diagnosis, nutrition intervention and nutrition monitoring and evaluation that typically results in the prevention, delay or management of diseases and/or conditions. [Academy of Nutrition and Dietetics (see latest edition)]

D. Partnership HealthPlan Perinatal Services (PHPS): CPSP-like services that are equivalent to, or substantially similar to, the services defined by the CDPH-defined CPSP program. (see also the Comprehensive Perinatal Services Program (CPSP) definition above)
E. Perinatal services are defined as pregnancy-related services given before and during delivery and for a period of 12 months following delivery
F. Registered Dietician (RD) or Registered Dietician Nutritionist (RDN): An individual who has met current minimum (Baccalaureate) academic requirements with successful completion of both specified didactic education and supervised-practice experiences through programs accredited by The Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics and who has successfully completed the Registration Examination for Dietitians. To maintain the RD credential, the RD must comply with the Professional Development Portfolio (PDP) recertification requirements (accrue 75 units of approved continuing professional education every five years.)

IV. ATTACHMENTS:

A. MNT Referral Guidelines ~~for Children/Adolescents~~
~~B. Referral Guidelines for Adults~~
~~C.~~B. Adult Body Mass Index

V. PURPOSE:

To define the criteria for medically necessary referrals and continuing services for medical nutrition therapy (MNT) and d~~D~~iabetes education services for children and adults. This policy uses evidence-based guidelines and currently recognized national standards of care to ensure access to MNT in the treatment and prevention of chronic diseases.

~~The Patient Protection and Affordable Care Act of 2010 requires all United States Preventive Services Task Force (USPSTF) recommendations with class A or B be covered. The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians. Grade: B Recommendation. Children are also covered under this policy, as an enhanced benefit.~~

VI. POLICY / PROCEDURE:

A. Medical nutrition therapy (MNT) must be provided by a Registered Dietitian (RD) or Registered Dietician Nutritionist (RDN) or Certified Diabetes Educator (CDE®).
   1. The RD, RDN or CDE may either be working for a provider contracted with Partnership HealthPlan of California (Partnership) (I including primary care, specialist, hospital, home health agency, or hospice) or may be an unaffiliated RD, RDN or CDE contracted individually with Partnership.
      a. In either case, the RD, RDN and/or CDE® documentation must be on file with the Provider Relations department of Partnership for claims to be paid.
      ~~a.~~b. No accreditation of the provider's overall diabetes self-management training program is required
B. The Patient Protection and Affordable Care Act of 2010 requires all United States Preventive Services Task Force (USPSTF) recommendations with C~~c~~lass A or B be covered.
   1. ~~The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease.~~ Intensive counseling can be delivered by primary care clinicians or by referral to other specialists~~,~~ such as nutritionists or dietitians. ~~Grade: B Recommendation.~~
   2. Children, adolescents and adults are ~~also~~ covered under this policy. ~~, as an enhanced benefit.~~
C. Authorization and Billing of MNT Services
   1. ~~MNT Services must meet state and federal standards of medical necessity. Diagnoses that are covered are listed in Attachments A and B. The frequency of services in Attachments A and B are~~

~~guidelines, not maximum requirements.~~ Members with a qualifying diagnosis(es) defined in Attachment A may receive MNT visits according to the frequency limits stated below (VI.C.2.) with no Treatment Authorization Request (TAR) requirement.

a. The Partnership frequency may exceed those allowed by Medi-Cal policy limits.
b. Stated frequency limits are based on Current Procedural Terminology (CPT) code units, in a rolling 12-month period.
c. A~~No~~ Referral Authorization Form (RAF) approved by Partnership is not required for MNT services outlined in this policy
d. Providers can refer patients for MNT services directly to a Partnership contracted /credentialed RD, RDN or CDE, noting the diagnosis for which MNT is needed and sharing appropriate clinical information.

~~2.~~ A ~~nor Treatment Authorization Request (~~TAR~~)~~ is required when services exceed frequency limits stated below. ~~.~~

~~3.~~2. The following codes should be used, as applicable, when submitting a claim for MNT services.

a. 97802: ~~-~~ Initial Visit - Medical Nutritional Therapy ~~(~~outpatient initial assessment
   1) Services are billed in increments of 15 minutes = 1 unit (1 hour – 4 units)
   2) Visits not to exceed 12 units (3 hours) in a rolling 12-month period. ~~is~~
   3) Initial visit is limited to one initial visit per Date of Service (DOS), ~~year~~ per diagnosis ~~grouping~~ listed in Attachment A~~the attached criteria~~. ~~No RAF is required, although a clinician referral (Physician or Non-Physician Clinician) must be documented in the medical record.~~
   ~~a.~~
b. 97803: ~~–~~Medical Nutrition Therapy - Individual follow-up outpatient nutritional counseling education
   1) Services are billed in increments of 15 minutes = 1 unit (1 hour = 4 units)
   ~~1)~~2) Up to 48 units (12 hours) in a rolling 12-month period may be provided without a TAR
c. 97804: ~~–~~ Medical Nutrition Therapy - Group reassessment and intervention
   ~~2)~~1) Member m~~M~~ust have an individual ~~assessment~~ visit prior to first group session ~~appointment~~.
   ~~3)~~2) Services are billed in increments of 30 minutes = 1 unit (1 hour = 2 units).
   3) Up to 72 units (36 hours) in a rolling 12-month period ~~per calendar year~~ may be provided without a TAR ~~or RAF based on the medical diagnoses in Attachment A,~~
   ~~4)~~ Duration of group therapy session not to exceed 2 hours per ~~date of service (~~DOS.
   ~~5)~~4)
d. 98970, 98971, ~~thru~~ 98972: ~~–~~Monitoring Meal Plan Journals virtually between sessions~~.~~
   1) Registered Dieticians may bill Partnership for these codes when treating a Member who has been diagnosed with a qualifying ~~an~~ eating disorder diagnosis(es) listed in Attachment A.
   2) ~~No TAR is required when the Member has an eating disorder diagnosis code on record (as defined in Attachments A and B.)~~ Services are billed in increments of 10 minutes = 1 unit (1 hour = 6 units)
   ~~6)~~3) Up to 72 units (12 hours) in a rolling 12-month period may be provided, inclusive of all three codes, without a TAR
e. G0108: ~~–~~Diabetes outpatient self-management training services, individual~~,~~
   1) Services are billed in increments of 30 minutes = 1 unit (1 hour = 2 units)
   2) ~~per 30 minutes. Partnership allows U~~up to 16 units (8 hours) in a rolling 12-month period may be provided ~~to be billed~~ without a TAR ~~in a rolling 12-month period~~.
   ~~b.~~3) C~~c~~ode may not be billed on same date of service as CPT codes 97802, 97803 or ~~thru~~ 97804~~)~~
f. G0109: ~~–~~Diabetes outpatient self-management training services, group session ~~(2 or more),~~
   1) Services are billed in increments of ~~per~~ 30 minutes = 1 unit (1 hour = 2 units)~~.~~

2) Up to 18 units (9 hours) in a rolling 12-month period may be provided without a TAR
~~c.~~3) Code ~~(~~may not be billed on same date of service as CPT codes 97802, 97803 or ~~thru~~ 97804~~)~~

g. Z6200, Z6202, Z6204: ~~–~~Medical nutrition therapy ante-partum/post-partum, individual~~,~~
~~d.~~1) ~~P~~provided in a Perinatal Services Program based on perinatal services program guidelines. (See policy MCUG3118 Prenatal & Perinatal Care)

h. Z6206, Z6208: ~~–~~Medical Nutrition Therapy antepartum, group~~,~~
~~e.~~1) R~~r~~ecommendations/ limits based on Perinatal Services Program allowances (See policy MCUG3118 Prenatal & Perinatal Care)

~~B.~~D. Nutrition supplements

1. Physician administered nutritional supplements require a TAR to be submitted to Partnership when the item is billed to Partnership's medical benefit and is not on Partnership's Medical Drug List (MDL), or when the MDL indicates a prior authorization is required.
2. Nutritional supplements provided by a Pharmacy must be submitted through the Medi-Cal Rx TAR process[1]~~*~~ when not on the Medi-Cal Rx Contract Drugs List (CDL).
3. Enteral formulas require a Medi-Cal Rx TAR when provided by a pharmacy.

~~*NOTE: Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy (prescription) benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 25-013 "Medi-Cal Rx Pharmacy Benefits, And Cell and Gene Therapy Coverage" and Executive Order N-01-19 . Please refer to the State Medi-Cal Rx webpage which is found at https://medi-calrx.dhcs.ca.gov/home/~~

VII. REFERENCES:

A. United States Preventive Services Task Force (USPSTF) recommendations
B. Medi-Cal Provider Manual/ Guidelines: Medicine: Nutrition Counseling *(medne nutri)*
C. Diabetes Care 2026 American Diabetes Association (ADA) Professional Practice Committee for Diabetes Care 2026 (Supplement 1) S89-S131
D. 2026 Dietary Guidance to Improve Cardiovascular Health: A Scientific Statement from the American Heart Association. Circulation vol 153 Number 18
E. Hepburn, C., von Roenn, N. Nutrition in Liver Disease – A Review. Curr Gastroenterol Rep 25, 242–249 (2023).
F. Tandon, P., Gramlich, L., & Jin, J. (2026). Nutrition in cirrhosis: bridging guidelines and practice in hepatic disease Current Opinion in Clinical Nutrition & Metabolic Care
G. Morgan-Bathke, M et al. Medical Nutrition Therapy Interventions Provided by Dieticians for Adult Overweight and Obesity Management: An Academy of Nutrition and Dietetics Evidence-Based Practice Guideline. J Acad Nutr Diet. 2023 Mar;123(3):520-545.e10.
H. National Comprehensive Cancer Network (NCCN) 2026 Guidelines - Survivorship: Preventive Health: Nutrition and Weight Management
I. Evert, A et al. Nutrition Therapy for Adults with Diabetes or Prediabetes: A Consensus Report. *Diabetes Care* 1 May 2019; 42 (5): 731–754.
J. World Health Organization (WHO) Body Mass Index (BMI) Classification Global Database on BMI Geneva: WHO 2008
~~B.~~K. Cederholm & Bosaeus, Malnutrition in Adults N.Eng J Med July 10 2024
~~C.~~L. DHCS All Plan Letter (APL) 25-013 "Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy

[1] Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy (prescription) benefit is carved-out to Medi-Cal Fee-for-Service as described in APL 25-013 "Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage" and Executive Order N-01-19. For pharmacy benefit administration and coverage requirements, please refer to the California Department of Health Care Services (DHCS) Medi-Cal Rx program and applicable guidance using the webpage which is found at https://medi-calrx.dhcs.ca.gov/home/.

Coverage" (09/18/2025)

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

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

X. REVISION DATES: 05/15/02, 08/20/03; 11/17/04; 11/16/05; 10/18/06; 08/15/07, 08/20/08; 07/21/10; 01/18/12; 08/21/13; 01/15/14; 02/18/15; 03/16/16; 03/15/17; *06/13/18; 06/12/19; 06/10/20; 01/13/21; 01/12/22; 08/10/22; 09/13/23; 08/14/24; 09/11/24; 11/12/25; 02/11/26; 09/09/26

*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.

~~02/11/2026~~09/09/2026

MEDICAL NUTRITION THERAPY REFERRAL GUIDELINES FOR ADULTS, CHILDREN AND ~~/~~ ADOLESCENTS

Nutrition Criteria/ ICD-10 Codes	Criteria Description ~~Definition of Child/Adolescent Criteria~~
Cardiovascular disease or risk of E78.0 – E78.3, E78.5 I70.0 – I70.249 I70.261 – I70.299 I70.401 – I70.419 I70.501 – I70.519 I70.8 – I70.92, I10 – I11.9	Hypertension, hyperlipidemia **and/or** coronary artery disease
Decubitus ulcer L89.90 – L89.95 L89.000 – L89.029 L89.110 – L89.149 L89.200 – L89.329 L89.500 – L89.819	Increased nutritional need due to wound
Pre-diabetes (impaired glucose tolerance) R73.01, R73.03 – R73.09	Impaired fasting glucose of ≥ 100 mg/dl, but <125 mg/dl. **and/or** impaired glucose tolerance (IGT), defined as oral glucose tolerance test value of ≥ 140 mg/dl, but less than 200 mg/dl ~~2 visits over 6 months~~
Diabetes E10.10 – E11.9	Type 1 & Type 2 ~~4 visits over 6 months~~
Eating disorders F50.00 - F50.029 F50.20 - F50.25, F50.8 – F50.9	Anorexia nervosa, bulimia or other feeding or eating disorder ~~4 visits over2 months~~
Gastrointestinal disease: **Crohn's Disease** K50.00, K50.10, K50.80, K50.90 **Ulcerative colitis** K51.00, , K51.20, K51.30, K51.40, K51.50, K51.80, K51.90 K52.9 **Irritable bowel syndrome** K58.9 **Malabsorption, s/p GI surgery**	Need for dietary manipulation due to gastrointestinal condition

MEDICAL NUTRITION THERAPY REFERRAL GUIDELINES FOR ADULTS, CHILDREN AND ~~/~~ ADOLESCENTS

Nutrition Criteria/ ICD-10 Codes	Criteria Description ~~Definition of Child/Adolescent Criteria~~
K90.0 – K90.3 K90.81 – K90.9	
HIV/AIDS B20	Nutritional problems related to HIV/AIDS
Lead poisoning T56.0X1A – T56.0X4S	~~N/A~~ Blood Lead Level ~~4 visits over 6 months~~
Liver disease K70.0 – K70.31 K72.91, K73.0, K73.2, K73.9, K74.5 – K75.1, K75.4, K75.9, K76.3, K76.6 – K77	Need for dietary manipulation due to declining liver function
Obesity ~~and Overweight~~ E66.0 – E66.2, E66.8, E66.9	**Adults:** BMI > 30 Kg/m² **and** at medical risk with concurrent medical problem(s) ~~—————~~ **or** BMI > 27 Kg/m² with CVD complications **Pediatric:** Ages 2 – 19 years: > 95th percentile by weight for height OR by BMI, using the appropriate growth chart for age (NCHS) ~~Ages 2 – 19 years: > 85th percentile by weight for height OR by BMI, using the appropriate growth chart for age (NCHS)~~ ~~8 visits over1 year~~
Overweight E66.3	**Adults:** BMI between 25 and 29.9 Kg/m² **and** Waist to Hip Ratio > .95 in men and > .85 in women **Pediatric:** Ages 2 – 19 years: > 85th and < 95th percentile by weight for height OR by BMI, using the appropriate growth chart for age (NCHS) ~~**Frequency:**~~
Pregnancy Related Conditions O09, O10-O16, O21, O24, O26.0 - O26.2, O26.8, O26.9, O30, O36.5, O36.6, O36.8, O36.9, O40, O48, Z34	All pregnant individuals with these diagnoses are eligible for MNT ~~**Frequency:**~~ ~~See Perinatal Services visit recommendations in policy MCUG3118 Prenatal & Perinatal Care~~ ~~OR~~ ~~1-2 visits per month up to 12 months after delivery~~

MEDICAL NUTRITION THERAPY REFERRAL GUIDELINES FOR ADULTS, CHILDREN AND ~~/~~ ADOLESCENTS

Nutrition Criteria/ ICD-10 Codes	Criteria Description ~~Definition of Child/Adolescent Criteria~~
Pre-End Stage Renal and/or Chronic Kidney Disease N01.0, N03.1 – N03.2, N03.5, N03.8 – N03.9, N04.0 – N04.2, N04.5, N04.8 - N04.9, N05.1 – N05.2, N05.5, N05.8 – N05.9, N08, N17.0 – N17.2, N17.8 – N17.9, N18.1 – N19	Need for dietary manipulation due to declining renal function (pre-dialysis) ~~2 visits over 2 months~~
Severe anemia D50.0 – D50.9 D53.0 – D53.9	Has received a trial of iron therapy for 2 months and **who still has a** Hemoglobin less than or equal to 9.0gm/dl **and a** hemoglobin electrophoresis which does not indicate hemoglobinopathy
Severe food hypersensitivity L27.2	Diagnosed food hypersensitivity to casein, gluten, or soy
Short Stature R62.0 R62.50 – R62.52	Measurement below the 5th percentile height for age using the appropriate growth chart for age (NCHS)
Substance abuse Z79, F10.10, F11.10, F11.20 – F11.21, F12.10, F12.20 – F12.21, F13.10, F13.20 – F13.21, F14.10, F14.20 – F14.21, F15.10, F15.20 – F15.21, F16.10, F16.20 – F16.21, F17.200, F18.20 – F18.21, F19.10, F19.20 – F19.21	Nutritional problems related to substance abuse
Undernutrition or risk of related to dietary deficiency: E40 – E41, E43 – E51.12, E51.8, E52 – E56.1, E56.9, E58, E63.8 – E63.9, E64.3 **Poor dentition, poor appetite, unexplained weight**	Poor nutritional status related to a variety of medical problems, including cancer, cancer treatment, frail, elder, etc.

MEDICAL NUTRITION THERAPY REFERRAL GUIDELINES FOR ADULTS, CHILDREN AND ~~/~~ ADOLESCENTS

Nutrition Criteria/ ICD-10 Codes	Criteria Description ~~Definition of Child/Adolescent Criteria~~
loss R63.0, R63.3 - R63.6 **Cachexia** R64	
Under-weight, and/or -failure to thrive R62.0 R62.50 – R62.52 R63.0	Measurement below the 5th percentile weight for height using the appropriate growth chart (NCHS) **or** Dramatic drop on the growth curve from previous visit by two percentiles

ADULT BODY MASS INDEX

Body weight in lb (kg)/height (m)²

Height in inches (cm)	BMI 25	BMI 27	BMI 30
58 (147.32)	119 (53.98)	129 (58.51)	143 (64.86)
59 (149.86)	124 (56.25)	133 (60.33)	148 (67.13)
60 (152.40)	128 (58.06)	138 (62.60)	153 (69.40)
61 (154.94)	132 (59.87)	143 (64.86)	158 (71.67)
62 (157.48)	136 (61.69)	147 (66.68)	164 (74.39)
63 (160.02)	141 (63.96)	152 (68.95)	169 (76.66)
64 (162.56)	145 (65.77)	157 (71.21)	174 (78.93)
65 (165.10)	150 (68.04)	162 (73.48)	180 (81.65)
66 (167.64)	155 (70.31)	167 (75.75)	186 (84.37)
67 (170.18)	159 (72.12)	172 (78.02)	191 (86.64)
68 (172.72)	164 (74.39)	177 (80.29)	197 (89.36)
69 (175.26)	169 (76.66)	182 (82.56)	203 (92.08)
70 (177.80)	174 (78.93)	188 (85.28)	207 (93.89)
71 (180.34)	179 (81.19)	193 (87.54)	215 (97.52)
72 (182.88)	184 (83.46)	199 (90.27)	221 (100.25)
73 (185.42)	189 (85.73)	204 (92.53)	227 (102.97)
74 (187.96)	194 (88.00)	210 (95.26)	233 (105.69)
75 (190.50)	200 (90.72)	216 (97.98)	240 (108.86)
76 (193.04)	205 (92.99)	221 (100.25)	246 (111.58)

MEDICAL NUTRITION THERAPY REFERRAL GUIDELINES FOR ADULTS

Nutrition Criteria/ ICD-10 Codes	Definition of Adult Criteria	Recommended Number of Visits
Cardiovascular disease/or risk of **E78.0 – E78.3, E78.5** **I70.0 – I70.249** **I70.261 – I70.299** **I70.401 – I70.419** **I70.501 – I70.519** **I70.8 – I70.92, I10 – I11.9**	Hypertension, hyperlipidemia **and/or** coronary artery disease	3 visits over 3 months
Decubitus ulcer **L89.90 – L89.95** **L89.000 – L89.029** **L89.110 – L89.149 L89.200 – L89.329 L89.500 – L89.819**	Increased nutritional need due to wound	1 visit
Pre-diabetes (impaired glucose tolerance) **R73.01, R73.03 – R73.09**	Impaired fasting glucose of ≥ 100 mg/dl, but <125 mg/dl. **and/or** impaired glucose tolerance (IGT), defined as oral glucose tolerance test value of ≥ 140 mg/dl, but less than 200 mg/dl	2 visits over 6 months
Diabetes **E10.10 – E11.9**	Type 1 & Type 2	4 visits over 6 months
Eating disorder **F50.00 – F50.029** **F50.20 – F50.25, F50.8 – F50.9**	Anorexia nervosa, bulimia or other feeding or eating disorder	4 visits over 2 months
Gastrointestinal disease: **Crohn's Disease** **K50.00, K50.10, K50.80, K50.90** **Ulcerative colitis** **K51.00, , K51.20, K51.30, K51.40, K51.50, K51.80, K51.90 K52.9** **Irritable bowel syndrome** **K58.9** **Malabsorption, s/p GI surgery** **K90.0 – K90.3** **K90.81 – K90.9**	Need for dietary manipulation due to gastrointestinal condition	2 visits over 2 months
HIV/AIDS **B20**	Nutritional problems related to HIV/AIDS	4 visits over 3 months

ARCHIVED 09/09/2026 - See Attachment A

MEDICAL NUTRITION THERAPY REFERRAL GUIDELINES FOR ADULTS

Nutrition Criteria/ ICD-10 Codes	Definition of Adult Criteria	Recommended Number of Visits
Liver disease **K70.0 – K70.31 K72.91, K73.0, K73.2, K73.9, K74.5 – K75.1, K75.4, K75.9, K76.3, K76.6 – K77**	Need for dietary manipulation due to declining liver function	2 visits over 2 months
Obesity **E66.0 - E66.9,**	BMI ≥ 30 Kg/m² **and** at medical risk with concurrent medical problem(s) **or** BMI ≥ 27 Kg/m² with CVD complications	2 individual appointments and group weight management program over 6 months
Overweight **E66.3**	BMI between 25 and 29.9 Kg/m², **and** Waist to Hip Ratio ≥ .95 in men and ≥ .85 in women	Group weight management program over 6 months
Pre-End Stage Renal and/or Chronic Kidney Disease **N01.0, N03.1 – N03.2, N03.5, N03.8 – N03.9, N04.0 – N04.2, N04.5, N04.8 - N04.9, N05.1 – N05.2, N05.5, N05.8 – N05.9, N08, N17.0 – N17.2, N17.8 – N17.9, N18.1 – N19**	Need for dietary manipulation due to declining renal function (pre-dialysis)	2 visits over 2 months
Pregnancy Related Conditions **O09, O10-O16, O21, O24, O26.0 - O26.2, O26.8, O26.9, O30, O36.5, O36.6, O36.8, O36.9, O40, O48, Z34**	All pregnant individuals with these diagnoses are eligible for MNT	see Perinatal Services visit recommendations in policy MCUG3118 Prenatal & Perinatal Care OR 1-2 visits per month up to 12 months after delivery
Substance abuse **Z79, F10.10, F11.10, F11.20 – F11.21, F12.10, F12.20 – F12.21, F13.10, F13.20 – F13.21, F14.10, F14.20 – F14.21, F15.10, F15.20 – F15.21, F16.10, F16.20 – F16.21, F17.200, F18.20 – F18.21, F19.10, F19.20 – F19.21**	Nutritional problems related to substance abuse	4 visits over 4 months

ARCHIVED 09/09/2026 - See Attachment A

MEDICAL NUTRITION THERAPY REFERRAL GUIDELINES FOR ADULTS

Nutrition Criteria/ ICD-10 Codes	Definition of Adult Criteria	Recommended Number of Visits
Undernutrition or risk of related to dietary deficiency: **E40 – E41, E43 – E51.12, E51.8, E52 – E56.1, E56.9, E58, E63.8 – E63.9, E64.3** **Poor dentition, poor appetite, unexplained weight loss** **R63.0, R63.3 - R63.6** **Cachexia** **R64**	Poor nutritional status related to a variety of medical problems, including cancer, cancer treatment, frail elder, etc.	2 visits over 2 months

ARCHIVED 09/09/2026 - See Attachment A

ADULT BODY MASS INDEX

Body weight in lb (kg)/height (m)²

Height in inches (cm)	BMI 25	BMI 27	BMI 30
58 (147.32)	119 (53.98)	129 (58.51)	143 (64.86)
59 (149.86)	124 (56.25)	133 (60.33)	148 (67.13)
60 (152.40)	128 (58.06)	138 (62.60)	153 (69.40)
61 (154.94)	132 (59.87)	143 (64.86)	158 (71.67)
62 (157.48)	136 (61.69)	147 (66.68)	164 (74.39)
63 (160.02)	141 (63.96)	152 (68.95)	169 (76.66)
64 (162.56)	145 (65.77)	157 (71.21)	174 (78.93)
65 (165.10)	150 (68.04)	162 (73.48)	180 (81.65)
66 (167.64)	155 (70.31)	167 (75.75)	186 (84.37)
67 (170.18)	159 (72.12)	172 (78.02)	191 (86.64)
68 (172.72)	164 (74.39)	177 (80.29)	197 (89.36)
69 (175.26)	169 (76.66)	182 (82.56)	203 (92.08)
70 (177.80)	174 (78.93)	188 (85.28)	207 (93.89)
71 (180.34)	179 (81.19)	193 (87.54)	215 (97.52)
72 (182.88)	184 (83.46)	199 (90.27)	221 (100.25)
73 (185.42)	189 (85.73)	204 (92.53)	227 (102.97)
74 (187.96)	194 (88.00)	210 (95.26)	233 (105.69)
75 (190.50)	200 (90.72)	216 (97.98)	240 (108.86)
76 (193.04)	205 (92.99)	221 (100.25)	246 (111.58)

ARCHIVED 09/09/2026-See Attachment B

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MCUP3119 (previously under QI - MCQP1020, QP100120)			**Lead Department: Health Services** **Business Unit**: Utilization Management	
Policy/Procedure Title: Sterilization Consent Protocol			☒**External Policy** ☐ **Internal Policy**	
Original Date: QI Medi-Cal-4/25/1994 UM Medi-Cal-10/17/2012		**Next Review Date:** ~~10/08/2026~~09/09/2027 **Last Review Date:** ~~10/08/2025~~09/09/2026		
Applies to:	☒ **Medi-Cal**		☐ **Employees**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~10/08/2025~~09/09/2026	

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MPUP3078 – Second Medical Opinions
C. ~~MCUP3064~~ MPUD3001 – ~~Communication Services~~Utilization Management Program Description
D. MPQP1022 – Site Review Requirements and Guidelines

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. DHCS Form 8649– *Previously known as Form PM330*, this form entitled "Consent for Sterilization" has been renamed by the California Department of Health Care Services (DHCS) as of 04/2025.
B. Mentally Incompetent: A mentally incompetent individual is a person who has been declared mentally incompetent by the federal, state or local court of competent jurisdiction for any purposes which include the ability to consent to sterilization.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

A. Member Consent
   1. Members who have procedures performed for the purpose of tubal sterilization or vasectomy shall receive adequate information to make an informed decision. This decision shall be reflected by a properly executed DHCS Consent Form 8649.
   2. A physician may perform or arrange for a (non-emergency) hysterectomy only if:
      a. The person who secures the authorization to perform the hysterectomy has informed the individual and the individual's representative, if any, orally and in writing that the hysterectomy will render the individual permanently sterile.

b. The individual (or representative) has signed a written acknowledgment of the receipt of the preceding information. The consent must be dated prior to the date of surgery.
c. The individual has been informed of the rights to consultation by a second physician. (see policy MPUP3078 – Second Medical Opinions).
d. A copy of the written acknowledgment signed by the patient must be:
   1) Provided to the patient
   2) Retained by the physician and the hospital in the patient's medical records, and
   3) Attached to claims submitted by physicians, assistant surgeons, anesthesiologists, and hospitals

3. Informed consent is not required for a hysterectomy if it is performed in a life-~~-~~threatening emergency situation in which a physician determines that prior acknowledgment was not possible. In these cases, a handwritten statement of the nature of the emergency signed by the physician shall be attached to the claim.
4. Translation and interpretation services will be provided if the Member to be sterilized does not understand the language used on the consent form or the verbal language used to obtain consent. Linguistic services are provided by Partnership HealthPlan (Partnership) at no cost to monolingual, non-English speaking or Limited English Proficiency (LEP) Medi-Cal beneficiaries as well as eligible Members with ~~sensory impairment~~disabilities. These services include written translations, qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters, use of California Relay Services for hearing impaired or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries.
5. Informed consent for sterilization is not required prior to a sterilizing or potentially sterilizing procedure if the Member has been previously sterilized as the result of a prior surgery, menopause, prior tubal ligation, pituitary or ovarian dysfunction, pelvic inflammatory disease, endometriosis or congenital sterility. In these cases, the provider must state the cause of sterility in the Remarks section of the claim form or as an attachment. This statement must be handwritten and signed by a physician. All assistant surgeon, anesthesiology and inpatient provider claims must include a copy of the primary physician's statement.
6. The HealthPlan is responsible for monitoring providers to assure compliance with their responsibilities as previously outlined.

B. Coverage Conditions
1. Some planned sterilization procedures require a Treatment Authorization Request (TAR). Providers should refer to the Medi-Cal Provider Manual/ Guidelines sections "Benefits: Family Planning" *(ben fam)*, ~~and~~ "Sterilization" *(ster)* or "Hysterectomy" (*hyst*) to determine if a TAR is required.
2. Sterilization shall be covered only if all of the following are true:
   a. The Member to be sterilized is at least 21 years of age at the time the consent for sterilization is obtained.
   b. The Member is mentally competent (refer to definition of mentally incompetent at III.B).
   c. The Member is able to understand the content and nature of the informed consent process; a mentally ill or developmentally disabled Member may consent to the sterilization if a physician determines the Member is capable of understanding the nature and the significance of the sterilization procedure.
   d. The Member is not institutionalized.
   e. The Member has voluntarily given informed consent.
   f. At least 30 calendar days, but not more than 180 calendar days, have passed between the date of the written and signed informed consent and the date of the sterilization. The calendar day after the date the informed consent was signed is the first day of the 30-days waiting period.
      1) Tubal sterilization may be performed at the time of an emergency abdominal surgery if the Member consented to the sterilization at least 30 calendar days before the intended date of

sterilization AND at least 72 hours have passed after written informed consent was given and the performance of the emergency surgery.

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

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

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

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

C. Informed Consent Process Performed by the Provider:

The informed consent process shall be initiated by a physician or by the physician's designee (with an interpreter if needed), and then completed/confirmed by the physician performing the surgery. These activities are documented on the DHCS Consent Form 8649.

1. A Member has given informed consent only if:

a. The provider who obtained consent for the sterilization procedure has completed the following requirements:

1) Offered to answer any questions the Member may have had concerning the sterilization procedure;

2) Provided the Member with a copy of the consent form and the booklet on sterilization published by the Department of Health Care Services;

3) Provided orally[1] all of the following information to the Member to be sterilized:

a) Advice that the Member is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the Member might be otherwise entitled;

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

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

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

2. The Member may withhold or withdraw consent for sterilization at any time prior to the procedure without adverse effect to his/her participation in the HealthPlan or right to future care.
3. Within 72 hours prior to the time the Member receives any pre-operative medication, the physician must advise the Member that federal benefits shall not be withheld or withdrawn if the Member chooses not to be sterilized. The physician certifies this action by signing the DHCS Consent Form 8649.
4. Informed consent shall not be obtained while the Member to be sterilized is subject to the following:
   a. In labor or within 24 hours postpartum or post abortion
   b. Must not be within 30 calendar days of seeking to obtain or obtaining an abortion
   c. Under the influence of alcohol or other substances that affect the Member's state of awareness

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

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

Member's medical record and include signature certifications as follows:

a. The Member to be sterilized~~;~~
b. The interpreter, if required to obtain informed consent
c. Individual who obtains the consent, and
~~b.~~d. The physician performing the sterilization procedure~~;~~
~~c.~~a. ~~The interpreter, if required to obtain informed consent~~

2. The signature certifications assure the following:
   a. The Member is mentally competent and knowledgeably and voluntarily consented;
   b. The Member has received oral delivery of the requirements for informed consent;
   c. The Member understood, to the interpreter's best belief, the translation of the physician's oral statements and the written consent statement.

E. Partnership HealthPlan of California Monitoring Procedure
1. Claims submitted for procedures requiring informed consent are manually reviewed by the Claims Department for compliance.
2. Review criteria included in the Facility Site Review:
   a. Office staff have received training on informed consent requirements
   b. Informed consent is present in the medical record for all operative and invasive procedures
   c. A DHCS Consent Form 8649 (New 04/2025) is present for human sterilization
3. A Treatment Authorization Request (TAR) is required for hysterectomy and will be reviewed by the Partnership Utilization Management (UM) staff for information about the medical necessity of a hysterectomy.

VII. REFERENCES:

A. Title 22 California Code of Regulations § 51305.1
B. Medi-Cal Provider Manual/ Guidelines: Benefits: Family Planning *(ben fam)*, Sterilization *(ster)*; Hysterectomy (*hyst*)
C. DHCS Form 8649 (New 04/2025) – Consent for Sterilization form which can be found on this webpage: https://www.dhcs.ca.gov/Pages/permanentbirthcontrol.aspx
D. DHCS Sterilization Materials (booklets on sterilization provided with consent forms)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

12/21/94; 10/10/97 (name change only), 06/20/01, 10/16/02; 02/16/05; 03/15/06; 03/21/07; 02/20/08; 03/18/09; 03/17/10; 05/18/11;(changed to UM) 10/17/12; 03/18/15; 03/16/16; 03/15/17; *06/13/18; 04/10/19; 05/13/20; 05/12/21; 06/08/22; 08/09/23; 09/11/24; 10/08/25; 09/09/26

*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:

****

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MPUP3035 (previously UP100335)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Preoperative Day Review</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 05/28/1999</td><td colspan="4">Next Review Date: ~~11/12/2026~~09/09/2027
Last Review Date: ~~11/12/2025~~09/09/2026</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td>☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="3">☒ QUAC</td></tr>
<tr><td>☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td colspan="2">☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~11/12/2025~~09/09/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MPUP3139 – Criteria and Guidelines for Utilization Management

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

Preoperative Day – The planned admission of a member to the acute hospital prior to a scheduled (elective) procedure.

1. As part of the precertification review process, patients are identified for Preoperative Day Review when the reasons for and the timing of admissions are submitted by the provider of service.
2. Preoperative Day Review is initiated for a patient to be admitted before surgery. If the admitting physician requests that the patient be admitted before surgery, all patient information is reviewed to determine if it meets medical necessity criteria for an elective admission. If necessary, the clinical information is referred to the Chief Medical Officer (CMO) or Physician Designee.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To identify elective surgical cases that may be admitted to the hospital the day prior to surgery rather than the day of surgery.

VI. POLICY / PROCEDURE:

A. Objective
   1. To determine the appropriateness of a patient's admission to the hospital prior to the day of surgery. Whenever possible, early morning admission on the day of a proposed surgical procedure should be utilized. If the patient's problem precludes such utilization, special certification consideration by the CMO/Physician Designee may be given through the prior authorization process.

B. Procedure
   1. Admissions for elective surgical procedures are identified during the precertification review process.
   2. If the admitting physician requests the patient be admitted prior to the day of surgery, a Nurse

Coordinator reviews all pertinent clinical information to see if it meets medical necessity criteria for a preoperative day admission. The authorization request must clearly explain the medical necessity of the requested preoperative day.

a. If medical necessity criteria elements are met, the Nurse Coordinator approves the admission for the day prior to the planned procedure.
b. If none of the criteria elements are met, or the medical need for the request is not clear, the case is referred to the CMO/Physician Designee for medical necessity review using criteria as described in policy MPUP3139 Criteria and Guidelines for Utilization Management.

3. The CMO or Physician Designee are the only individuals who can deny a request based on lack of medical justification.

VII. REFERENCES:

A. InterQual® criteria

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
05/17/00; 09/19/01; 10/16/02, 10/20/04; 10/19/05; 10/18/06; 08/20/08; 11/18/09; 10/01/10; 05/16/12; 08/20/14; 01/20/16; 09/21/16; 09/20/17; *10/10/18; 11/13/19; 11/11/20; 10/13/21; 10/12/22; 10/11/23; 10/09/24; 11/12/25; 09/09/26

*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:

Healthy Kids - MPUP3035 (Healthy Kids program ended 12/01/2016)
10/18/06; 08/20/08; 11/18/09; 10/01/10; 05/16/12; 08/20/14; 01/20/16; 09/21/16 to 12/01/2016
PartnershipAdvantage:
MPUP3035 - 10/18/2006 to 01/01/2015
Healthy Families:
MPUP3035 - 10/01/2010 to 03/01/2013

****

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

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

Policy/Procedure Number: MPUP3035 (previously UP100335)		**Lead Department: Health Services**
Policy/Procedure Title: Preoperative Day Review		☒ **External Policy** ☐ **Internal Policy**
Original Date: 05/28/1999	**Next Review Date: 11/12/202609/09/2027** **Last Review Date: 11/12/202509/09/2026**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

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 MEETING SUMMARY
(Confidential – Protected by CA. Evidence Code 1157)
*=by phone conference

Committee:	Credentials Committee
Date:	DATE 07/08/2026 START TIME: 7:00 A.M.
Members Present: by phone conference*	Steven Gwiazdowski, MD; David Gorchoff, MD*; Michele Herman, MD; Bradley Sandler, MD* ; Brian Montenegro, MD; Craig Rhoades, PA-C*
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; Danika Ahedo, Supervisor of Credentialing; 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 Credentials Chair Mark Netherda, MD called the meeting to order at 7:00AM. Credentials Committee roll call taken by Credentials Chair. Mark Netherda, MD reminded everyone that all items discussed are confidential. a. Partnership Credentials Chair Mark Netherda, MD reminded The Credentials Committee of who the voting members are, and voting is restricted to non-PHC staff. Mark Netherda, MD reminded the committee that all information discussed is confidential in nature.			07/08/2026 07/08/2026
II. Review and approval of June 10, 2026 Credentials Meeting Summary.	II. The Credentials Committee Meeting Summary for June 10, 2026 was reviewed by the Committee.	II. Summary was reviewed. A motion for approval of the Summary was made. First motion approved by Craig Rhoades, PA-C and the second motion approved by Michele Herman, MD. Meeting Summary' motions approved by committee unanimously with no objections.		07/08/2026

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
III. Old Business. a. No Old Business to report.	III. Old Business a. No Old Business to report.	III. Old Business a. No Old Business to report.		07/08/2026
IV. New Business a. Review and Approval of Routine Practitioner List.	IV. New Business a. Mark Netherda, MD referred the Credentials Committee to review the routine list of practitioners.	IV. New Business a. The Committee reviewed the Routine Practitioner List**.** A Motion to approve the Routine Practitioner List was made. First motion approved by Michele Herman, MD and the second motion approved by Craig Rhoades, PA-C. Routine Practitioner List motions approved by committee unanimously with no objections.		07/08/2026
b. MPCR200 Clean/Routine Practitioners and Ancillary Practitioners	b. Mark Netherda, MD directed the Credentials Committee to the MPCR200 Clean/Routine Practitioners and Ancillary Practitioners list. These practitioners are approved by Mark Netherda, MD Pre-Credentials Committee meeting.	b. The Credentials Committee reviewed the MPCR200 Clean/Routine list. A motion to approve the MPCR200 Clean/Routine Practitioners and Ancillary Practitioners list was made. First motion approved by Brian Montenegro, MD and the second motion approved by Michele Herman, MD. MPCR200 Clean/Routine list motions approved by committee unanimously with no objections.		07/08/2026
c. Review and Approval of Revised Policies.	c. Review and Approval of Revised Policies presented by Danika Ahedo, Supervisor of Credentialing. Danika explained the following policies:	c. The Committee reviewed the Revised Policies. A motion to approve the revised policies was made. First motion approved by Craig Rhoades, PA-C and the second motion approved by		07/08/2026

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	• **MPCR13C** – Osteopathic Manipulation Treatment Credentialing. Policy changes include consent calendar date updates and simple language changes. • **MPCR702** – Initial and Ongoing Vetting Requirements and Sanction Monitoring for Transportation Service Providers. Policy changes include consent calendar date updates and credentialing primary source link updates.	Michele Herman, MD. Revised Policies motions approved by committee unanimously with no objections		
V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List.	V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List.	V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List.		
a. Review and Approval of Ongoing Monitoring of Sanctions Report.	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.	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 Brian Montenegro, MD and the second motion approved by Michele Herman, MD. Ongoing Monitoring of Sanctions Report motions approved by committee unanimously with no objections.		07/08/2026
b. Practitioner Monitoring List. *Information only.*	b. The Credentials Committee was asked to review the Practitioner Monitoring list. Mark Netherda, MD reminded the committee that the credentialing department monitors these boards for any actions regarding our providers.	b. *Information only*.		07/08/2026

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	Information only.			
VI. Review and Approval of Consent Calendar Items. a. Report of Long-Term Care Facility, Hospital, and Ancillary provider list. b. Annual Delegation Audits	VI. Review and Approval of Consent Calendar Items. a. Mark Netherda, MD asked the Credentials Committee members to review the report of Long-Term Care Facility, Hospital, and Ancillary provider list. b. Mark Netherda, MD presented the Annual Delegation Audits for: • University of California Davis Health – the annual audit for UC Davis was presented to the committee on May 13, 2026, which included an open Corrective Action Plan (CAP). The CAP is completed and closed. • Vision Service Plan (VSP) The audit included Partnerships review and evaluation of the credentialing information integrity results.	VI. Review and Approval of Consent Calendar Items. a/b. The Credentials Committee members reviewed the list of Consent Calendar items. A motion for approval was made for Report of Long Term Care Facility, Hospital and Ancillary provider list and Annual Delegation Audits. First motion approved by Michele Herman, MD and the second motion approved by Brian Montenegro, MD. Consent Calendar items motions approved by committee unanimously with no objections.		07/08/2026
VII. Meeting Adjourned.	VII. Meeting adjourned.			07/08/2026

Credentials Meeting Summary for July 08, 2026 respectfully prepared and submitted by J'aime Seale, Credentialing Lead.

7/8/2026

Chairman Signature of Approval _____ ***Date***_____

Mark Netherda, MD *Credentialing Chairman*

App. Ty	Full Name	NPI Number	Provider Type C	Inital Appmnt Date	Name/Street	County Name	Specialty Description	Board Name	Initial Cert Date
I	Alden, Brittany BCBA	1154848331	BHP		BM Behavioral Center, LLC	Solano	BCBA	Behavior Analyst Certificatio	03/14/2020
R	Alfano, Amy A.,CNM	1588159776	SPEC	08/12/2020	Open Door Community Heal	Humboldt	Certified Nurse Midwife	American Midwifery Certifica	06/12/2018
I	Ali, Nisreen F.,MD	1700272077	PCP		Feather River Tribal Health	Butte	Pediatrics	ABMS of Pediatrics	10/18/2018
I	Aliabadi, Hamidreza MD	1942474713	SPEC		Spine & Neurosurgery Asso	Placer	Neurological Surgery	ABMS of Neurological Surge	11/10/2015
R	Ammar, Mustafa MD	1558363168	PCP	09/13/2023	Ampla Health Marysville Me	Yuba	Internal Medicine	Meets MPCR#17, Previously	08/26/1998
I	Anderson, Charles K.,MD	1215191259	SPEC		Willamette Valley Cancer In	Solano	Gynecologic Oncology	ABMS of Obstetrics and Gyn	04/07/2017
I	Araujo, Luis BCBA	1922475318	BHP		SPLENDID ABA LLC	Solano	BCBA	Behavior Analyst Certificatio	08/31/2017
R	Arellanes, Carolyn L.,PA-C	1659501880	PCP	08/13/2014	UIHS - Crescent City Health	Del Norte	Physician Assistant Certifiec	National Commission on Ce	07/09/2009
R	Arvizu, Joshua A.,MD	1255968590	PCP	09/13/2023	Blue Stone Health & Wellne	Placer	Family Medicine	ABMS of Family Medicine	07/01/2023
R	Aung, Thinn T.,MD	1528050770	PCP	09/13/2023	Ampla Health Yuba City	Sutter	Pediatrics	ABMS of Pediatrics	10/16/2001
I	Ayala, Jocelyn BCBA	1174006589	BHP		Roman Empire ABA Service	Solano	BCBA	Behavior Analyst Certificatio	11/23/2021
R	Bacon, Allison D.,MD	1720254584	PCP	09/25/2023	Santa Rosa Community Hea	Sonoma	Family Medicine	ABMS of Family Medicine	07/12/2011
I	Bader, Danielle SUDCC	1649676057	W&R		Recover Medical Group	Solano	Wellness and Recovery	California Substance Use Di	11/12/2025
R	Bajwa, Kulbir K.,MD	1912000126	PCP	03/12/2003			Internal Medicine	ABMS of Internal Medicine	08/24/2004
I	Barrera-Calix, Jonathan MD	1356797864	SPEC		Enloe Health and Wellness	Butte	Nephrology	ABMS of Internal Medicine	10/14/2021
R	Berk, David R.,MD	1205045192	SPEC	09/10/2014	Direct Dermatology Professi	Solano	Dermatology	ABMS of Dermatology	08/11/2008
R	Bhavsar, Jessica M.,PA-C	1275877599	SPEC	09/25/2023	Recover Medical Group	Solano	Physician Assistant	National Commission on Ce	09/06/2012
I	Biradar, Shradha DO	1063161297	PCP		Petaluma Health Center	Sonoma	Family Medicine	ABMS of Family Medicine	07/11/2025
R	Boparai, Nanak S.,MD	1225183221	PCP	09/13/2023	Ampla Health Medical	Sutter	Pediatrics	Meets MPCR #17, Verified F	
R	Borruso, Adam R.,FNP-C	1285931147	PCP	09/13/2023	Chapa-De Indian Health (Au	Placer	Family Nurse Practitioner	American Academy of Nurse	02/01/2011
R	Brenta, Marcia J.,NP	1710355607	SPEC	07/08/2020	Open Door Community Heal	Humboldt	Nurse Practitioner	None	
R	Breton, Jenna R.,NP	1427222538	SPEC	01/11/2012	Adventist Health Ukiah Valle	Mendocino	Nurse Practitioner	None	
R	Brockington, Nancy S.,MD	1629119334	BOTH	07/08/2020	Aegis Treatment Center LLC	Humboldt	Family Medicine	Meets MPCR#17, Previously	07/12/1991
R	Bromer, Steven P.,MD	1689671968	BOTH	12/14/2005			Family Medicine	ABMS of Family Medicine	07/09/1999
I	Bronson, Derek C.,PA-C	1962932343	SPEC		Sacramento Ear Nose and T	Placer	Physician Assistant Certifiec	National Commission on Ce	08/21/2017
I	Brooks, Lindsay BCBA	1821599572	BHP		Momentum Behavior Servic	Sonoma	BCBA	Behavior Analyst Certificatio	08/02/2021
R	Carini, Renee M.,FNP-BC	1346287356	PCP	09/13/2023	Ampla Health Chico Medica	Butte	Family Nurse Practitioner	American Nurses Credential	08/01/1999
I	Carpenter, Charles F.,MD	1457520462	W&R		Transitions Clinic of Sacram	Solano	Addiction Medicine	ABMS of Addiction Medicine	01/01/2022
I	Carrillo, Gustavo PA-C	1114542255	PCP		Mendocino Community Heal	Mendocino	Physician Assistant Certifiec	National Commission on Ce	09/07/2021
I	Casarez, Genesha BCBA	1841085735	BHP		Roman Empire ABA Service	Solano	BCBA	Behavior Analyst Certificatio	04/14/2026
I	Casey, Alison Doula	1770450561	SPEC		Raya Health	Solano	Doula	None	
I	Casillas-Ta, Brittany BCBA	1154899268	BHP		Center for Social Dynamics	Solano	BCBA	Behavior Analyst Certificatio	03/11/2026
R	Castillo, Lydia BCBA	1760952451	BHP	09/25/2023	Autism Intervention Professi	Solano	BCBA	Behavior Analyst Certificatio	10/07/2020
R	Caufield, Desiree M.,SUDCC II	1568084754	W&R	07/08/2020	Empire Recovery Center	Shasta	Wellness and Recovery	California Substance Use Di	03/02/2026
R	Chan, Vicky BCBA	1003487620	BHP	09/25/2023	Autism Intervention Professi	Placer	BCBA	Behavior Analyst Certificatio	06/28/2021
I	Chang, Margaret A.,MD	1477504405	SPEC		Retinal Consultants Medical	Placer	Ophthalmology	ABMS of Ophthalmology	10/28/2007
I	Chokshi, Nikhil K.,MD	1942413018	SPEC		Banner Health Clinic	Lassen	Orthopaedic Surgery	ABMS of Orthopaedic Surge	07/24/2014
I	Clancy, Morgan P.,APCC	1306775432	W&R		Recover Medical Group	Solano	Associate Professional Clini	None	
R	Cline, Jerry M.,MD	1336126374	BOTH	09/25/2023	Adventist Health Ukiah Valle	Mendocino	Family Medicine	ABMS of Family Medicine	07/13/2001
R	Cokgor, Ilkcan MD	1235100603	SPEC	01/11/2012	Neurology Clinic of Marin	Marin	Neurology	ABMS of Psychiatry & Neurc	03/31/1998
R	Cole, Deanna BCBA	1487124756	BHP	09/13/2023	Advance Kids	Placer	BCBA	Behavior Analyst Certificatio	12/17/2021
I	Collins, Heather .,FNP-C	1215766753	SPEC		Collabria Care DBA Napa V	Napa	Family Nurse Practitioner	American Academy of Nurse	04/02/2024
R	Cortez, Brandon J.,MD	1538521828	PCP	09/13/2023	Santa Rosa Community Hea	Sonoma	Family Medicine	ABMS of Family Medicine	07/01/2019
R	Coulter, Pippa E.,MD	1033183777	PCP	08/09/2023	Open Door Community Heal	Humboldt	Pediatrics	ABMS of Pediatrics	10/09/1996
R	Crisp, Allison J.,DO	1710399118	PCP	09/13/2017	Ole Health	Napa	Pediatrics	ABMS of Pediatrics	10/18/2017
I	Crowley, John D.,MD	1053476135	SPEC		Lassen County Behavioral H	Lassen	Psychiatry	ABMS of Psychiatry & Neurc	01/30/1993
R	Crummey, Daniel J.,SUDCC	1811673668	W&R	08/09/2023	Archway Recovery Services	Solano	Wellness and Recovery	California Substance Use Di	01/21/2026
I	Cuadra, German I.,DO	1215450739	SPEC		Mendocino Community Heal	Mendocino	Obstetrics and Gynecology	Meets MPCR #17, Verified F	
I	Curran, Jesse R.,MD	1164942827	PCP		SCHC: Anderson Family He	Shasta	Family Medicine	ABMS of Family Medicine	11/09/2021
I	Curtis, Felicia L.,Doula	1285371872	SPEC		Raya Health	Solano	Doula	None	
I	Doak, Darcy M.,SUDRC I	1194676791	W&R		Aegis Treatment Centers, LI	Shasta	Wellness and Recovery	California Substance Use Di	02/15/2026
I	Donner, Barry S.,MD	1679534796	SPEC		Providence Medical Group,	Humboldt	Gastroenterology	ABMS of Internal Medicine	09/12/1984
R	Dow, Eliot R., MD	1740711647	SPEC		Retinal Consultants Medical	Yolo	Opthalmology	ABMS of Ophthalmology	10/21/2023

App. Ty	Full Name	NPI Number	Provider Type C	Inital Appmnt Date	Name/Street	County Name	Specialty Description	Board Name	Initial Cert Date
R	Duncan, Jennifer A.,FNP-BC	1043495021	BOTH	09/13/2023	Adventist Health Physicians	Sutter	Family Nurse Practitioner	American Nurses Credential	12/21/2007
R	Dzurella, Scott A.,FNP-C	1093153322	PCP	09/25/2023	Chapa-De Indian Health (Au	Placer	Family Nurse Practitioner	American Academy of Nurse	07/03/2013
R	Eaton, Mark H.,MD	1952353575	SPEC	01/08/2003	Sacramento Heart & Vascul	Yolo	California Children's Service	None	03/30/2016
I	Edelman, Tressa R.,FNP-BC	1578515961	PCP		Open Door Community Heal	Humboldt	Family Nurse Practitioner	American Nurses Credential	09/01/1998
I	Edwards, Jessica I., DO	1265848121	PCP		Chapa-De Indian Health (Au	Nevada	Family Medicine	AOB of Family Medicine	08/16/2017
I	Elegino, Junali BCBA	1538663968	BHP		Center for Social Dynamics	Solano	BCBA	Behavior Analyst Certificatio	10/21/2024
I	Elison, Jasmine R.,MD	1740219583	SPEC		West Coast Retina Medical	Solano	Ophthalmology	ABMS of Ophthalmology	11/06/2005
R	English, Brittany L.,FNP-BC	1770059750	SPEC	09/13/2023	Santa Rosa Community Hea	Sonoma	Family Nurse Practitioner	American Nurses Credential	08/30/2018
I	Fernando, Rajeev R.,MD	1952651382	SPEC		Adventist Health Ukiah Valle	Mendocino	Cardiovascular Disease	ABMS of Internal Medicine	10/06/2015
R	Figurski, Ann C.,DO	1790981132	PCP	08/09/2023	West County Health Centers	Sonoma	Family Medicine	ABMS of Family Medicine	07/15/2010
R	Finch, Kathryne BCBA	1619492634	BHP	09/13/2023	Autism Intervention Professi	Placer	BCBA	Behavior Analyst Certificatio	05/31/2017
I	Flores, Samuel BCBA	1417421876	BHP		Roman Empire ABA Service	Solano	BCBA	Behavior Analyst Certificatio	11/30/2018
I	Garcia, Krystal BCBA	1013486794	BHP		Burnett Therapeutic Service	Napa	BCBA	Behavior Analyst Certificatio	06/22/2021
R	Geller, Ryan BCBA	1164938668	BHP	09/13/2023	Autism Intervention Professi	Placer	BCBA	Behavior Analyst Certificatio	07/31/2021
R	Ghassemi, Roxana BCBA	1164796702	BHP	09/13/2023	Autism Intervention Professi	Solano	BCBA	Behavior Analyst Certificatio	11/30/2014
I	Ghazizadeh, Sayeh Psy.D	1679098875	BHP		Burnett Therapeutic Service	Napa	Behavioral Health	None	
I	Gillette, Lexis D.,AGPCNP-BC	1821984311	BOTH		Health Care Medical Associ	Humboldt	Adult-Gerontology Primary C	American Nurses Credential	02/10/2026
I	Girot, Chloe O.,Doula	1730868480	SPEC		Raya Health	Solano	Doula	None	
R	Giusty, Lisa M.,PT	1649517152	Allied	07/08/2020	Proactive Spine and Sports	Shasta	Physical Therapy	None	
R	Goldberg, Roger A.,MD	1184866584	SPEC	09/10/2014	Bay Area Retina Associates	Solano	Ophthalmology	ABMS of Ophthalmology	10/27/2013
R	Goldberger, Megan BCBA	1821715749	BHP	09/13/2023	SunRise ABA, LLC	Solano	Board Certified Behavior An	Behavior Analyst Certificatio	09/23/2022
I	Gordon, Jennifer C.,MD	1417362914	SPEC		Willamette Valley Cancer In	Solano	Gynecologic Oncology	ABMS of Obstetrics and Gyr	04/11/2025
R	Granados, Linda BCBA	1629554688	BHP	09/25/2023	Autism Intervention Professi	Placer	Behavioral Health	Behavior Analyst Certificatio	05/31/2018
I	Granados-Layoso, Samantha K.,FNP-BC	1871281949	SPEC		Pacific Skin Institute	Solano	Family Nurse Practitioner	American Nurses Credential	03/15/2023
I	Gray, Wade J.,MD	1508861782	PCP		Mendocino Coast Clinic	Mendocino	Family Medicine	ABMS of Family Medicine	07/09/1993
I	Greentree, David M., MD	1972208023	SPEC		Mercy Redding Heart Cente	Shasta	Thoracic Surgery	None	
R	Hall, Debra G.,NP	1700936655	PCP	09/13/2023	Ampla Health Chico Medica	Butte	Nurse Practitioner	None	
I	Hamblin, Basil C.,MD	1114095106	PCP		West Marin Medical Center	Marin	Family Medicine	ABMS of Family Medicine	07/11/2003
I	Harper, Keyani R.,Doula	1659264414	SPEC		Raya Health	Solano	Doula	None	
I	Harrington, Jeff RADT	1043976863	W&R		Recover Medical Group	Solano	Wellness and Recovery	California Consortium of Ad	09/01/2021
I	Heide, Aaron C.,MD	1891722773	SPEC		TeleMed2U	Placer	Neurology	ABMS of Psychiatry & Neur	05/12/2003
R	Her, Nou FNP-C	1013149996	PCP	09/13/2023	Adventist Health	Butte	Family Nurse Practitioner	American Academy of Nurse	04/23/2018
R	Hernandez, Christy L.,LVN	1255026761	W&R	07/12/2023	Hilltop Recovery Services -	Lake	Licensed Vocational Nurse	None	
I	Hicks, Wanda D.,FNP-BC	1033206545	PCP		UIHS - Potawot Health Villa	Humboldt	Family Nurse Practitioner	American Nurses Credential	06/29/2006
R	Hu, Calvin T.,MD	1093724635	SPEC	10/14/2020	Enloe Orthopedic & Trauma	Butte	Orthopaedic Surgery	ABMS of Orthopaedic Surge	07/23/2015
R	Hurtado-Reyes, Jacqueline BCBA	1881077949	BHP	09/25/2023	Autism Intervention Professi	Solano	Board Certified Behavior An	Behavior Analyst Certificatio	02/28/2018
I	Johnson, Jami N.,LM	1740713452	SPEC		Redwoods Rural Health Cer	Humboldt	Licensed Midwife	None	
R	Jones, Athena CADC I	1477102622	W&R	07/12/2023	Aegis Treatment Centers, LI	Shasta	Wellness and Recovery	California Consortium of Ad	09/05/2023
R	Kavanaugh, Pete R.,SUDRC II	1649974759	W&R	08/09/2023	Hilltop Recovery Services -	Lake	Wellness and Recovery	California Substance Use Di	03/24/2026
R	Keighley, Ember MD	1295025039	PCP	10/08/2014	Alliance Medical Center	Sonoma	Family Medicine	ABMS of Family Medicine	07/01/2014
I	Keller, Lisa K.,MD	1497780795	SPEC		Sutter Lakeside Community	Lake	Obstetrics and Gynecology	ABMS of Obstetrics and Gyr	12/31/1985
R	Ketchum, Molly S.,SUDCC II-CS	1831716588	W&R	07/08/2020	Empire Recovery Center	Shasta	Wellness and Recovery	California Substance Use Di	06/20/2026
R	Kime, Aaron M.,MD	1841635869	SPEC	07/12/2023	Adventist Health Physicians	Napa	Thoracic & Cardiac Surgery	ABMS of Thoracic Surgery	09/24/2021
R	Kira, David T.,MD	1689696411	SPEC	08/12/2020	Eye Site Sacramento	Yolo	Ophthalmology	ABMS of Ophthalmology	06/11/2006
I	Kiser, Heather M.,FNP-C	1861372898	PCP		Anderson Walk In Medical C	Shasta	Family Nurse Practitioner	American Academy of Nurse	09/23/2025
I	Kreitinger, Kimberly Y.,MD	1518494921	PCP		Stallant Health and Wellnes	Del Norte	Internal Medicine	ABMS of Internal Medicine	08/26/2020
I	Krinard, Alanna AMFT	1154142370	W&R		Drug Abuse Alternatives Ce	Sonoma	Associate Marriage and Fan	None	
I	Kumari, Anita MD	1518128222	SPEC		Providence Medical Group,	Humboldt	Hematology	ABMS of Internal Medicine	10/28/2015
R	Lara, Roberta CADC II	1043946379	W&R	08/09/2023	UIHS - Potawot Health Villa	Humboldt	Wellness and Recovery	California Consortium of Ad	02/04/2024
R	Lee, James F.,MD	1366476970	PCP	03/01/2001	River Bend Medical Associa	Yolo	Family Medicine	ABMS of Family Medicine	07/14/1995
I	Lehman, Ludivine Doula	1467252759	SPEC		Raya Health	Solano	Doula	None	
I	Levy, Joshua M.,MD	1265992168	PCP		Chapa-De Indian Health (Au	Placer	Family Medicine	ABMS of Family Medicine	07/01/2022
I	Lewis, Daniel G.,MD	1831278563	W&R		Transitions Clinic of Sacram	Sacramento	Internal Medicine	ABMS of Internal Medicine	09/13/1989

App. Ty	Full Name	NPI Number	Provider Type C	Inital Appmnt Date	Name/Street	County Name	Specialty Description	Board Name	Initial Cert Date
I	Lilly, Amanda BCBA	1346772183	BHP		Kadiant, LLC	Solano	BCBA	Behavior Analyst Certificatio	04/27/2022
R	Lim, Cynthia C.,MD	1093730301	PCP	09/14/2005	Concepcion & Lim M.D. Fan	Solano	General Practice	Meets MPCR#17, sufficient	
R	Lin, Andrew P.,MD	1689617565	SPEC	09/10/2008	NBHG: Center for Women's	Solano	Obstetrics and Gynecology	ABMS of Obstetrics and Gyr	11/12/1999
I	Lindgren, Jessica BCBA	1861156184	BHP		Maxim Healthcare Sevices I	Yolo	BCBA	Behavior Analyst Certificatio	01/16/2026
R	Loftis, Brent DO	1639348683	SPEC	07/08/2020	Brent Loftis MD	Napa	Dermatology	AOB of Dermatology	12/14/2011
I	Lor, Nina BCBA	1992221279	BHP		Learning Solutions Kids, Inc	Yolo	BCBA	Behavior Analyst Certificatio	05/04/2026
I	Lorah, Emily BCBA	1912888249	BHP		Roman Empire ABA Service	Solano	BCBA	Behavior Analyst Certificatio	06/24/2025
I	Louwrens, Neil A.,MD	1174621320	W&R		Visions of the Cross/ Wome	Shasta	Wellness and Recovery	None	
R	Luo, Caesar K.,MD	1669684072	SPEC	11/08/2017	Bay Area Retina Associates	Solano	Ophthalmology	ABMS of Ophthalmology	10/16/2011
I	Mabin, Carolina C.,FNP-BC	1770326449	BOTH		SCHC: Anderson Family He	Shasta	Family Nurse Practitioner	American Nurses Credential	04/29/2025
I	Maisterra, Nina A.,MD	1356497259	PCP		Alliance Medical Center	Sonoma	Family Medicine	ABMS of Family Medicine	07/12/2002
I	Malain, Rebekah L.,FNP-C	1760361133	PCP		SCHC: Anderson Family He	Shasta	Family Nurse Practitioner	American Academy of Nurse	07/15/2025
I	Manzo-Padilla, Sandra SLP	1811411804	Allied		Proficio Speech Therapy Gr	Placer	Speech & Language Pathol	None	
I	Maravilla, Irisbelle BCBA	1043712268	BHP		Kyo Autism Therapy LLC, fk	Marin	BCBA	Behavior Analyst Certificatio	08/01/2025
R	Marlow Lehrburger, Elizabeth D.,MD	1336568815	SPEC	09/09/2020	Bay Area Retina Associates	Solano	Ophthalmology	ABMS of Ophthalmology	09/21/2019
I	Martinez, Amanda BCBA	1649756529	BHP		Burnett Therapeutic Service	Napa	BCBA	Behavior Analyst Certificatio	04/08/2025
I	Masters, Chrishay T.,Doula	1720829526	SPEC		Raya Health	Solano	Doula	None	
R	Matel, Joseph R.,MD	1871792382	BOTH	10/08/2014	Santa Rosa Community Hea	Sonoma	Family Medicine	ABMS of Family Medicine	07/09/2009
R	Matheson, Donald M.,MD	1629060900	PCP	01/11/2012	Baechtel Creek Medical Clir	Mendocino	Family Medicine	Meets MPCR#17, Previously	08/27/1978
I	McDavit-Aron, Janice L.,Psy.D	1306493168	BHP		Jigsaw Diagnostics	Solano	BCBA	None	
I	McKenzie, Franceska R.,AMFT	1740117183	W&R		Recover Medical Group	Solano	Associate Marriage and Fan	None	
R	McLarty, Marcella R.,MD	1841295706	SPEC	09/13/2023	Adventist Health Howard Me	Mendocino	General Surgery	ABMS of Surgery	04/22/1996
I	Miley, William CADC II	1538001326	W&R		Recover Medical Group	Solano	Wellness and Recovery	California Consortium of Ad	04/06/2019
R	Miramontes, Natasha A.,MD	1770110058	PCP	09/25/2023	CommuniCare Ole - Davis (	Yolo	Family Medicine	ABMS of Family Medicine	07/01/2023
I	Miranda Olivera, Laura I., Psy.D	1003414855	BHP		Jigsaw Diagnostics	Solano	Behavioral Health	None	
R	Montague, Glenda L.,MD	1043508872	SPEC	08/09/2017	BASS Medical Group dba N	Napa	Otolaryngology,Head, and N	ABMS of Otolarynology - He	06/01/2017
R	Morgan, Jennifer SUDCC	1346864865	W&R		New Life Discovery Project	Shasta	Wellness and Recovery	None	
I	Mortensen, Lynn M.,MD	1588796700	PCP		Santa Rosa Community Hea	Sonoma	Family Medicine	ABMS of Family Medicine	07/09/1999
R	Moses, Marianne D., FNP-BC	1225317290	PCP		Ampla Health Magalia Medi	Butte	Family Nurse Practitioner	American Nurses Credential	09/12/2011
R	Mullick, Alpna MD	1285622837	PCP	09/13/2023	Ampla Health Yuba City	Sutter	Pediatrics	ABMS of Pediatrics	10/16/2001
R	Mulligan, Meagan K., FNP-BC	1093071078	PCP		Chapa-De Indian Health (Au	Placer	Family Nurse Practitioner	American Nurses Credential	11/18/2011
I	Najibi, Skender S.,MD	1295229441	PCP		One Community Health - Inf	Solano	Family Medicine	ABMS of Family Medicine	06/26/2021
R	Nallamothu, Ratnaji B.,MD	1407877608	SPEC	03/12/2003	Capital Nephrology Medical	Yolo	Nephrology	ABMS of Internal Medicine	11/03/1999
I	Oates, Andrea S.,FNP-C	1417884669	PCP		Ampla Health Chico Medica	Butte	Family Nurse Practitioner	American Academy of Nurse	01/09/2026
I	Ohkubo, Anandi S.,FNP-C	1912793977	SPEC		Redwood Orthopaedic Surg	Sonoma	Family Nurse Practitioner	American Academy of Nurse	01/28/2026
R	Oldach, Benjamin R.,DO	1366930893	SPEC	09/13/2023	Chapa-De Indian Health (Au	Placer	Addiction Medicine	ABMS of Preventive Medicir	01/01/2025
I	Olukoya, Funmi O.,FNP-C	1629307202	PCP		Lassen Indian Health Cente	Lassen	Family Nurse Practitioner	American Academy of Nurse	11/18/2015
R	Ong, Steven H.,MD	1225006349	SPEC	04/12/2006	Solano Kidney Care	Solano	Nephrology	ABMS of Internal Medicine	10/27/2005
I	Orlova, Natalia Doula	1093507006	SPEC		Raya Health	Solano	Doula	None	
I	Ortega, Veronica BCBA	1386384428	BHP		Pantogran LLC dba Center	Solano	BCBA	Behavior Analyst Certificatio	12/30/2024
I	Oskuie, Camellia BCBA	1700421658	BHP		Kyo Autism Therapy LLC, fk	Marin	BCBA	Behavior Analyst Certificatio	01/28/2025
R	Owens, Charles L.,Jr., CADC II	1568640142	W&R	06/10/2020	Visions of the Cross/ Wome	Shasta	Wellness and Recovery	California Consortium of Ad	01/29/2010
I	Palumbo, Angela BCBA	1932859196	BHP		Positive Behavior Supports	Yolo	Board Certified Behavior An	Behavior Analyst Certificatio	05/08/2026
R	Patel, Swati P.,MD	1437256120	SPEC	04/06/1994	East Bay Nephrology Medic	Solano	Nephrology	ABMS of Internal Medicine	11/06/1990
I	Pena, Manuel A.,PMHNP-BC	1083567283	SPEC		SCHC: Anderson Family He	Shasta	Psychiatric Mental Health Nu	American Nurses Credential	10/16/2025
I	Perryman, Stan C.,SUDCC	1689067894	W&R		Recover Medical Group	Solano	Wellness and Recovery	California Substance Use Di	03/18/2026
R	Petrick, Maria M., MD	1396743605	SPEC		FamilyCare Allergy & Asthm	Sonoma	Allergy & Immunology	ABMS of Allergy and Immun	10/14/2005
R	Philbin-Muldoon, Eileen M.,FNP-C	1073849162	PCP	09/25/2023	Santa Rosa Community Hea	Sonoma	Family Nurse Practitioner	American Academy of Nurse	09/01/2009
R	Price, Charles N.,DC	1457568867	SPEC	08/09/2023	Peach Tree Clinic - Spec	Yuba	Chiropractic	None	
R	Pundi, Ramesh S.,MD	1508099508	SPEC	08/09/2023	Ampla Health Lindhurst Mec	Yuba	Obstetrics and Gynecology	Meets MPCR #17, Verified F	
I	Rabadi, Najeb G.,SUDRC II	1538963186	W&R		Archway Recovery Services	Solano	Wellness and Recovery	California Substance Use Di	12/10/2025
R	Rafanov, Vladimir S.,MD	1477537413	SPEC	02/14/2001	Manzanita Medical Clinic	Placer	Neurology	ABMS of Psychiatry & Neurc	01/17/2000
I	Rattanapote, Marlayna E.,LPCC	1689816837	W&R		Recover Medical Group	Solano	Wellness and Recovery	None	

App. Ty	Full Name	NPI Number	Provider Type C	Inital Appmnt Date	Name/Street	County Name	Specialty Description	Board Name	Initial Cert Date
R	Reber, Brian A.,PA-C	1952338907	SPEC	10/08/2014	CK Derm	Shasta	Physician Assistant Certifiec	National Commission on Ce	12/29/1994
I	Reyes, Erika M.,BCBA	1447737978	BHP		Center for Social Dynamics	Solano	BCBA	Behavior Analyst Certificatio	02/26/2026
I	Ring, Mary M.,RD	1417192337	Allied		TeleMed2U	Placer	Registered Dietitian	Commission of Dietetic Reg	04/08/2005
I	Ritchie, Courtney B.,MD	1073176442	SPEC		Urogynecology Consultants	Placer	Urgynecology & Reconstruct	None	
R	Rivera, Christine S.,Psy.D	1316340474	SPEC	08/09/2023	Jigsaw Diagnostics	Solano	Psychology	None	
I	Rivera, Sharon BCBA	1134711443	BHP		Autism Learning Partners	Solano	Behavior Analyst	Behavior Analyst Certificatio	04/13/2022
I	Rockwell, Denise B.,Psy.D	1578829552	BHP		Burnett Therapeutic Service	Napa	Clinical Psychologist	None	
R	Roitman, Jay S.,DO	1366461220	PCP	08/09/2017	Dignity Health-Mercy Family	Shasta	Family Medicine	ABMS of Family Medicine	07/12/1991
I	Roth, Jill R.,MD	1962791947	SPEC		Clarity Pediatrics Medical Gi	Solano	Obesity Management	None	
R	Rubin, Oleg F.,MD	1790762763	SPEC	04/12/2006	Solano Kidney Care	Solano	Nephrology	ABMS of Internal Medicine	10/27/2005
I	Ryan, Marissa BCBA	1427633742	BHP		Family Behavior Solutions	Butte	BCBA	Behavior Analyst Certificatio	01/22/2026
I	Sabo, Anthony J.,DO	1386084283	SPEC		Trinity Community Health Cl	Trinity	Surgery	ABMS of Surgery	11/13/2024
I	Sandhu, Harkesh S.,MD	1457334062	SPEC		Advanced Wound Care & S	Solano	Wound Care	None	
R	Sarker, Upal MD	1083025365	PCP	09/13/2017	CommuniCare Ole- Vida Fa	Yolo	Family Medicine	ABMS of Family Medicine	04/19/2018
R	Saunders, Suzanne L.,CNM	1326195660	SPEC	07/12/2023	Mendocino Community Heal	Mendocino	Certified Nurse Midwife	American Midwifery Certifica	06/01/2015
I	Shahi, Kavian MD	1174509418	SPEC		Spine & Neurosurgery Asso	Placer	Neurological Surgery	ABMS of Neurological Surge	11/11/2005
I	Shank, Thomas A.,MD	1972130664	W&R		Transitions Clinic of Sacram	Solano	Addiction Medicine	None	
I	Shreve, Nicole M.,SUDRC I	1124956495	W&R		Visions of the Cross/ Wome	Shasta	Wellness and Recovery	California Substance Use Di	04/14/2026
I	Sinclair, Barbara A.,MD	1154430890	PCP		Alliance Medical Center	Sonoma	Family Medicine	ABMS of Family Medicine	07/14/1995
I	Slingwine, Rebecca L.,DO	1043665466	PCP		Open Door Community Heal	Humboldt	Family Medicine	AOB-Family Medicine	07/19/2019
I	Smith, Chad D., MD	1265602320	SPEC		Redding Rancheria: Churn C	Shasta	Urgent Care	None	
R	Stevens, Alinea S.,MD	1669817540	PCP	09/13/2023	Chapa-De Indian Health (Au	Placer	Family Medicine	ABMS of Family Medicine	11/19/2016
I	Strouse, Amy E.,DO	1164832721	SPEC		Interventional Pain Solutions	Butte	Physical Medicine & Rehabi	ABMS of Physical Medicine	07/01/2019
R	Susman, Kenneth R.,MD	1962551119	SPEC	01/11/2012	Kenneth R. Susman, MD	Mendocino	Surgery	ABMS of Surgery	04/22/1996
I	Taylor, Julie Doula	1447025325	SPEC		Let's Doula This, LLC	Solano	Doula	None	
I	Taylor, Rian Doula	1811884307	SPEC		Raya Health	Solano	Doula	None	
I	Tolani, Renuka N., DO	1457972820	SPEC		East Bay Nephrology Medica	Solano	Nephrology	ABMS of Internal Medicine	10/23/2025
I	Tong, Shuyi SLP	1669209078	Allied		Proficio Speech Therapy Gr	Solano	Speech & Language Pathol	None	
I	Torres, Sarah A.,Doula	1013619162	SPEC		Nueva Vida Doula LLC	Humboldt	Doula	None	
I	Tripaldi, Kaitan N.,Doula	1487507349	SPEC		Kaitan Tripaldi Holistic Doul	Mendocino	Doula	None	
R	Tunuguntla, Rashmi DO	1639543572	PCP	08/09/2023	Peach Tree Healthcare	Sutter	Pediatrics	ABMS of Pediatrics	10/18/2018
I	Turk, Rami J.,MD	1619155900	SPEC		Enloe Cardiology Services &	Butte	Cardiovascular Disease	ABMS of Internal Medicine	11/04/2009
I	Tyler, LaShawnna S.,FNP-C	1477354231	PCP		Elica Health Centers - Marys	Placer	Family Nurse Practitioner	American Academy of Nurse	12/30/2024
R	Ulloa, Brianda B.,PA-C	1770188468	SPEC	09/13/2023	TeleMed2U	Placer	Physician Assistant Certifiec	National Commission on Ce	10/15/2020
I	Ursem, Carling MD	1740555317	SPEC		Marin Cancer Care Inc.	Marin	Hematology	ABMS of Internal Medicine	10/30/2018
I	Varma, Allen K.,PMHNP-C	1508703224	PCP		Northeastern Rural Health C	Lassen	Psychiatric Mental Health Nu	American Academy of Nurse	02/27/2026
R	Vaughn, Kevin L.,PT	1447329834	SPEC	09/13/2023	Coast Physical Therapy and	Butte	Physical Therapy	None	
I	Villela, Kathy M.,SUDCC II	1588178354	W&R		Recover Medical Group	Solano	Wellness and Recovery	California Substance Use Di	01/13/2025
I	Vincent, Thelmisha BCBA	1306082011	BHP		Kadiant, LLC	Solano	BCBA	Behavior Analyst Certificatio	03/31/2007
I	Walker, Donald R.,SUDCC	1427851617	W&R		Recover Medical Group	Solano	Wellness and Recovery	California Substance Use Di	08/31/2025
I	Wallace, Angela D.,FNP-C	1972230738	PCP		SCHC: Anderson Family He	Shasta	Family Nurse Practitioner	American Academy of Nurse	03/21/2022
I	Wang, Yao PA-C	1346800349	BOTH		Generations Urgent Care PC	Shasta	Physician Assistant Certifiec	National Commission on Ce	06/06/2019
R	Warden, Kimberly C.,FNP-BC	1437238953	PCP	02/11/2009	CommuniCare Ole - Davis C	Yolo	Family Nurse Practitioner	American Nurses Credential	02/01/2016
I	Wendel, Robert T.,MD	1235234634	SPEC		Retinal Consultants Medical	Placer	Ophthalmology	ABMS of Ophthalmology	10/20/1984
R	Whipkey-Olson, Elizabeth J.,DO	1306870605	PCP	01/11/2012	Adventist Health Ukiah Valle	Mendocino	Family Medicine	ABMS of Family Medicine	07/27/2006
R	Wilbur, Erika L.,PT	1407914088	Allied	09/13/2023	Coast Physical Therapy and	Butte	Physical Therapy	None	
I	Williams, Kiyanna M.,MD	1487008751	SPEC		LA Laser Center PC Inc	Shasta	Dermatology	ABMS of Dermatology	10/24/2020
R	Winchell, Stacy P.,NP	1912937095	PCP	08/09/2023	Peach Tree Healthcare	Sutter	Nurse Practitioner	None	
R	Winoto, Johan MD	1780635920	SPEC	08/10/2011	Capital Nephrology Medical	Yolo	Nephrology	ABMS of Internal Medicine	11/04/2010
R	Wong, Bryan M., MD	1407953755	SPEC		East Bay Nephrology Medica	Berkeley	Nephrology	ABMS of Internal Medicine	11/11/1986
R	Wright, Hiedi M.,FNP-BC	1215629407	PCP	09/25/2023	Open Door Community Heal	Del Norte	Family Nurse Practitioner	American Nurses Credential	09/29/2022
I	Ye Tay, Joselyn M.,MD	1609515477	PCP		Mendocino Community Heal	Mendocino	Pediatrics	ABMS of Pediatrics	10/16/2025
I	Yoshida, Merin A.,DPM	1487965448	SPEC		Stallant Health and Wellnes	Del Norte	Podiatry	AB of Foot and Ankle Surge	

App. Ty	Full Name	NPI Number	Provider Type C	Inital Appmnt Date	Name/Street	County Nam	Specialty Description	Board Name	Initial Cert Date
R	Young, Aaron T.,MD	1942705827	SPEC	08/09/2023	Solano Kidney Care	Solano	Nephrology	ABMS of Internal Medicine	11/20/2023
R	Zamani, Hamed MD	1265758023	PCP	08/12/2020	OLE Health	Solano	Family Medicine	ABMS of Family Medicine	11/19/2011

App. Ty	Full Name	NPI Number	Board Certified	Hospital Name	Staff Cat Description
I	Alden, Brittany BCBA	1154848331	Yes		
R	Alfano, Amy A.,CNM	1588159776	Yes		
I	Ali, Nisreen F.,MD	1700272077	Yes	Admitting Agreement	None
I	Aliabadi, Hamidreza MD	1942474713	Yes	Sutter Roseville Medical Ce	Active
R	Ammar, Mustafa MD	1558363168	Yes	Adventist Health + Rideout	Active
I	Anderson, Charles K.,MD	1215191259	Yes	Admitting Agreement	None
I	Araujo, Luis BCBA	1922475318	Yes		
R	Arellanes, Carolyn L.,PA-C	1659501880	Yes		
R	Arvizu, Joshua A.,MD	1255968590	Yes	Admitting Agreement	None
R	Aung, Thinn T.,MD	1528050770	Yes	Admitting Agreement	None
I	Ayala, Jocelyn BCBA	1174006589	No		
R	Bacon, Allison D.,MD	1720254584	Yes	Admitting Agreement	None
I	Bader, Danielle SUDCC	1649676057	Yes		
R	Bajwa, Kulbir K.,MD	1912000126	Yes	NorthBay Medical Center/No	Active
I	Barrera-Calix, Jonathan MD	1356797864	Yes	Admitting Agreement	None
R	Berk, David R.,MD	1205045192	Yes	Admitting Agreement	Active
R	Bhavsar, Jessica M.,PA-C	1275877599	Yes		
I	Biradar, Shradha DO	1063161297	Yes	Admitting Agreement	None
R	Boparai, Nanak S.,MD	1225183221	No	Adventist Health + Rideout	Active
R	Borruso, Adam R.,FNP-C	1285931147	Yes		
R	Brenta, Marcia J.,NP	1710355607	No		
R	Breton, Jenna R.,NP	1427222538	No		
R	Brockington, Nancy S.,MD	1629119334	No	Admitting Agreement	None
R	Bromer, Steven P.,MD	1689671968	Yes	Admitting Agreement	None
I	Bronson, Derek C.,PA-C	1962932343	Yes		
I	Brooks, Lindsay BCBA	1821599572	Yes		
R	Carini, Renee M.,FNP-BC	1346287356	Yes		
I	Carpenter, Charles F.,MD	1457520462	Yes	Admitting Agreement	None
I	Carrillo, Gustavo PA-C	1114542255	Yes		
I	Casarez, Genesha BCBA	1841085735	Yes		
I	Casey, Alison Doula	1770450561	No		
I	Casillas-Ta, Brittany BCBA	1154899268	Yes		
R	Castillo, Lydia BCBA	1760952451	Yes		
R	Caufield, Desiree M.,SUDCC II	1568084754	Yes		
R	Chan, Vicky BCBA	1003487620	Yes		
I	Chang, Margaret A.,MD	1477504405	Yes	Mercy General Hospital of S	Active
I	Chokshi, Nikhil K.,MD	1942413018	Yes	Banner Lassen Medical Cen	Locum Tenens
I	Clancy, Morgan P.,APCC	1306775432	No		
R	Cline, Jerry M.,MD	1336126374	Yes	Adventist - Ukiah Valley	Active
R	Cokgor, Ilkcan MD	1235100603	Yes	Marin Health Medical Cente	Active
R	Cole, Deanna BCBA	1487124756	Yes		
I	Collins, Heather .,FNP-C	1215766753	Yes		
R	Cortez, Brandon J.,MD	1538521828	Yes	Admitting Agreement	None
R	Coulter, Pippa E.,MD	1033183777	Yes	Admitting Agreement	None
R	Crisp, Allison J.,DO	1710399118	Yes	Providence Queen of the Va	Active
I	Crowley, John D.,MD	1053476135	Yes	Admitting Agreement	None
R	Crummey, Daniel J.,SUDCC	1811673668	Yes		
I	Cuadra, German I.,DO	1215450739	Yes	Adventist - Ukiah Valley	Active
I	Curran, Jesse R.,MD	1164942827	Yes	Admitting Agreement	None
I	Curtis, Felicia L.,Doula	1285371872	No		
I	Doak, Darcy M.,SUDRC I	1194676791	Yes		
I	Donner, Barry S.,MD	1679534796	Yes	St Joseph Hospital	Provisional
R	Dow, Eliot R., MD	1740711647	Yes	Methodist Hospital of Sacra	Provisional

App. Ty	Full Name	NPI Number	Board Certified	Hospital Name	Staff Cat Description
R	Duncan, Jennifer A.,FNP-BC	1043495021	Yes		
R	Dzurella, Scott A.,FNP-C	1093153322	Yes		
R	Eaton, Mark H.,MD	1952353575	No	Admitting Agreement	None
I	Edelman, Tressa R.,FNP-BC	1578515961	Yes		
I	Edwards, Jessica I., DO	1265848121	Yes	Admitting Agreement	None
I	Elegino, Junali BCBA	1538663968	Yes		
I	Elison, Jasmine R.,MD	1740219583	Yes	Admitting Agreement	None
R	English, Brittany L.,FNP-BC	1770059750	No		
I	Fernando, Rajeev R.,MD	1952651382	Yes	Adventist - Ukiah Valley	Temporary
R	Figurski, Ann C.,DO	1790981132	Yes	Admitting Agreement	None
R	Finch, Kathryne BCBA	1619492634	Yes		
I	Flores, Samuel BCBA	1417421876	No		
I	Garcia, Krystal BCBA	1013486794	Yes		
R	Geller, Ryan BCBA	1164938668	Yes		
R	Ghassemi, Roxana BCBA	1164796702	Yes		
I	Ghazizadeh, Sayeh Psy.D	1679098875	No	None	
I	Gillette, Lexis D.,AGPCNP-BC	1821984311	Yes		
I	Girot, Chloe O.,Doula	1730868480	No		
R	Giusty, Lisa M.,PT	1649517152	No		
R	Goldberg, Roger A.,MD	1184866584	Yes	Alta Bates Summit Medical (	Active
R	Goldberger, Megan BCBA	1821715749	Yes		
I	Gordon, Jennifer C.,MD	1417362914	Yes	Admitting Agreement	None
R	Granados, Linda BCBA	1629554688	Yes		
I	Granados-Layoso, Samantha K.,FNP-BC	1871281949	Yes		
I	Gray, Wade J.,MD	1508861782	Yes	Admitting Agreement	None
I	Greentree, David M., MD	1972208023	No	Mercy Medical Center of Re	Active
R	Hall, Debra G.,NP	1700936655	No		
I	Hamblin, Basil C.,MD	1114095106	Yes	Petaluma Valley Hospital	Consulting
I	Harper, Keyani R.,Doula	1659264414	No		
I	Harrington, Jeff RADT	1043976863	Yes		
I	Heide, Aaron C.,MD	1891722773	Yes	Admitting Agreement	None
R	Her, Nou FNP-C	1013149996	Yes		
R	Hernandez, Christy L.,LVN	1255026761	No		
I	Hicks, Wanda D.,FNP-BC	1033206545	Yes		
R	Hu, Calvin T.,MD	1093724635	Yes	Enloe Medical Center	Active
R	Hurtado-Reyes, Jacqueline BCBA	1881077949	Yes		
I	Johnson, Jami N.,LM	1740713452	No		
R	Jones, Athena CADC I	1477102622	Yes		
R	Kavanaugh, Pete R.,SUDRC II	1649974759	Yes		
R	Keighley, Ember MD	1295025039	Yes	Sutter Santa Rosa Regional	Active
I	Keller, Lisa K.,MD	1497780795	Yes	Sutter Lakeside Hospital	Active
R	Ketchum, Molly S.,SUDCC II-CS	1831716588	Yes		
R	Kime, Aaron M.,MD	1841635869	Yes	Adventist Health - St. Helen	Active
R	Kira, David T.,MD	1689696411	Yes	Mercy General Hospital of S	Courtesy
I	Kiser, Heather M.,FNP-C	1861372898	Yes		
I	Kreitinger, Kimberly Y.,MD	1518494921	Yes	Admitting Agreement	None
I	Krinard, Alanna AMFT	1154142370	No	None	
I	Kumari, Anita MD	1518128222	Yes	Admitting Agreement	None
R	Lara, Roberta CADC II	1043946379	Yes		
R	Lee, James F.,MD	1366476970	Yes	Methodist Hospital of Sacra	Courtesy
I	Lehman, Ludivine Doula	1467252759	No		
I	Levy, Joshua M.,MD	1265992168	Yes	Admitting Agreement	None
I	Lewis, Daniel G.,MD	1831278563	Yes	Admitting Agreement	None

App. Ty	Full Name	NPI Number	Board Certified	Hospital Name	Staff Cat Description
I	Lilly, Amanda BCBA	1346772183	Yes		
R	Lim, Cynthia C.,MD	1093730301	No	Admitting Agreement	None
R	Lin, Andrew P.,MD	1689617565	Yes	NorthBay Medical Center/ N	Active Attending
I	Lindgren, Jessica BCBA	1861156184	Yes		
R	Loftis, Brent DO	1639348683	Yes	Admitting Agreement	None
I	Lor, Nina BCBA	1992221279	Yes		
I	Lorah, Emily BCBA	1912888249	Yes		
I	Louwrens, Neil A.,MD	1174621320	No	Admitting Agreement	None
R	Luo, Caesar K.,MD	1669684072	Yes	John Muir Medical Center	Active
I	Mabin, Carolina C.,FNP-BC	1770326449	Yes		
I	Maisterra, Nina A.,MD	1356497259	Yes	Admitting Agreement	None
I	Malain, Rebekah L.,FNP-C	1760361133	Yes		
I	Manzo-Padilla, Sandra SLP	1811411804	No		
I	Maravilla, Irisbelle BCBA	1043712268	Yes		
R	Marlow Lehrburger, Elizabeth D.,MD	1336568815	Yes	John Muir Health Walnut Cr	Courtesy
I	Martinez, Amanda BCBA	1649756529	No		
I	Masters, Chrishay T.,Doula	1720829526	No		
R	Matel, Joseph R.,MD	1871792382	Yes	Admitting Agreement	None
R	Matheson, Donald M.,MD	1629060900	No	Admitting Agreement	None
I	McDavit-Aron, Janice L.,Psy.D	1306493168	No		
I	McKenzie, Franceska R.,AMFT	1740117183	No		
R	McLarty, Marcella R.,MD	1841295706	Yes	Adventist - Howard Memoria	Active
I	Miley, William CADC II	1538001326	Yes		
R	Miramontes, Natasha A.,MD	1770110058	Yes	Admitting Agreement	None
I	Miranda Olivera, Laura I., Psy.D	1003414855	No	None	
R	Montague, Glenda L.,MD	1043508872	Yes	Queen of the Valley	Active
R	Morgan, Jennifer SUDCC	1346864865	No	None	
I	Mortensen, Lynn M.,MD	1588796700	Yes	Admitting Agreement	None
R	Moses, Marianne D., FNP-BC	1225317290	Yes	None	
R	Mullick, Alpna MD	1285622837	Yes	Adventist Health + Rideout	Active
R	Mulligan, Meagan K., FNP-BC	1093071078	Yes	None	
I	Najibi, Skender S.,MD	1295229441	Yes	Admitting Agreement	None
R	Nallamothu, Ratnaji B.,MD	1407877608	Yes	Sutter Medical Center Sacra	Active
I	Oates, Andrea S.,FNP-C	1417884669	Yes		
I	Ohkubo, Anandi S.,FNP-C	1912793977	Yes		
R	Oldach, Benjamin R.,DO	1366930893	Yes	Admitting Agreement	None
I	Olukoya, Funmi O.,FNP-C	1629307202	Yes		
R	Ong, Steven H.,MD	1225006349	Yes	NorthBay Medical Center/No	Active Attending
I	Orlova, Natalia Doula	1093507006	No		
I	Ortega, Veronica BCBA	1386384428	Yes		
I	Oskuie, Camellia BCBA	1700421658	Yes		
R	Owens, Charles L.,Jr., CADC II	1568640142	Yes		
I	Palumbo, Angela BCBA	1932859196	Yes		
R	Patel, Swati P.,MD	1437256120	Yes	Alta Bates Summit Medical	Active
I	Pena, Manuel A.,PMHNP-BC	1083567283	Yes		
I	Perryman, Stan C.,SUDCC	1689067894	Yes		
R	Petrick, Maria M., MD	1396743605	Yes	Admitting Agreement	None
R	Philbin-Muldoon, Eileen M.,FNP-C	1073849162	Yes		
R	Price, Charles N.,DC	1457568867	No		
R	Pundi, Ramesh S.,MD	1508099508	No	Admitting Agreement	None
I	Rabadi, Najeb G.,SUDRC II	1538963186	Yes		
R	Rafanov, Vladimir S.,MD	1477537413	Yes	Admitting Agreement	None
I	Rattanapote, Marlayna E.,LPCC	1689816837	No		

App. Ty	Full Name	NPI Number	Board Certified	Hospital Name	Staff Cat Description
R	Reber, Brian A.,PA-C	1952338907	Yes		
I	Reyes, Erika M.,BCBA	1447737978	Yes		
I	Ring, Mary M.,RD	1417192337	Yes		
I	Ritchie, Courtney B.,MD	1073176442	No	Admitting Agreement	None
R	Rivera, Christine S.,Psy.D	1316340474	Not Applicable		
I	Rivera, Sharon BCBA	1134711443	Yes		
I	Rockwell, Denise B.,Psy.D	1578829552	No		
R	Roitman, Jay S.,DO	1366461220	Yes	Mercy Medical Center of Re	Active
I	Roth, Jill R.,MD	1962791947	No	Admitting Agreement	None
R	Rubin, Oleg F.,MD	1790762763	Yes	NorthBay Medical Center/Nc	Active Attending
I	Ryan, Marissa BCBA	1427633742	Yes		
I	Sabo, Anthony J.,DO	1386084283	Yes	Admitting Agreement	None
I	Sandhu, Harkesh S.,MD	1457334062	No	Admitting Agreement	None
R	Sarker, Upal MD	1083025365	Yes	Admitting Agreement	None
R	Saunders, Suzanne L.,CNM	1326195660	Yes		
I	Shahi, Kavian MD	1174509418	Yes	Sutter Roseville Medical Ce	Active
I	Shank, Thomas A.,MD	1972130664	No		
I	Shreve, Nicole M.,SUDRC I	1124956495	Yes		
I	Sinclair, Barbara A.,MD	1154430890	Yes	Admitting Agreement	None
I	Slingwine, Rebecca L.,DO	1043665466	No	Providence St. Joseph Hosp	Provisional
I	Smith, Chad D., MD	1265602320	No	Admitting Agreement	None
R	Stevens, Alinea S.,MD	1669817540	Yes	Admitting Agreement	None
I	Strouse, Amy E.,DO	1164832721	Yes	Admitting Agreement	None
R	Susman, Kenneth R.,MD	1962551119	Yes	Mendocino Coast District Hc	Active
I	Taylor, Julie Doula	1447025325	Not Applicable		
I	Taylor, Rian Doula	1811884307	No		
I	Tolani, Renuka N., DO	1457972820	Yes	Admitting Agreement	None
I	Tong, Shuyi SLP	1669209078	No		
I	Torres, Sarah A.,Doula	1013619162	No		
I	Tripaldi, Kaitan N.,Doula	1487507349	Not Applicable		
R	Tunuguntla, Rashmi DO	1639543572	Yes	Admitting Agreement	None
I	Turk, Rami J.,MD	1619155900	Yes	Admitting Agreement	None
I	Tyler, LaShawnna S.,FNP-C	1477354231	Yes		
R	Ulloa, Brianda B.,PA-C	1770188468	Yes		
I	Ursem, Carling MD	1740555317	Yes	Marin Health Medical Cente	Active
I	Varma, Allen K.,PMHNP-C	1508703224	Yes		
R	Vaughn, Kevin L.,PT	1447329834	Not Applicable		
I	Villela, Kathy M.,SUDCC II	1588178354	Yes		
I	Vincent, Thelmisha BCBA	1306082011	Yes		
I	Walker, Donald R.,SUDCC	1427851617	Yes		
I	Wallace, Angela D.,FNP-C	1972230738	Yes		
I	Wang, Yao PA-C	1346800349	Yes		
R	Warden, Kimberly C.,FNP-BC	1437238953	Yes		
I	Wendel, Robert T.,MD	1235234634	Yes	Dignity Health Medical Foun	Active
R	Whipkey-Olson, Elizabeth J.,DO	1306870605	Yes	Adventist - Ukiah Valley	Active
R	Wilbur, Erika L.,PT	1407914088	No		
I	Williams, Kiyanna M.,MD	1487008751	Yes	Admitting Agreement	None
R	Winchell, Stacy P.,NP	1912937095	No		
R	Winoto, Johan MD	1780635920	Yes	Methodist Hospital of Sacra	Active
R	Wong, Bryan M., MD	1407953755	Yes	Alta Bates Summit Medical (	Active
R	Wright, Hiedi M.,FNP-BC	1215629407	Yes		
I	Ye Tay, Joselyn M.,MD	1609515477	Yes	Admitting Agreement	None
I	Yoshida, Merin A.,DPM	1487965448	No	Admitting Agreement	None

App. Ty	Full Name	NPI Number	Board Certified	Hospital Name	Staff Cat Description
R	Young, Aaron T.,MD	1942705827	Yes	NorthBay Medical Center/ N	Active
R	Zamani, Hamed MD	1265758023	Yes	Admitting Agreement	None

4665 Business Center Drive
Fairfield, California 94534

MEETING Minutes

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

Date: 7/21/2026 **Time**: 7:30 a.m. – 9:00 a.m.

Facilitator: Mohamed Jalloh, Pharm D

Coordinator: Bethany Hannah

Meeting Locations:

- Webex

Attendees: Aaron Brincko; Amanda Harrison; Anna Cambell; Anthony Sackett; Ben Spencer; Brandon Yadi; Candy Stockton; Bethany Hannah; Christine Smith; Dawn Cook; Denise Whitsett; Denise Rivera; Emily Wellander; Folo Akintan; Hannah O'Leary; Jesus Hermosillo; Kermit Jones; James Devan; Juan Godinez; Katherine Barresi; Kimberly Robertello; Kory Watkins; Kristine Gual; Lisa Wada; Liz Romero; Liat Vaisenberg; Manleen Randhawa; Mark Bontrager; Mark Netherda; Marshall Kubota; Michele Grupe; Melissa Schumann; Mohamed Jalloh, PharmD; Monika Brunkal; Naz Sattari; Nicole Curreri, MPH CHES; Rod Grace; Roni Schultz; Shahrukh Chishty; Shantal Shamoiel; Sunshine Jackson; Sydni Aguirre; Valerie Padilla; Stan Leung, Sue Lee; Robert Moore, MD; Sue Quichocho; Tiffany Tryan; Tony Hightower; Vicky Klakken; 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;; 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; Bridget Gast; Dana Codron; Monica Ferguson; Priscila Ayala; Katheryn Power, Wendi Davis; Monica Ferguson; Chloe Ungaro; Kristina Coester; Ledra Guillory; Lisa Wada; Tiffani Thomas; Chloe Ungaro; Kristina Coester; Ledra Guillory; Dana Constantino; Sydni Aguirre; Eugene Durrah; Eva Julian; Jeffrey DeVido; Kelly YoungsStone; Liz Romero; Amanda Kim; Arlene Pena; Cathryn Couch; DeLorean Ruffin, DrPH, MPH; Isaac Brown; Jason Cunningham; Leila Romero; Lilly Merino

4665 Business Center Drive
Fairfield, California 94534

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	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	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 -	Lake County	Public Health Department	X	X	X		

Health Equity							
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	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	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 5 external members attended. C. Motion to approve meeting minutes from May 2026. 1st: Candy Stockton 2nd Valerie Padilla	Motion to approve meeting minutes from May 2026. 1st: Candy Stockton 2nd Valerie Padilla

Agenda Topic	Notes	Action Item
Agenda Item 2 **CMO Health Plan Updates** *Speaker: Kermit Jones MD, JD on behalf of Robert Moore, MD, MPH, MBA*	A. Organization updates are divided into 3 main areas; external factors and responses, internal strategies to improve quality, and compliance modernization initiatives that we are undergoing. B. On June 11th CMS released new guidance on its 1115 Medicaid demonstration budget neutrality policy that came into effect with HR1 last year. HR1 established the first statutory requirement for Medicaid 115 budget neutrality. The CMS guidance is designed to give states early notice of budget neutrality changes. This means that with this statute for the first time budget neutrality is codified in federal law. It is a requirement that the CMS Chief Actuary needs to certify that a section of 1115 demonstration is budget neutral before approval. The secretary may not approve new demonstrations or renew existing ones on or after January 1st, 2027, absent that certification. C. California has multiple years long section 1115 demonstrations. One example of this is the CalAim 1115 waiver demonstration which was approved December 2021 and is effective until December 31st of this year. Falling under CalAim are the community supports in lieu of services, housing navigation, incubative care, ECM, and justice involved reentry initiatives among others. D. The BH connect, approved in 2024 which is the behavioral health community-based organization networks of equitable care and treatment, which was DHCS's effort to build out community based behavioral health continuum for MediCal members with serious mental health illnesses and serious emotional disturbances. E. The practical effect of these certification requirements is that at the state level it is going to result in increased documentation. States will have to invest in much more time and resources, there will be less financial flexibility, fewer activities will be accepted.	

Agenda Topic	Notes	Action Item
	F. Internally, Partnership Health Plan is nearing completion of its organization wide plan for quality, 2026-2029. In broad strokes, the purpose of this plan is to improve outcomes with our members, strengthen relationships with providers, align across departments within QI, and focus on greater quality impact in the communities we serve. G. With the modernization aspects of the organizational updates, a new claims processing system, HRP will be implemented.	
Agenda Item 3 **HEO Health Plan Health Equity Updates** *Speaker: Mohamed Jalloh, Pharm.D*	A. New guidance from CMS regarding HR1 for work requirements. Many of these requirements have been published regarding what are going to the requirements for these upcoming years. B. Community reinvestment: The health plans are obligated to reinvest a certain amount of their net income back into the community. $10 million that Partnership will be giving to its 14 counties. This is based on Partnership's 2024 net income. As of now, we have reviewed the information that the state has provided and met with respective counties, guiding them as well as encouraging them to work with their county leaders, specifically behavioral health and public health directors, they are ultimately the ones who have to sign off for each county's respective amount for community reinvestment. C. We have provided the funding amounts to the county leaders, as well as providing guidance on what they should consider. Counties had autonomy over choosing what they would decide, they have submitted that to Partnership and Partnership is in the process of getting ready to package it and submit it to DHCS. D. Dr. Jalloh directs the group to review the Committee Charter. Candy Stockton asks to clarify whether new members joining the committee would be subject to a majority vote. Dr. Jalloh clarifies that we would at least have a motion to vote someone in, and that they were likely	Motion to approve the Charter contingent on policy notating Simple Majority Vote for including new committee members and clarification of which types of analyses QIHEC will review. 1st: Candy Stockton 2nd Denise Whitsett

Agenda Topic	Notes	Action Item
	endorsed by a current QIHEC member. Candy suggests a simple majority vote or an endorsement from someone on the committee and she wants to clarify what is required in the vote. Dawn Cook asks to clarify who is responsible for analyzing and evaluating the results, to which Dr. Jalloh clarified that QIHEC is responsible for analyzing and evaluating the results of QI and Health Equity activities. Dawn feels there is a word or two missing that make it unclear. Dr. Jalloh suggests to separate those statements into two sentences.	
Agenda Item 4 **Tribal Engagement workgroup updates** *Speaker: Sunshine Jackson*	A. The Tribal Perinatal Program's goal is to support Tribal communities to achieve the best possible outcomes for Native Americans in Northern California. There are now 8 Tribal Health Programs fully contracted and 2 contracts in process. This upcoming year TPP will focus on PPC 1st visit within 21 days and two postpartum visits. B. Sunshine is working on a Partnership Prenatal and Postpartum Passport. She is also in the process of planning a Tribal Maternal Photoshoot. Sunshine is also working with Dr. Townsend to develop a detailed PP presentation that uses real-life PHPS case scenario to help TPP's better understand the services available through the program. Additionally, Sunshine is setting up a Tribal Perinatal Program Collaborative. C. This year we are holding a 4th Annual Partnership HealthPlan Tribal Convening. The convening will focus on vaping prevention and smoking cessation. Tribal singers from Butte County will provide the opening blessing and welcome. Dr. Cutcha Risling-Baldy, Daniel Calac and Roland Moore have confirmed as keynote speakers. Virgina Hedrick(California Rural Indian Health Board CEO) and Andrea Zubitate(Chief of the Office of Tribal Affairs) are presenting as well. There will be breakout sessions with Tribal Health programs. There will also be a Elder/Youth Panel. D. Medi-Cal & Partnership updates affecting Tribal Health:	

Agenda Topic	Notes	Action Item
	• Legislative update • TPP & other OB/GYN updates • QI/PI initiatives and presentation on Colorectal Project • HEDIS/Health Equity • CalAIM updates E. CMO updates: • BH: Traditional healing • Patient Experience • Partnership Leadership Academy F. Awards: • Most Improved & Highest Score QIP • Small but Mighty QIP • Maternal & Child Health Champion • Traditional Healing Integration • Excellence in Patient Care • Tribal Advocacy G. Sunshine states that they are being very intentional this at this years convening and will hire indigenous caterers and will have indigenous artwork on the SWAG.	
Agenda Item 5 **Grand Analysis** *Speaker: Hannah O'Leary*	A. Hannah reviews findings from the Population Health 2025 Impact Analysis. . • This grand analysis does not include the Population Program Description, Strategy, or the Annual Plan as in the previous year and was notated to be included in a future meeting. B. The Growing Together Program has 3 pillars: • Healthy Babies (0-30 months) • Healthy Kids (ages 3-6)	

Agenda Topic	Notes	Action Item
	• Perinatal program (covers prenatal and postpartum period) C. Engaged members - members who qualified for the program, reached by phone and opted in to program participation • Declined – members who qualified for the program, reached by phone, and opted against program participation • Left message – members who qualified for the program, did not answer the phone, and were left a voice message encouraging a behavior • Unable to reach – members who qualified for the program but were not able to be reached via phone • Not referred - members who qualified for the program retrospectively but were not identified prospectively for campaign inclusion D. Partnership offers the Growing Together Prenatal outreach campaign, enrolling members identified as pregnant to receive targeted program outreach and support. PHM staff contacts these members and offers engagement in a campaign that supports prenatal care, reinforces the importance of Tdap vaccinations during pregnancy, and reminds them of the importance of post-partum care, as well as well-child visits and vaccinations in the first months following delivery. E. In addition to Partnership's Growing Together Prenatal outreach campaign, Population Health offers a campaign for members after delivery to encourage them to attend post-partum care visits as well as encourages early entrance to care by bringing their child to well-baby visits. F. The goal was for 75% of engaged members to attend a postpartum visit within 60 days of delivery. Postpartum visit attendance exceeded	

Agenda Topic	Notes	Action Item
	the goal at 79% among engaged members. Engagement clearly drives better outcomes, as all other groups performed significantly lower. G. Goal 2 is to attend a well child visit within the first 60 days of life. The target was met with a 76% completion rate among engaged members. Engagement again showed a strong positive impact, with higher rates than other groups. Unlike other measures, we didn't see significant differences across racial groups here, suggesting a more uniform effect. Overall, this is another strong indicator that the program is working. H. Population Health enrolls infants under 24 months of age in the Healthy Babies Growing Together Program the month they become Partnership members. The program provides health education and promotion of well-child visits and the importance of timely vaccinations to support the child's lifetime of immunity. Incentives are also offered for completing well-care visits with immunizations throughout the duration of the program. I. Healthy Babies goal outcome: 80% of engaged members will complete 50% or more of their vaccinations during the program period. This goal was met at 83% of engaged members. Goal 2: 65% of engaged members would be compliant with well-child visits. The goal was met at a rate of 89% compliance. Goal 3 J. This was the most ambitious Healthy Babies goal, completing *all* well-child visits, and engaged members exceeded the target by a wide margin, achieving a 60% completion rate. The 26-point gap between	

Agenda Topic	Notes	Action Item
	engaged and unreachable families reinforces that engagement is the key lever. While overall performance is strong, recurring equity differences point to opportunities for more tailored outreach. K. The biggest gap is around contact and not program effectiveness . L. For Healthy Babies vaccinations, engaged members achieved an 83% completion rate, the highest of any group. All other categories performed significantly worse, including members who were not referred. Even voicemail contact improved outcomes, but live engagement clearly drives the strongest results. M. 60% of families who engaged with the outreach team completed all recommended visits, the highest rate by far. N. The Healthy Kids program aims to reach all children between the ages 3 through 6 that have not had a well-child visit in the last 11 months or longer. Once identified, these members are offered an incentive to encourage the completion of their annual well-child visits prior to their next birthday. O. Healthy Kids goals outcomes: The first goal for this intervention is for 50% of members engaged in the program to have a well-child visit within 120 days of the phone call outcome referred to as “Agreed to Participation.”	

Agenda Topic	Notes	Action Item
	P. Goal 1: 70% of engaged members will have a well-child visit between July 2024 – June 2025. This goal was met at a rate of 80%. Engaged members had a statistically significantly higher rate of completing well child visits than any of our other campaign categories. Q. Transitional Care Services (TCS) focuses on members who are transitioning across settings or benefit structures with a high-risk of poor outcomes. R. The criteria for members identified (Adults) are > 20 and are discharging home from an inpatient admission with any length of stay and meet the criteria for high-risk transitioning members. (Pediatric) criteria are under age 21 and discharging home from an inpatient stay with an admission date > 60 days from their date of birth and having any length of stay. S. The program is performing well from a member experience standpoint, demonstrating effective care transitions and strong care team impact. T. Transitional Care Services Goals: Goal 1 is that 75% of members surveyed agree with each statement of the Adult TOC or TCS satisfaction Survey. This goal was met. Goal 2 is that 75% of members surveyed agree with each statement of the Pediatric TCS satisfaction survey. This goal was also met.	

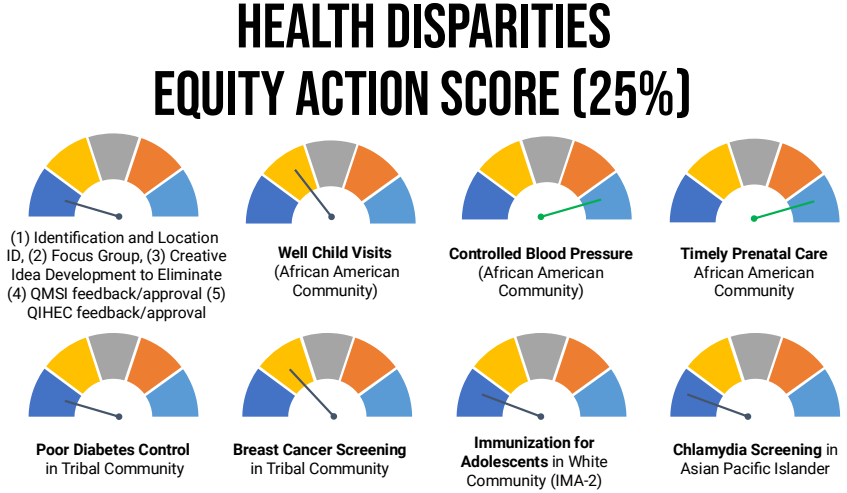
Agenda Topic	Notes	Action Item
	U. Complex Case Management is support for members who have multiple chronic conditions, social determinants of health barriers and/or have difficulty navigating the healthcare system without the intensive support of a care coordinator and an individualized care plan. The criteria for members is that they have multiple chronic conditions, social determinants of health barriers and/or difficulty navigating the healthcare system, and/or CCS condition. Member satisfaction with the complex case management program is ascertained via telephonic survey by a Partnership designee either annually (for multi-year interventions) or upon case closure, if the case is active for less than one year. V. Complex case management goals: Goal 1 is that 75% of members surveyed agree with each statement of the Adult CCM satisfaction survey. This goal was met. Goal 2 is that 75% of members surveyed agree with each statement of the Pediatric CCM satisfaction survey. This goal was met. W. Lessons learned have shown that the most effective programs utilize multiple modalities of reaching members, such as combining mailings with phone calls and with incentives to maximize engagement. A significant finding that has carried on through 2025 is feedback from members about the ongoing challenges around scheduling well child visits due to the lack of provider availability to serve the member population in a timely manner.	

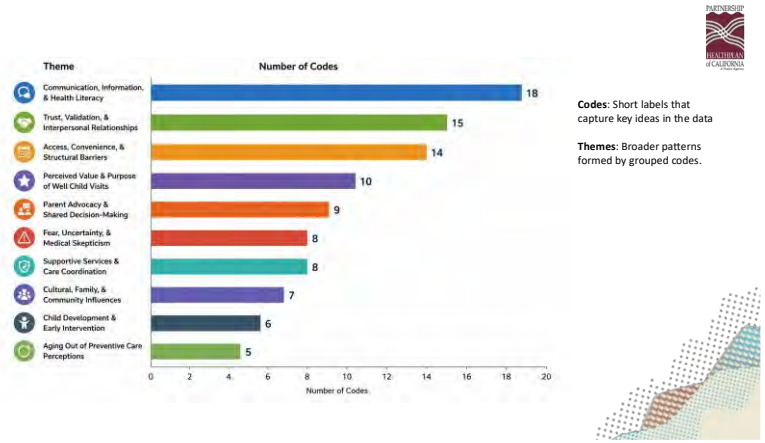
Agenda Topic	Notes	Action Item
Agenda Item 6 **Grand Analysis discussion and vote** **Speaker: All**	A. Marshall Kubota shares feedback that you can't stratify a historic group retrospectively, but you can take the total group data after the intervention and compare it to no intervention. Candy Stockton comments that if we are focusing on cost effective interventions, we need to be careful not to confirm our own biases.	Motion to approve the inclusion of an additional analysis of a total group historical data comparison 1st Candy Stockton 2nd Valerie Padilla Motion to approve the 2025 Grand analysis. (Population Health) 1st Candy Stockton 2nd Valarie Padilla
Agenda Item 7 **Behavioral Health Presentation** *Speaker: Brandon Yadi*	A. Starting with the Access Line, Back in 2025, Partnership made a decision to bring some member-facing responsibilities in-house instead of leaving them fully with Carelon Behavioral Network — that included access, care coordination, G&A, and UM. B. The goal was to directly improve the experience our members were having while at the same time making sure the referrals going into the network were actually good ones – because that increases chances of closing the loop on a referral.	*Motion to approve the Grand Analysis.(Behavioral Health)* *1st Candy Stockton* *2nd Denise Whitsett*

Agenda Topic	Notes	Action Item
	C. Outreach and Education: The goal is to engage staff and providers in promoting service delivery, and most importantly, making sure our members actually understand their mental health benefits. A lot of underutilization isn't about access; it's that people just don't know what's available to them. D. Each year will start with a utilization review to spot disparities and service gaps. The review tells where to focus for the upcoming year. Then the review and action plan are put together in an annual report, which goes to DHCS every year . E. Member Experience is more formally addressed through NCQA measure ME7 E&F, where the health plan is reviewed against 2 areas: grievance & appeals and member survey. F. The cycle looks like: distributing questions through an annual member experience survey, review G&A data for behavioral health, and bring both data sources together to write a Grand Analysis Report. G. DHCS requires us to do an annual utilization assessment for non-specialty mental health, identify where utilization is low, and build a outreach plan to close those gaps. H. For 2026, input was received from several different groups; the Consumer Advisory Committee, the Quality Improvement Health	

Agenda Topic	Notes	Action Item
	Equity Committee, PCPs through an engagement survey, and our Tribal partners. I. PCP engagement around a new BH Access Line, perinatal mental health outreach, community events, and specific work in Modoc County around school-based referral coordination for youth. Sierra County is also exploring MH telehealth through their County Office of Education. And social media and text campaigns are running throughout the year. J. Data capture: dividing utilization by race and ethnicity, collect SDoH and demographic data, and separating survey results by population. K. Targeting strategy: looking at underutilization by demographic and by county, Tribal outreach and hold an annual convening, and building language and cultural responsiveness directly into our messaging . L. Interventions: the text messaging pilot in Solano and Modoc, follow-up outreach for members after an ED discharge, quarterly social media and in-person MH fair presence, and monthly COE meetings along with Tribal outreach. M. Utilization trends : non-specialty mental health utilization rose to 8.6% in 2024, up from 7% in 2023. With adding specialty mental health, utilization climbs past 12%, compared to 9% in 2023. And when primary care data is added in too, there is an even bigger jump —	

Agenda Topic	Notes	Action Item
	which likely reflects the safety-net role our medical system is supporting our members who aren't otherwise directly engaging BH services. N. Breakdown by race and ethnicity: White members have the highest utilization at 12%. Asian members have the lowest, at 1.7%. Hispanic members sit at 6.4%. Black members increased slightly to 7.6% in 2024, up from 5% the year before. Native American members — utilization jumped to 10.2% in 2024, up from 5.5% in 2023 O. Geographically: Shasta County has the highest utilization at 15%. That's likely driven by strong FQHC-integrated behavioral health there, plus North American Mental Health Services has a large clinic in-county. Modoc County is one of our lowest utilizers at 3.5%, P. Candy Stockton asked if we had more mental health support services which look like the communities that we served. Brandon didn't have that data but will circle back and see if that is something they have implemented in the last year or so. Q. Dr. Kubota would like some data about Spanish speaking behavioral health practitioners and PHC panels.	

Agenda Topic	Notes	Action Item
Agenda Item 8 **Health Equity Tracker** *Speaker: Mohamed Jalloh, Pharm.D*	A. Dr. Jalloh shared the Health Disparities Equity Action Score.  	
Agenda Item 9 **Health Equity Policy Review** *Speaker: Mohamed Jalloh, Pharm.D*	A. Dr. Jalloh shares the QIHETP program description. B. The Program Description Name was changed from the "Quality Improvement and Health Equity Transformation Program Description" to the "Health Equity and Community Reinvestment Strategy and Program Description" to increase ease of communication to internal team members C. Health Equity Accreditation Name Change on Page 10: The Program Description changed the NCQA HEA name to HOA to reflect NCQA's changes. D. Quality Improvement Priorities on Page 11, 13: The Program Description was updated to include the top Quality Improvement Priorities and how Partnership clarified it's health disparity priorities. E. Health Disparity Measures on Page 14: The Program Description was updated to reflect which annual QIHETP administrative measures will	*Policy will be sent out, and will be discussed as old business in the next meeting due to low amount of time to review.*

Agenda Topic	Notes	Action Item
	be measured per department (e.g. Quality Improvement, Population Health, Human Resources, etc) F. Community Reinvestment Updates on Page 17: The Program Description was updated to reflect the updated change of the community reinvestment management. Specifically, it was changed to reflect that Public Health Directors and Behavioral Health Directors per county will lead county selection efforts versus Partnership providing a specified list for the counties to pick. G.	
Agenda Item 10 **Focus Group Updates** **Health Disparities Action Review (Focus group and Project Updates** *Speaker: Jesus Hermosillo, MPH*	A. Jesus conducted two focus groups in the Fairfield region on the topic of Well Child Visits on 5/22/26 and 6/16/26.  B. Top themes that came out of the focus groups were: communication, information, and health literacy. C. Findings were that members don't connect with the term Well Child Visits, and don't understand the purpose of the visit. There is a lack of understanding of the purpose of these WCVs. Families that participate in WCVs don't really know that they are engaging in a WCV.	

Agenda Topic	Notes	Action Item
	D. Parents see these visits as not urgent. They don't know what to expect at these visits. Families are asking for some type of flyer that explains the WCV and a checklist that they could use during the WCV.	
Agenda Item 11 **Adjournment** *Speaker: Mohamed Jalloh, Pharm.D*	Next meeting: **September 15, 20267:30 a.m. - 9:00 a.m. PST**	

4665 Business Center Drive
Fairfield, California 94534

AGENDA ITEM: III.C.1
DATE: 09/09/2026

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

TO: Physician Advisory Committee

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

DATE: 09/09/2026

SUBJECT: Partnership Committee Memberships

Appointment

Physician Advisory Committee

Dr. Harry Ko, Family Medicine, Medical Director for Feather River Tribal Health, volunteers to serve as a PAC voting member.

His appointment as a voting member is recommended.

Contact

www.linkedin.com/in/harry-ko-9114364 (LinkedIn)

Top Skills

Flight Surgeon
Occupational Health
AAAHC

Harry Ko

Feather River Tribal Health Medical Director
Rochester, Michigan, United States

Summary

Chief of Operational Medicine and Executive Physician Leader responsible for the delivery of healthcare to over 47,000 USCG active duty and reserve members through the USCG health care system. Clinical supervisor over
43 Medical Clinics and 122 Sickbays (afloat and ashore) with over 1000 clinical staff members. Active management/oversight of Medical, Dental, Pharmacy, Behavioral Health, Nursing, Laboratory, and Physical Therapy services in addition to serving as the lead for USCG's Quality Assurance and Quality Improvement Programs, Remote Health and Readiness Program, USCG Medical and Dental Radiology Program, Flight Medicine, Dive Medicine, Maritime Medicine, and Contingency Support. Responsible for Healthcare Process Assessment Program to ensure continued quality healthcare delivery from all 43 clinics through triennial clinic inspections.
Continues to serve as a Family Physician and Flight Surgeon through intermittent coverage of clinics with clinical support needs.

Experience

Feather River Tribal Health, Inc.
Medical Director
June 2025 - Present (1 year 4 months)
Oroville, California, United States

U.S. Public Health Service Commissioned Corps
Family Physician
May 2006 - June 2025 (19 years 2 months)

U.S. Coast Guard
14 years 11 months

Chief, Operational Medicine
July 2020 - May 2025 (4 years 11 months)
Norfolk, Virginia, United States

Flight Surgeon
July 2015 - July 2020 (5 years 1 month)
Detroit, Michigan, United States

Flight Surgeon
July 2010 - July 2015 (5 years 1 month)
Traverse City, MI

Southcentral Foundation
4 years 10 months

Assistant Medical Director
September 2009 - June 2010 (10 months)

Family Physician
September 2005 - September 2009 (4 years 1 month)

US Navy
Family Physician
August 1999 - August 2005 (6 years 1 month)

Education

Western University of Health Sciences
Doctor of Osteopathy, Medicine

UC Irvine
Bachelor's degree, Biology, General · (1986 - 1991)

2027 ECM QIP Measurement Set Proposal

January 1, 2027 – December 31, 2027 (Incentive payout is quarterly)

Key: New Measure | Change to Measure | ~~Removed Measure~~

2026 Measures	Proposed 2027 Measures
Gateway Measure: Timely Reporting Providers are required to submit three monthly reports on or before their due date. Incentive: $100 per member per month Dollars earned are placed into an incentive pool. • 100% is placed in incentive pool if all reports are received on or before due date. • 50% is placed in incentive pool if all reports are received within one (1) week or five (5) business days past the due date. • Reports received after five (5) business days will not be eligible for an incentive pool or participation in program measures.	No changes
Measure 1: Care Plan and Release of Information (ROI) Forms Uploaded into PointClickCare within 60 Days Providers are required to upload a Care Plan and ROI forms into PointClickCare for all ECM enrolled members within 60 days of TAR request date. Targets: • Full credit: > 70% • Partial credit: 60% - 69% No reporting to Partnership is required.	No changes
Measure 2: Depression Screening Depression screening is required for all ECM enrolled members, ages 12 years and older. Targets: • Full credit: > 90% • Partial credit: 80% - 89% Providers will submit a quarterly screening template.	No changes

2027 ECM QIP Measurement Set Proposal

Measure 3: Blood Pressure Screening Blood pressure screening is required for all ECM enrolled members ages 18 years and older. Targets: • Full credit: > 80% • Partial credit: 70% - 79% Providers will submit a quarterly screening template.	No changes
Measure 4: Timely Review of ED / Admissions Notifications in PointClickCare **Part 1:** New ECM providers are required to set up the Notification Alerts function in PointClickCare by contacting PointClickCare® for assistance. Targets: • Full credit. • No partial credit **Part 2:** Providers are required to review ED/Admissions notifications received in PointClickCare® within 72 hours of receiving notifications. Targets: • Full credit: ≥ 70% • Partial credit: 60-69% No reporting to Partnership is required.	No changes

2027 EXT QIP Measurement Set Proposal

2027 Extended Care Center (EXT) QIP (January 1, 2027 – December 31, 2027)

Key: New Measure | Change to Measure | ~~Removed Measure~~

2026 Measures	Proposed 2027 Measures
Gateway Measures	
Gateway Measure 1: CMS Five-Star Overall Rating Points: N/A Target: 2 or more stars to be eligible for other program measures	No changes
Gateway Measure 2: California Immunization Registry (CAIR) Enrollment Points: N/A Target: CAIR enrollment required to be eligible for other program measures	No changes
Gateway Measure 3: Quality Assurance and Performance Improvement (QAPI) Plan Submission Points: N/A Target: Submission by 6/30/27: Full credit Submission between 7/1/27 - 12/31/27: 50% decrease Submission after 12/31/27 will result in gateway not met and ineligibility for other measures.	No changes
Clinical Domain	
Measure 1: Percentage of long-stay high-risk residents with pressure ulcers Points: 10 Target: Full Points: < 5.1% Partial Points: 5.1 - 5.3%	Target: Full Points: < 4.3% Partial Points: 4.3 - 4.5% 2026 Natl AVG: 4.6% 2026 CA AVG: 4.3%

2027 EXT QIP Measurement Set Proposal

Measure 2: Percentage of long-stay residents who lose too much weight Points: 10 Target: Full Points: < 4.3% Partial Points: 4.3 - 5.4%	Target: Full Points: < 4.0 % Partial Points: 4.0 - 5.1% 2026 Natl AVG: 5.2% 2026 CA AVG: 4%
Measure 3: Percentage of long-stay residents who needed and got a flu shot Points: 10 Target: Full Points: > 98.4% Partial Points: 93.5 - 98.4%	Measure 3: Percentage of long-stay residents who needed and got a flu shot *AND* successful entry into CAIR Target: Full Points: > 98.2% Partial Point: 95.6 - 98.2% 2026 Natl AVG: 95.5% 2026 CA AVG: 98.2%
Measure 4: Percentage of long-stay residents who received a vaccine to prevent pneumonia Points: 10 Targets: Full Points: > 98.5% Partial Points: 93.5 - 98.5%	Measure 4: Percentage of long-stay residents who received a vaccine to prevent pneumonia *AND* successful entry into CAIR Target: Full Points: > 98.6% Partial Point: 93.6- 98.6% 2026 Natl AVG: 93.5% 2026 CA AVG: 98.6%
Functional Status Domain	
Measure 5: Percentage of long-stay residents experiencing one or more falls with major injury Points: 10 Target: Full Points: < 1.7% Partial Points: 1.7 - 3.2%	Target: Full Points: < 1.6% Partial Points: 1.6 - 3.1% 2026 Natl AVG: 3.2% 2026 CA AVG: 1.6%
Measure 6: Percentage of long-stay residents who have or had a catheter inserted and left in their bladder Points: 10 Target: Full Points: < 1.2% No Partial Points	Target: Full Points: < 0.8% No Partial Points 2026 Natl AVG: 0.8% 2026 CA AVG: 0.8%
Resource Use Domain	
Measure 7: Number of hospitalizations per 1,000 long-stay resident days Points: 15 Target: Full Points: < 1.83% Partial Points: 2.17 - 1.83 %	Points: 10 Target: Full Points: < 1.90 Partial Points: 2.24 - 1.90 2026 Natl AVG: 1.90 2026 CA AVG: 2.25

2027 EXT QIP Measurement Set Proposal

Operations & Satisfaction Domain	
Measure 8: Health Inspection Star Rating Points: 10 Target: Full Points: 4 or more stars Partial Points: 3 stars	No changes
Measure 9: Staffing Rating Points: 15 Target: Full Points: 4 or more stars Partial Points: 3 stars	Points: 10
	ADD: Measure 10 – Health Equity Impact Analysis and Plan Facilities are required to submit an updated Health Equity Impact Analysis and Plan that addresses health disparity in at least one of the following measures listed below: • Percent of high-risk residents with pressure ulcers • Percent of residents who lose too much weight • Long-stay residents who needed and received a flu shot • Long-stay residents who received a vaccine to prevent pneumonia • Percent of residents experiencing one or more falls with major injury • Percent of residents who have/had a catheter inserted and left in bladder Points: 10 Target: Full Points No Partial Points Providers are required to submit analysis and plan by August 31, 2027. Partnership will review and notify facilities if approved or rejected. Logic: At Partnership, health equity means ensuring everyone has a fair and just opportunity to achieve optimal health. We recognize that many factors influence health outcomes and are committed to supporting the diverse communities we serve. Every patient deserves a high-quality healthcare experience, regardless of socioeconomic status, race, gender, or other identifying characteristics.

HQIP 2027 Measure Proposal

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

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

Key: Change to Measure Design || Proposed New Measure || Removed Measures

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

Programmatic Changes:

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

A. Revisions to Existing Measures:

Measure 8: Expanding Delivery Privileges

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

Specifications

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

Measure Requirement Targets

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

X-Large Hospitals with >100 LGA Beds:

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

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

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

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

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

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

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

Measure 9: Doula Support

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

Specifications

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

Phase Two Measure Requirements

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

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

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

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

Measure 13 Summary

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

Substance Use Disorder 7-day Follow-up After ED Visit (FUA) Specifications

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

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

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

Full Points Target (10 pts): > 32.60%
Partial Points Target (5 pts): Between 26.90 – 32.5 %
Hospital's percentages will be rounded to the nearest 10th.

B. New Measures/Returning Measures

Measure 10 - Hepatitis B Vaccination:

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

Hepatitis B Vaccination Measure Summary

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

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

Specifications

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

Specification for Hospitals Providing Maternity Services:

Numerator:

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

Denominator:

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

Measure 11 – ALSO & BLSO Certification Training:

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

Specifications

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

ALSO & BLSO Measure Summary

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

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

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

ALSO & BLSO Measure Target Requirements

Hospitals with Obstetrics:

Full Points Target (5 pts):

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

Partial Points Target (2.5 pts.):

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

Hospitals without Obstetrics:

Full Points Target (5 pts):

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

Patial Points Target (2.5 pts):

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

Measure 14 - Quality Improvement Capacity:

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

Measure 16 - California Hospital Compare:

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

Measure 17 – Health Equity

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

Health Equity Measure Summary

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

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

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

HCAI is responsible for providing public access to these reports and equity plans through its website, and participating hospitals are also required to post the reports on their own websites.

Health Equity Measure Requirements

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

C. Removal of Existing Measures for 2027

Increased Mammography Capacity

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

Vaccines For Children (VFC) Enrollment

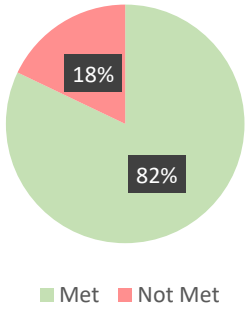
It is proposed to remove the Vaccines For Children (VFC Enrollment) and replace with the Hepatitis B Vaccination measure. This is consistent with what was planned for the measure from the beginning.

QI TRILOGY PROGRAM

Background: The QI Work Plan is designed to track progress on key Quality Improvement (QI) activities and initiatives throughout the year. Approved by our Board of Commissioners and quality committees, it includes progress updates on planned activities and objectives for improving quality of clinical care, safety of clinical care, quality of service and members' experience. The Work Plan is set on a FY 2025-2026 schedule. This update includes progress on activities included in the FY 2025-2026 QI Work Plan from July 1, 2025, to June 30, 2026.

Of the 72 goals outlined in the QI Work Plan, 59 were complete, 9 were terminated, and 4 were delayed or incomplete.

Goal Status July 1, 2025 – June 30, 2026		
Status	**Total Number:**	**%**
Met	59	82%
Not Met	13	18%



QI Major Milestones and Activities:

- The Perinatal Quality Incentive Program (PQIP) supported providers with onboarding and ECDS implementation to satisfy programmatic gateway measure (ECDS). The Perinatal QIP team worked closely with both the DataLink vendor and participating providers, resulting in successful data extraction for 29 of the 33 providers.
- The Palliative Care Quality Incentive Program (PC QIP) revised the PC QIP Data Validation Framework document to include the payment process for the new measure, Palliative Care Survey, that will be replacing measure III Completion of Assessments and Use of the PCQC Tool, along with making any necessary revisions to the payment processes for measure I, Avoiding Hospital and Emergency Room admissions, and measure II, Completion of a POLST, to ensure these

processes reflect the enhanced validation that is conducted for payment processing accuracy and timeliness. The PC QIP Data Validation Framework document was implemented in the payment processing for 2025 measure period I (January-June).

- The HEDIS team significantly expanded their use of clinical data acquired through use of an NCQA Data Aggregator (DataLink) for MY2025 HEDIS measure rate generation, increasing participating practices from six (6) practices to over (30). DataLink will continue to be adopted by the Partnership network in 2026 onward as an important preparation step towards Electronic Clinical Data Systems (ECDS) measure readiness and support of CMS Interoperability Framework.
- The Member Safety Quality Investigations team reviewed and updated the Corrective Action Plan (CAP) monitoring tool and desktop to ensure it is effective and aligns with more directive CAP procedures.
- The Member Safety Quality Investigations team upgraded their Potential Quality Issue documentation system, SUGARCRM PQI app, from version 8 to version 14.
- The Site Review Inspections Team initiated a new process to monitor sites on two contact attempts to get members into the clinic within 120 days by having providers attest that they are meeting requirements to contact all new members to schedule and/or complete an Initial Health Appointment (IHA) within 120 days per APL 22-030 (Replaced with 26-001 as of January 2026). A desktop was written to maintain the new process for IHA tracking.
- The Site Review Inspections Team created a comprehensive directory of Medi-Cal Dental providers capturing provider type, staffing demographics, and estimated monthly patient volume with a desktop created to ensure that all information contained in the dental directory is accurate and consistently maintained. The directory has been key to understanding the overall capacity of the Denti-Cal dental system within the Partnership region, supporting Partnership's Care Coordination department in identifying dental providers for members, and is used to support updates to the Smile California provider directory. Annual outreach will be conducted with each dental location to confirm their details and make any necessary corrections to the directory.
- Pharmacy conducted a concurrent review of Latent Tuberculosis Infection (LTBI) medication treatments including 30-doses of isoniazid/rifapentine (1HP), 12-doses of isoniazid/rifapentine (3HP), 90-doses of isoniazid/rifampin (3HR), and 120-doses of rifampin (4R) was conducted and timely notification of all identified potential LTBI treatment regimen gaps, which result from late refill, non-adherence, inappropriate prescribing, and/or inappropriate dispensing were provided with 315 notification letters faxed to prescribers regarding identified treatment gaps for 295 members.
- The Primary Care Provider Quality Incentive Program (PCP QIP) reviewed its existing Data Validation framework to identify areas for improvement, based on learnings over the past year. This review involves confirming that data sources are clearly defined, with proper lineage and ownership established, and that validation

procedures include thorough checks for data completeness, accuracy, consistency, and timeliness. Check lists were created in conjunction with the PCP QIP Data Validation Framework document. Finance executive leadership will now be added to review during the payment validation process.

- The Quality Measure Score Improvement (QMSI) initiative successfully engaged four (4) measure-specific workgroups. Each workgroup monitored and reviewed measure performance, as data was available, identified and completed score improvement activities for all stated deliverables by the end of the fiscal year. Highlights include:
  1. Behavioral Health
     - Facilitated collaboration among Partnership's Behavioral Health, Care Coordination, Population Health, Pharmacy and Quality Improvement to monitor and evaluate the implemented interventions by the respective departments aiming to improve the BH measures scores.
     - Improved the percentage of provider notifications and follow-up for members with Serious Mental Health (SMH) diagnoses within 7 days of an Emergency Department (ED) visit. (DHCS-Non-Clinical PIP).
     - Worked with the County Department of Behavioral Health (DBH) to utilize SacValley MedShare Data Exchange for FUM (follow-up after mental illness) data.
     - Extended the Community Health Workers (CHWs) in Partner hospitals' Emergency Departments to the end of 2025.
     - Partnered with Counties to increase the percentage of members who received Peer Support Services (DHCS-Clinical PIP).
     - Improved the rate for the Follow-Up After Emergency Department Visit for Substance use (FUA) (DHCS Non-Clinical PIP).
  2. Chronic Diseases
     - Monitored, evaluated and improved the use of the diabetes management program offered by TeleMed2U. Looked at utilization data to decide if the program is showing success or if efforts for this measure should be focused elsewhere.
     - Educated providers on Colorectal Cancer screening modalities (such as FIT testing, Cologuard, Colonoscopy) to serve their unique population.
     - Promoted at-home blood pressure monitoring to improve hypertension control—educating providers on correct technique, encouraging regular logging, and supporting data sharing with care teams for timely follow-up.
     - Worked with UC Davis Cancer comprehensive center on a collaborative around strategies engaging clinics by county data around Colorectal Cancer to provide support and education for improvements to their workflows.
     - Implemented Kidney Health Evaluation for Patients with Diabetes as a QIP measure for the PCP QIP MY2026.
  3. Women's Health and Perinatal

- Explored aligning PPC Pre timeliness of prenatal care across Partnership's Perinatal QIP, HEDIS, and Clinical Compliance.
- Continued providing support and education to our network to promote the HPV Self-Collect option for patients in clinic.
- Explored and implement opportunities for provider education and resources on chlamydia screening and adolescent sexual and reproductive health.
- Partnered with Improvement Advisors to discuss PPC Pre: timeliness of prenatal care measure requirements with Perinatal QIP providers to strengthen staff awareness and improve adherence.
- Continued to work with Tribal entities to increase participation in Tribal Perinatal Programs and address access to timely prenatal and post-partum care.

4. Pediatrics
    - Facilitated two Pediatric Preventative Care Improving Measure Outcomes webinars
    - Interviewed high-performing providers in WCV (Well Care Visit) and IMA (Immunization for Adolescents) to identify best practices
    - Developed and implemented new one-on-one Provider Education on Developmental Screening in the First Three Years of Life to improve DEV (Developmental Screening) rates
    - Evaluated the expanded Promotion of Healthy Babies Growing Together Program to Provider Network ($100 for completion of CIS-10)
    - Added W30-2+ as a new monitoring measure in QIP to improve completion rates
    - Launched newborn pilot project with Fairchild to improve W30-6+ completion rates in Siskiyou County

- The Performance Improvement (PI) team collaborated with local consortia's to bring Quality Improvement (QI) awareness and education to providers.
    - For the Redding and Eureka regions Health Alliance of Northern California (HANC) and North Coast Clinics Network (NCCN) hosted their spring Rural Round Table in Eureka on 2/27/2026. The consortia's continue to host bimonthly peer networks for QI, CEOs, and CMOs. Partnership was invited to present 2025 PCP QIP rates to the QI peer network on 2/26/2026 and participated in a patient journey mapping training hosted by the consortia's. The consortia's will be completing their organizational profiles following publication of UDS data and has completed their updated measure specifications toolkit.
    - In the Santa Rosa region , Partnership has maintained close ties with the regional consortia, Aliados Health. Performance Improvement staff attend most Aliados QI Peer meetings and regional leadership of both organizations meet quarterly to discuss Partnership and Aliados' regional strategic goals and find alignment. Recent measure priorities include Vaccine Hesitancy,

Self-collected Cervical screening, and Universal Screening protocols for Chlamydia testing. Our monthly SQIP-I meetings continue to be jointly facilitated by Partnership and Aliados Health.

- For the Chico and Auburn region providers, the Central Valley Health Network was identified as the consortium that supports the majority of large FQHC's in the area. After consultation with the Director of Workforce Development and the Senior Director of Quality and Performance Improvement, it was decided that we would not seek collaboration on quality improvement at this time because our providers are a smaller base for their whole region.

- The Performance Improvement (PI) team had engagement with all high-volume Primary Care Providers practices in each quality region on high-priority measures.
  - Auburn and Chico region: Large volume provider organizations have engaged in monthly coaching meetings with an Improvement Advisor with the Mobile Mammography program, Partnering for Pediatric Lead Prevention program, and cervical self-swab adoption all being areas of focus.
  - Redding and Eureka region: All providers have been assigned a Performance Improvement coach with all large volume providers working towards improving priority measures. Open Door Community Health Centers in the Eureka Region worked with Partnership to identify a data gap with DHCS and dental claims for fluoride varnish and have since implemented an updated billing code to help capture fluoride application in their dental practice. PI has also worked with United Indian Health Services in the Eureka region to conduct disparity interventions in cancer screening for Native Americans. Shasta Community Health Centers in the Redding region has implemented an updated protocol for chlamydia screening after speaking with their PI coach and Partnership Medical Director. Fairchild Medical Center in the Redding region has also participated in a project to expedite newborn enrollment and is working with the Population Health team to do warm handoffs for the Growing Together Program.
  - Santa Rosa and Fairfield region: Santa Rosa Community Health worked with Partnership to address underperformance in Lead Screening for Children and Topical Fluoride Application and implemented Point-of-Care Lead testing at all of its 10 locations. They also began topical fluoride application in medical visits and implemented coding changes to more accurately reflect their current TFL rate in DHCS reports to Partnership HealthPlan. Solano County Family Health Center in the Fairfield region was identified with improvement plans for 4 measures (Breast and Cervical Cancer Screening, WCV and W15-6). They were able to hold 4 mobile mammography events to help improve their breast cancer screening rates and introduced additional cervical cancer screening opportunities; however, they suffered significant staffing losses within their Quality Department and pediatric providers, which

significantly delayed their work on Well Child Measures and prevented them from meeting with their Improvement Coach. Despite these setbacks, they have committed to a renewed focus on measure improvement in 2026.

- Regional quality meetings have been implemented for all regions with a survey following to evaluate all participants' experience:
    - Fairfield office held 4 quarterly meetings with Voices of the Field presentations from the areas health centers who discussed their successful strategies for universal chlamydia screening.
    - Santa Rosa office held 4 quarterly meetings where they featured measure improvements and successes related to Childhood Immunizations and Chlamydia Screening. A panel of local medical experts was also featured to discuss the challenges and strategies to improving childhood immunizations. This panel discussion led to a Webinar hosted by Partnership that was open to the whole network and recorded for later viewing.
    - Chico and Auburn offices held two quarterly meetings with an inventory of improvements projects currently in planning for FY 26-27.
    - Redding and Eureka offices held two quarterly meetings that featured successful strategies for measure improvement in Controlling High Blood Pressure, and Cervical Cancer Screening using hrHPV self-swab.
- Improvement Academy offered six (6) virtual trainings in 2025 highlighting priority MCAS measures including Pediatric Preventative Care for Ages 0 - 30 Months, Pediatric Preventative Care for Ages 3 - 17 years, Preventive Cancer Screenings: Improving Outcomes through Early Detection, Managing Chronic Disease: Strategies for Blood Pressure and Diabetes Control, Sexual and Reproductive Health, and Improving Perinatal Outcomes. Improving Member Outcomes webinar attendance ranged from 52 to 72 attendees per session, with each session representing 31 to 45 unique organizations. Of attendees who completed the post session evaluations for all six webinars, 100% selected "strongly agree" or "agree" when asked if the webinar was relevant and useful.
- Improvement Academy hosted three (3) ABCs of Quality Improvement in-person trainings:
    1. Fairfield - 63 attendees, representing 22 unique organizations with 95% of evaluation respondents being extremely satisfied/satisfied with this course.
    2. Redding - 46 attendees, representing 22 unique organizations with 100% of evaluation respondents being extremely satisfied/satisfied with this course.
    3. Auburn - 24 attendees, representing 16 unique organizations with 100% of evaluation respondents being extremely satisfied/satisfied with this course.

- Improvement Academy collaborated with the Performance Improvement team and conducted an evaluation of both the ePrompts and Preventive Care microlearnings with 100% of respondents stating the microlearning length was appropriate; 83% of respondents stated they could apply learnings to their job; anecdotally respondents stated the microlearnings were well organized and appreciated the resource.
- Improvement Academy improved in-person training attendance by 37% by implementing a marketing strategy that targeted sites with zero (0) attendance of ABCs of QI and working to minimize identified attendance barriers.
- Improvement Academy conducted an evaluation to meet the training needs of the network and received 34 responses from 25 organizations that identified preferred training topics and formats that will be integrated into the design of future trainings. Key findings included:
    - Preferred modalities: Live webinars (most popular), microlearnings, on-demand recordings, and written toolkits/guides.
    - Top strategies: Patient engagement and leveraging quality data to build a culture of quality/provide performance feedback to clinicians.
    - Session length preferences: Webinars at 60 minutes; in-person sessions as half-day events.
    - Priority measures: Child and adolescent measures (Child and Adolescent Well-Care Visits, Immunizations for Adolescents, Depression Screening and Follow-Up for Adolescents).
    - Top barriers to QI efforts: Competing priorities, limited time, and lack of staff.
- QI Program & Project Management piloted a QI Project Toolkit & Training Program with 26 participants representing 13 different organizations. This program was launched into a full-scale program made available to eligible Partnership entities. The first cohort launched in early 2026 with 61 participants from over 30 provider and community based organizations. All program materials including the toolkit, microlearning modules, curriculum outline, and resource documents are available on the public-facing QI Project Training webpage under the Improvement Academy page.
- The Healthy Kids Growing Together Program provided outreach to members who were 3 – 6 years old and have never had a well-child visit in the last eleven (11) months and offered an incentive to the members who had a 3rd, 4th, 5th, or 6th within the upcoming 120 days and completed a well-child visit within 90 days of the outreach. Reminder mailers were sent to the entire eligible population and conducting up to two outbound phone calls. Claims data was reviewed and if not showing after completed appointment, outreach was then done to the provider to confirm the appointment then mail out incentive card. A 41% of those who agreed to participate were successful in completing their appointment and receiving the incentive.

- The Your Partner in Prevention (YPIP) program piloted 4 Women's Wellness Days across 4 provider organizations by having providers add additional preventative health screenings to their Partnership sponsored Mobile Mammography event days.
- The 2025 Primary Care Provider Quality Incentive Program (PCP QIP) Breast Cancer Screening 75th percentile benchmark has been met in the Fairfield and Santa Rosa Partnership regions, and the 50th percentile benchmark met in the Chico, Eureka, and Redding regions. This improvement was largely influenced by 109 Mobile Mammography event days, resulting in 2,465 completed breast cancer screenings.
    - 4 event days in the Auburn region.
    - 18 event days in the Chico region.
    - 35 event days in the Eureka region.
    - 15 event days in the Fairfield region.
    - 27 event days in the Redding region.
    - 10 event days in the Santa Rosa region.

FY25/26 Final Goal Status: Delayed/Terminated

Project or Program	Goal	Status Details	Next Steps
2.g. Partnership Quality Dashboard (PQD)	**Goal #1:** By June 30, 2026, apply annual development updates of the MY2026 HEDIS® Monthly Exploratory Dashboard in accordance with identified stakeholder needs (Contingent on HRP® implementation).	Terminated	HEDIS team streamlined the development and publication of the dashboard which eliminated the need to send data exports from Inovalon to EDW.
2.h. Enterprise Information Management	**Goal #1:** By June 30, 2026, integrate the HRP® version of the HEDIS® project data into the Enterprise Data Warehouse and use this data to create the HRP® version of the HEDIS® PQD modules.	Terminated	The priority of this task has changed, now working towards implementing automated solution on the Inovalon Data Lake.

Project or Program	Goal	Status Details	Next Steps
2.h. Enterprise Information Management	**Goal #2:** By June 30, 2026, Plan, Develop, Test, and have the files ready for Wakely to integrate the test data to their environment to help build STAR measures dashboard for Medicare LOB	Delayed	Delayed due to postponement of D-SNP program. Deliverables will be resumed in the 26-27 FY.
2.h. Enterprise Information Management	**Goal #4:** By June 30, 2026, Plan, Develop, Test, and have the test files ready for PCP QIP project to support Medicare Line of Business (LOB). Integrate the necessary datasets to Cozeva platform to support QIP measures.	Terminated	This goal is terminated due to postponement of D-SNP program to 1/1/28 and Cozeva contract termination. The PCP QIP program for D-SNP line of business will be addressed later
2.i. Dual Eligible Special Needs Plan (D-SNP)	**Goal #1:** By June 30, 2026, develop the Quality Improvement framework to support the proposed Dual Eligible Special Needs Plan (D-SNP) program and monitoring of associated quality metrics.	Terminated	The termination of this goal is due to a significant shift in organizational priorities for the D-SNP program and changes in vendor contracting. Partnership is eliminating D-SNP work with Inovalon and concentrating on fulfilling reporting requirements with Cirdan Wakely in the future. Additional delegation changes have changed the scope of this work to the point that this deliverable was terminated.
2.j. HEDIS Reporting to Support D-SNP Data Collection and Analysis	**Goal #1:** By August 29, 2025 provide first set of data for DSNP Monthly MY2025	Terminated	This goal has been terminated due to the decision to report DSNP data collection and

Project or Program	Goal	Status Details	Next Steps
	data to the QI DSNP Team and, send data monthly thereafter after each data refresh.		analysis using a new third party vendor, Wakely.
3.a. Primary Care Provider Quality Improvement Program (PCP QIP)	**Goal #1:** By June 30, 2026, the PCP QIP Program will be leveraged to support existing and newly added low performing providers in the Modified QIP measure set. This support will include provider education and encouragement to increase on-line data platform usage and monitoring which results in improved engagement and performance improvement activities.	Terminated	As of 1/1/2026, MQIP program was discontinued due to the Federal Ruling contract agreements requirements. The Enhanced Provider Engagement program has been created to support low performing providers in the PCP QIP. The PCP QIP team continues to collaborate with Performance Improvement Advisors to engage and train these specific providers as needed through Partnership's Enhanced Provider Engagement strategy which is owned by the Performance Improvement team.
3.b. Hospital Quality Incentive Program (H-QIP)	**Goal #2:** By June 30, 2026, develop Partnership's Hospital Quality Symposium for the 2026-2027 H-QIP measurement year.	Terminated	This goal has been terminated due to programmatic changes caused by new federal regulations that necessitate the HQIP transitioning from a fiscal year program to a calendar year program. These changes do not make it feasible or practical to hold the event this year. The Hospital Quality Symposium will not be held in 2026 but will be held in 2027.
3.f. Dual Eligible Special Needs Plan (D-SNP) Quality Incentive	**Goal #1:** By October 31, 2025, complete the Advance Care	Delayed	The Annual Wellness Visit (AWV) goal has been delayed due to the Medicare DSNP go-live

Project or Program	Goal	Status Details	Next Steps
Program (QIP) Development	Planning and Annual Wellness Visit (AWV) measure development for inclusion in the 2027 D-SNP QIP measurement year.		date being postponed to January 1, 2028. The proposed AWV measure will still require approval from the Executive team before it can be included in the 2028 DSNP QIP measures.
3.f. Dual Eligible Special Needs Plan (D-SNP) Quality Incentive Program (QIP) Development	**Goal #2:** By October 31, 2025, obtain a signed contract agreement with Partnership HealthPlan of California and our selected D-SNP system vendor, Cozeva.	Terminated	After careful consideration, leadership has chosen to take a more streamlined approach to our DSNP QIP in the first year of our Medicare product, and as a result, will not be utilizing Cozeva's services at this time. We will maintain open communication with Cozeva and may consider partnering with them in the future if our needs evolve.
3.f. Dual Eligible Special Needs Plan (D-SNP) Quality Incentive Program (QIP) Development	**Goal #3:** By June 30, 2026, develop a detailed implementation plan and timeline (Project kick-off, Pre-Implementation phase, Implementation phase) with internal PHC teams and Cozeva.	Terminated	After careful consideration, leadership has chosen to take a more streamlined approach to our DSNP QIP in the first year of our Medicare product, and as a result, will not be utilizing Cozeva's services at this time. We will maintain open communication with Cozeva and may consider partnering with them in the future if our needs evolve.
3.f. Dual Eligible Special Needs Plan (D-SNP) Quality Incentive Program (QIP) Development	**Goal #4:** By June 30, 2026, the D-SNP Quality Incentive Program (QIP) will prepare Cozeva systems for the anticipated 2027 go-live.	Terminated	After careful consideration, leadership has chosen to take a more streamlined approach to our DSNP QIP in the first year of our Medicare product, and as a result, will not be utilizing Cozeva's services at this time. We will maintain open communication with

Project or Program	Goal	Status Details	Next Steps
			Cozeva and may consider partnering with them in the future if our needs evolve.
4.c. Mobile Mammography Program	**Goal #2:** By June 30, 2026, complete at least 3 wellness days as part of the new Your Partner in Prevention Program (YPIP).	Terminated	The YPIP Team has decided to organize strategy meetings in collaboration with the Performance Improvement Team to develop strategies on executing Kid and Adolescent Wellness Days.
7.c. Provider Coaching and Engagement	**Goal #1:** By June 30, 2026, the Performance Improvement teams will launch interventions with 80 percent of provider organizations identified as low performing providers on the 2024 Primary Care Provider Quality Incentive Program (PCP QIP) assigned to Enhanced Provider Engagement or a Corrective Action Plan, aimed at improving performance on the Modified QIP.	Terminated	Conducting Needs Assessments with select Provider Organizations continued to be a challenge in the second part of this year due to the difficulty of scheduling with such a large group of people at the Provider Organization. Leadership has revised the Enhanced Provider Engagement Program for 2026 based on an evaluation of the program with the Needs Assessment becoming optional but further discussion and socialization of this tool is important for driving cross-measure change.
9.a. Compliance with NCQA HOA and Sustain Performance	**Goal #1:** By June 30, 2026, departments will maintain compliance of all assigned NCQA Health Outcomes Accreditation (HOA) Standards and Guidelines, following the 2026 HOA Standards and Guidelines once	Delayed	NCQA Program Management Team will continue to work with the selected department(s) to complete their annual HOA Workbook and 2026-2028 HOA Report Schedule. NCQA will ensure there are no issues identified due to the incomplete submission. The NCQA Program Management Team will

Project or Program	Goal	Status Details	Next Steps
	available, as measured by the three (3) deliverables listed.		host meetings with the Consultant and the department(s), to clarify the NCQA standards, understand the operation workflows, explore new processes, and then define roles and responsibilities to comply with the Renewal Survey requirements. No immediate risks or issues identified at this time. Will be completed in the next FY.

Summary of QI Trilogy Documents

August 2026

Annually, the Quality and Performance Improvement Team updates three documents that reflect past, present, and future work related to quality improvement at Partnership HealthPlan of California (Partnership):

1. Quality Improvement Program Description
2. Quality Improvement Program Evaluation
3. Quality Improvement Work Plan

Each document is a regulatory and NCQA Accreditation requirement. The Quality Improvement Project Management team, in partnership with the Senior Director of Quality and Performance Improvement and Director of Quality Management, serves as the QI Trilogy Document Team. The team leads the preparation of the documents for review by Partnership's quality committees. These documents will be presented during the quality committees in August and final approval will be sought from the Board of Commissioners in the fall. Along with this review cycle, each document accounts for activities on a fiscal year cycle. These documents will be submitted to the State after Board approval and shared with Partnership members via the website and upon request.

DOCUMENT SUMMARIES:

QI Program Description

The QI Program Description is a summary of the QI program with content including the structure, processes, and intra and interdepartmental work that supports quality improvement efforts at Partnership. The program description contains the following components per the NCQA accreditation standards (QI 1A):

- The QI program structure.
- The behavioral healthcare aspects of the program.
- Involvement of a designated physician in the QI program.
- Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program.
- Oversight of QI functions of the organization by the QI Committee.

The Partnership fiscal year 2026-2027 document reflects revisions completed through interdepartmental review and collaboration, particularly in the following areas:

1. Updated the Quality Improvement program scope and strategic direction to reflect current organizational planning, including future Medicare/D-SNP integration, quality oversight for dental services, and the planned transition of the Wellness and Recovery Program.
2. Refined governance structures by removing obsolete committees, adding D-SNP quality oversight, clarifying delegated responsibilities, and aligning committee membership and meeting cadence with current operations.
3. Strengthened leadership accountability through updated roles, clarified Medicare/D-SNP oversight responsibilities, and revised organizational documentation to address audit expectations.
4. Aligned health equity and accreditation language with updated NCQA terminology and clarified which activities remain discretionary versus compliance driven.

5. Updated behavioral health oversight to reflect de-delegation of member-facing functions from Carelon Behavioral Health while retaining delegated quality, network, and claims-related responsibilities.
6. Revised value-based payment program language to reflect the re-establishment, completion, or status changes of key incentive programs.
7. Expanded the Pathway to Excellence framework to emphasize continuous learning, implementation of science, leadership accountability, and sustainability of quality improvement efforts.

QI Evaluation

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

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

The evaluation includes work directly completed by the Quality and Performance Improvement department and other departmental partners within Partnership. In preparing the 2025-2026 evaluation, the following items were given greater consideration.

1. Continued analysis of the QI program structure and how the roles defined within the QI department and senior leadership/physician roles fulfill it.
2. Enhanced trend analysis and implementation of interventions for measurements related to clinical quality, member safety, and member experience outcomes, reflecting the most recent 12-month period compared to the prior year.
3. Continued assessment of barriers in quality improvement with corresponding health plan adaptations to member and provider engagement strategies and tactics.
4. Member experience priorities, including CAHPS, access, transportation, and benefit understanding.
5. Health equity and disparity reduction by maintaining Health Plan Accreditation and maintaining Health Equity Accreditation readiness and compliance through NCQA and DHCS priorities.
6. Assessment of resources and organization of quality and performance improvement activities to accommodate the growing scope and complexity of quality measurement and reporting under both DHCS and NCQA accreditation. In FY 25-26, of particular focus was the preparation for the implementation of Partnership's Dual Eligible Special Needs Plan (D-SNP) and Health Rules Payer (HRP), evaluation of achieving at least a 3.5 STAR health plan rating as an NCQA accredited health plan, and achievement of NCQA Health Equity Accreditation requirements.

QI Work Plan

The QI Work Plan outlines major activities for the QI Department and organization as a whole that advances quality and performance improvement.

Summary of QI Trilogy Documents

August 2026

There are four main areas the Work Plan is designed to monitor and increase accountability per the NCQA technical specifications (QI 1B):

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

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

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

Annually, the process for completing the trilogy documents is assessed for improvement. In developing the 2026-2027 Work Plan, QI leadership worked to proactively identify new and adapted projects and programs based on the closeout of the 2025-2026 Work Plan. This led to greater dialog among sponsors, business owners and contributors on lessons learned, which correlates to the accomplishments and challenges cited in the 2025-2026 QI Evaluation. Ultimately, this refined approach aided the work plan change process and led to sound goal setting and deliverable identification in the 2026-2027 Work Plan.

Quality Improvement Program Evaluation

2025-2026

EVALUATION PERIOD

(JULY 1, 2025 – JUNE 30, 2026)

Approval of Quality Improvement Program Evaluation

	8/19/2026

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

	9/9/2026

Angela Brennan, DO Date Approved
Physician Advisory Committee Chairperson

	10/28/2026

Dean Germano Date Approved
Board of Commission Chairperson

TABLE OF CONTENTS

Quality Improvement Overview and Program Oversight	
Scope of Data and Results Reported in the 2025-2026 Quality Improvement (QI) Program Evaluation	7
Quality Improvement Program Structure	9
Quality Improvement Governance	11
Board of Commissioners	12
Internal Quality Improvement Committee	12
Quality and Utilization Advisory Committee	13
Physician Advisory Committee Oversight of QI Program	13
Quality Incentive Program Advisory Groups	14
Quality Improvement Leadership Engagement & Commitment	14
Chief Executive Officer	15
Chief Operating Officer	15
Chief Medical Officer	15
Chief Health Services Officer	17
Chief Strategy & Government Affairs Officer	17
Quality Improvement Departmental Changes	17
Changes within QI Department	18
Quality Improvement Executive Summary	
Executive Summary	20
2024-2025 QI Work Plan Summary	21
Background	21
2024-2025 QI Major Milestones and Activities	21
FY 24/25 Work Plan Final Goal Status	22
National Committee for Quality Assurance (NCQA) Accreditation	
NCQA Overview	27
NCQA Health Plan Accreditation (HPA) and Health Equity Accreditation (HOA) Key Activities	27
Compliance with NCQA Survey Standards	27
Preparation for HPA and HOA Renewal Surveys	28
CAHPS® and HEDIS® Reporting for Health Plan Accreditation	30
Partners in Quality	31
Key Benefits of Being a Partner in Quality (PIQ) Recognized Organization	31
Preparations for Partnership Advantage D-SNP	
Preparations for Partnership Advantage (D-SNP)	33
Model of Care	33
Integrating Partnership Advantage D-SNP	33
HealthPlan Quality Performance	
Overall Summary	36
Partnership HEDIS Reporting Populations – MY2025	36
Supplemental Data Within MY2025 HEDIS Annual Project	37
DHCS MCAS Accountable Measures	38
MY2025 MCAS Plan-Wide Rates	39
NCQA Health Plan Accreditation (HPA) – Health Plan Rating (HPR) Methodology	42
MY2024 HPA Star Rating Results	43

Summary of Measures in the Primary Care Provider Quality Incentive Program (PCP QIP)	43
Quality in Data Governance	
Data Governance, Stewardship, and Analytics Integration	46
Data Governance	46
Data Stewardship	46
Analytics Center of Excellence	47
Partnership Quality Dashboard	49
Provider Network Quality Improvement Support and Initiatives	
Quality & Performance Improvement Initiatives and Projects	54
Overview	54
Quality Measure Score Improvement	55
Improvement Team Workgroups	55
Chronic Disease	55
Behavioral Health	60
Pediatric Preventive Care	63
Women's Health and Perinatal Care	74
New Dashboards in Development	92
Quality Improvement Coaching	93
Enhanced Provider Engagement and Modified PCP QIP	93
Expansion Region Coaching	95
Equity and Practice Transformation	95
Provider Coaching	99
Joint Leadership Initiative	100
Expansion of Regional Quality Meetings	100
QI Technical Assistance in Partnership with Northern Region Consortia	102
Other QI Provider Resources Updates and Changes	102
Quality Improvement Training	103
Improving Measure Outcomes	103
ABCs of Quality Improvement	105
Microlearnings	106
Value Based Pay-for-Performance Programs	106
Primary Care Provider Quality Incentive Program	107
Hospital Quality Incentive Program	108
Perinatal Quality Incentive Program	111
Palliative Care Quality Incentive Program	115
Enhanced Care Management Quality Incentive Program	116
Long-Term Care Quality Incentive Program	118
D-SNP Quality Incentive Program	119
Member Safety and Quality Compliance Activities	
Member Safety and Quality Compliance Activities	122
Potential Quality Issues	122
Assignment of Practitioner Performance and Systems Scores	124
Site Reviews	126
Medical Record Reviews	127
Provider Billing Guide	128

Provider Educational Trainings	128
Improving Blood Lead Screening	129
Physical Accessibility Review Survey	129
Initial Health Appointment	130
Improvement Activities	131
Delegation Oversight	132
Latent TB Infection – 12 Dose Treatment	132
Quality in Member Experience	
Care for Members with Complex Needs and Community Partnerships	135
Care for Members with Complex Needs	135
Complex Case Management	135
Community Resource Web Pages	136
Services and Patient Experience	136
Access to Care	140
Methodology and Notable Findings	141
Member Service Access	143
Opportunities for Improvement	144
Activities to Improve Access	144
CAHPS® Program | Member Experience	145
Evaluation Summary	147
Identification of Opportunities and Priority	151
FY 2024-2025 Summary of Activities and Interventions	154
Web Based Member Information Assessment	156
Quality In Grand Analyses	
NCQA - Grand Analyses	170
Access and Availability (NET 3) Report	170
Pharmacy & Utilization Management (UM1B) Report: Utilization Management	172
Member Experience (ME 7) Report	172
HE-6 Grand Analysis	173
Evaluation Conclusion	
Evaluation Conclusion	184
Appendices	
Appendix A: Access and Availability (NET3) Report	
Appendix B: Pharmacy & Utilization Management (UM1B) Report: Utilization Management	
Appendix C: Member Experience (ME 7) Report	
Appendix D: HE-6 Grand Analysis	
Appendix E: HEDIS® MY2024 / RY2025 Annual Summary of Performance Report (MCAS)	
Appendix F: HEDIS® MY2024 / RY2025 Annual Summary of Performance Report (HPA)	
Appendix G: 2025-2026 QI Work Plan Summary	
Appendix H: 2025 Grievance & Appeals Annual Report	

Quality Improvement Overview and Program Oversight

QI TRILOGY

Scope of Data and Results Reported in the 2025-2026 Quality Improvement (QI) Program Evaluation

Partnership HealthPlan of California's (Partnership) Quality and Performance Improvement (QI) program provides a systematic process to monitor the quality of clinical care and health care service delivery to all Partnership members. It includes an organized framework for ongoing review of activities to identify opportunities to improve the quality of health care services provided, promote efficient and effective use of health plan financial resources, and partner with internal and external stakeholders to support performance improvement and to improve health outcomes and advance health equity. The program promotes consistency in application of quality assessment and improvement functions for the full scope of health care services while providing a mechanism to:

- Ensure integration with current community health priorities, standards, and goals that impact the health of the Partnership member population
- Ensure alignment with DHCS' Comprehensive Quality Strategy Report
- Identify and act upon opportunities to improve care and service
- Identify overuse, misuse, and underuse of health care services
- Identify and act on opportunities to improve processes to ensure member safety
- Identify and act on opportunities to address disparities in health access and outcomes
- Address potential or tangible quality issues
- Review data for trends that suggest variations in health care service delivery processes or disparities in care

The QI Program adheres to the following goals to improve the quality and effectiveness of clinical care and service to Partnership members:

- Improve the health of the populations Partnership serves
- Enhance the member care experience
- Support the delivery of high-quality clinical care
- Reduce disparities in health access and outcomes
- Ensure member safety
- Measure and encourage appropriate use of clinical resources
- Strengthen a culture of continuous quality improvement throughout the Partnership network

The QI Program accomplishes these goals by:

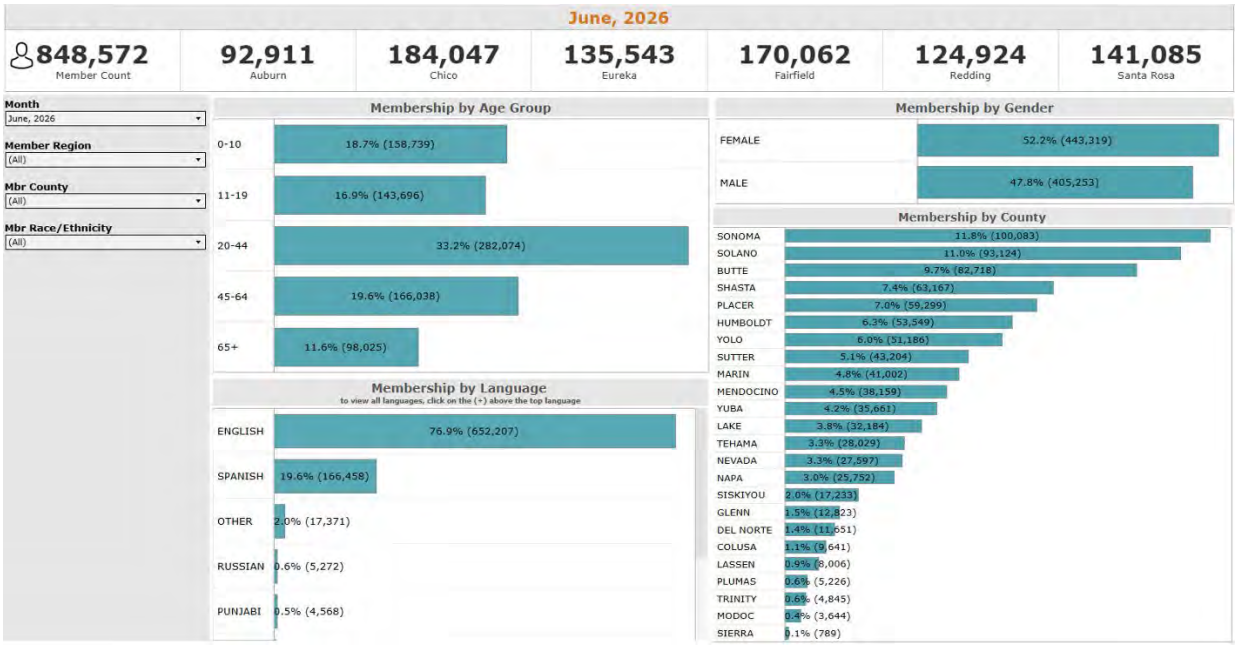
- Systematically monitoring and evaluating service and care provided
- Continuously improving data and analytics to validate care outcomes
- Actively pursuing opportunities for improvement in areas that are relevant and important to Partnership members' health
- Implementing strong interventions when opportunities for improvement are identified
- Addressing overall member experience by improving provider access and member awareness of the health plan's role and responsibilities

Detailed results of projects, programs, and quality assurance activities regulated by the Department of Health Care Services (DHCS) were presented to the various quality committees throughout the year. This evaluation provides highlights of activities led by or in partnership with the Quality and Performance Improvement department. The evaluation does not include detailed results from the Grievance and Appeals Department, Pharmacy Department, Utilization Management, Care Coordination, or Population Health Departments. Separate evaluations address these functional areas. Additionally, the Quality and Performance Improvement Department partners closely with its Health Equity and Population Health Departments, as defined in Partnership's Quality Improvement and Health Equity Transformation Program (QIHETP) Description. The QIHETP is designed to develop, implement, monitor, and maintain a health equity transformation system to address improvements in the quality of care delivered by all its providers in any setting, and take appropriate action to improve upon the health equity and health care delivered to members. The Quality Improvement and Health Equity Committee (QIHEC) oversees the QIHETP, and the program's overall effectiveness is evaluated in a separate annual evaluation, which complements this overall program evaluation.

The 2025-2026 QI program covers Medi-Cal lines of business across 24 counties: Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo and Yuba. Associated quality improvement initiatives and programs are designed to encourage appropriate care at the right time while being cognizant of resource utilization. Initiatives target areas of under-use, misuse, and overuse in addition to exploring different strategies and payment models for improving access to care and the care of medically complex patients. The time period of this evaluation is July 1, 2025, to June 30, 2026. QI staff are aligned by region, where appropriate, to fulfill quality programs and initiatives designated under the overall QI Program. Since Partnership's last evaluation (FY 2024-2025), Partnership's total membership has decreased from 910,339 (as of July 1, 2025) to 848,572 (as of June 1, 2026).

Across all 24 counties, 52.2% of Partnership members are female and 47.8% are male. Caucasians represent (38.3%); Hispanic (33.7.%); Unknown (13.8%); members who identify as "Other" (4.6%); Black (3.6%); Asian (2.4%); Native American (1.7%); Asian Indian (1.6%); and Native Hawaiian or other Pacific Islander (0.2%). English speakers comprise 76.9%; followed by Spanish (19.6%); Other (2.0%); Russian (0.6%) and Punjabi (0.5%). Members ages 0-10 comprise 18.7%; members ages 11-19 comprise 16.9% of the population; followed by members ages 20-44 (33.2%); members ages 45-64 (19.6%); and 11.6% of Partnership's membership is 65 or older.

Below is a summary of membership by county.



Quality Improvement Program Structure

This section outlines the structure of the Quality Improvement Program, including executive leadership, departmental organization, collaboration mechanisms, and operational capabilities for FY 2025-2026, in accordance with NCQA QI 1 Element C.

To address evolving priorities and increasing operational complexity, the following structural highlights illustrate how the Quality Improvement Program was organized and mobilized throughout FY 2025–2026.

The QI Program operates under the executive leadership of the Chief Medical Officer (CMO) and Senior Director of Quality and Performance Improvement, supported by the leadership team that includes Directors of Quality Management, Quality Measurement, and the Medical Director for Quality. Together, this team guided execution of the 5-Star Quality Strategy and objectives outlined in the QI Tactical Plan.

Department managers led teams focused on: Member Safety-Quality Investigations and Clinical Compliance; Accreditation; Quality Measurement; Performance Improvement (PI); Quality Incentive Programs (QIP); Medicare Quality; and Quality Improvement Programs and Project Management. Within these teams, there are efforts to support data quality and validation in collaboration with IT and Finance – Health Analytics. The department periodically utilizes external consultants to support QI training for provider organizations and internal staff and National Committee for Quality Assurance (NCQA) Accreditation and contract employees for Healthcare Effectiveness Data and Information Set (HEDIS®)-related data collection and reviews.

Programmatic and Operational Highlights

- **Support for Geographical Expansion**: A cross-section of representatives under the QI program continued efforts to ensure regulatory alignment and high-quality services within its expanded provider network for new members gained through the 10-county geographic expansion in January 2024. These activities included expanding the scope of quality measurement in HEDIS and QIP, proactive provider engagement, onboarding, and strategic support to promote quality program success in the newly integrated counties. This work contributed to sustaining Partnership's regional support overall and resulted in allocating additional resources across QI teams.

- **Expansion and Roles of the Program and Project Management Team**: The Quality Improvement Program and Project Management Team (PPMT), established in 2023, continued to expand its role during FY 25-26. The team supports key program activities central to fulfilling DHCS quality regulatory requirements and NCQA Health Plan Accreditation deliverables. Their scope also includes transitioning successful pilots for further scaling. Then, with continued results, the team leads conversion to sustained program offerings plan-wide. In addition, the PPMT serves as the core QI project management function, providing structure, accountability, and urgency to new initiatives and priorities brought forward by DHCS, internal stakeholders, the provider network, and community partners.

- **Enhanced Regional PI Team Capacity and Alignment**: In early FY 2024–2025, executive leadership restructured regional operations from three to six regions for improved local support. QI's PI teams were realigned accordingly, and a new regional PI Manager role was introduced, along with additional staff positions, to ensure sufficient capacity and alignment with the expanded regional model. Building on this, the focus in FY 25-26 was on stabilizing and optimizing the regional PI structure. Increased staffing capacity enabled more consistent support of regionally driven initiatives, as well as stronger alignment with enterprise QI priorities. While progress has been made in strengthening regional support and alignment, opportunities remain to further standardize approaches across regions and enhance visibility into the impact of regional interventions.

- **Sustained Leadership of QMSI Workgroups**: Performance Improvement Teams continue to lead measure-focused improvement workgroups under the Quality Measure Score Improvement Initiative (QMSI). Each workgroup is responsible for a specified measure domain and has 1-2 designated leaders to facilitate cross-departmental analysis and review of quality measure performance, assess and initiate new interventions to address prioritized care gaps.

- **Enhanced Provider Engagement (EPE) and Modified PCP QIP**: In 2025-2026, Partnership continued its EPE and Modified PCP QIP coaching programs focused on providers facing significant infrastructure and workforce challenges, serving members in communities with historical healthcare disparities, and reporting low performance in the PCP QIP. Provider organizations demonstrating improvement transitioned to coaching and collaboration activities that are elective and less prescriptive, while new participants were onboarded based on low performance in priority quality measures.

Cross-Functional Alignment and Special Projects

- **CAHPS / Member Experience Efforts**: In FY 2025-2026, CAHPS® and broader member experience improvement efforts continued to advance, with a focus on implementing targeted interventions. Key initiatives included efforts to improve transportation services, establish rapid response approaches to address member dissatisfaction, enhance member understanding of available benefits, and more intentionally integrate health equity considerations across all member experience initiatives.

- **Support for D-SNP Implementation**: In FY 2025-2026, Partnership dedicated significant effort to preparing for the launch of its Medicare Dual-Eligible Special Neds Plan (D-SNP), known as Partnership Advantage. The go-live date is planned for January 2028. The QI D-SNP team, including the Manager of Medicare Quality, was fully integrated into the QI Program structure starting in FY 24/25 and continued building the team in FY 25/26. Reporting into the Director of Quality Measurement, this position worked closely with the Medicare Medical Director, Medicare Program Manager, QI leaders, and other Health Services leaders to develop, implement, and sustain the Model of Care and lead organization-wide implementation of Partnership's CMS Medicare STARS Quality strategy, which is crucial to the organization achieving an optimal STARS rating. QI added new resources across QI teams to support implementation planning activities central to the QI Program. QI also facilitated cross-functional collaboration with internal and external stakeholders to prepare for program launch activities, including quality strategy alignment, readiness assessments, and infrastructure planning key to the long-term needs of the QI Program.

- **HRP Implementation**: In FY 2025-2026, QI resources continued supporting the development and testing related to the transition from Partnership's prior core claims processing system, Amisys, to the new core claims processing system, HealthRules Payer® (HRP®). The QI Department remains actively engaged in ongoing work to ensure quality and compliance alignment throughout the system implementation lifecycle and will continue supporting this work through its launch.

Conclusion and Structural Growth

In response to organizational expansion and increasing program complexity, the QI Department added multiple new roles, aligned regional operations, and refined team responsibilities to support sustained quality oversight and performance improvement across all regions. Additional details on personnel changes are provided in the Quality Improvement Departmental Changes section.

Quality Improvement Governance

Partnership HealthPlan of California maintains a comprehensive and well-integrated Quality Improvement (QI) governance structure designed to ensure strong oversight, accountability, and collaboration across all levels of the organization. The QI governance framework brings together diverse specialties and expertise through multiple committees and advisory groups. These committees work in alignment to oversee, monitor, and continuously improve the quality of care and services provided to members.

The organization is satisfied with the number and types of specialties represented across its governance bodies including the Board of Commissioners, Physician Advisory Committee (PAC), Quality and Utilization Advisory Committee (Q/UAC), Internal Quality Improvement (IQI) Committee, and the Quality Incentive Program (QIP) Advisory Groups — each playing a critical role in supporting Partnership's mission and advancing quality initiatives.

Board of Commissioners

The purpose of the Commission is to arrange for the provision of health care services to qualifying individuals, as well as other purposes set forth in the enabling ordinances established by the respective counties. The Commission promotes, supports, and has ultimate accountability, authority, and responsibility for a comprehensive and integrated QI Program. The Commission is ultimately accountable for the quality of care and services provided to members. The Commission has delegated direct supervision, coordination, and oversight of the QI Program to the Physician Advisory Committee (PAC), which serves as the main Quality Improvement committee. PAC is supported by two (2) other quality committees – the Quality and Utilization Advisory Committee (Q/UAC) and the Internal Quality Improvement (IQI) Committee, which are described in more detail below. The county Boards of Supervisors for each geographic area appoints members of the Commission, which include representation from the community, consumers, business, physicians, providers, hospitals, community clinics, HMOs, local government, and County Health departments. The Commission meets six (6) times per year.

Internal Quality Improvement Committee

The Internal Quality Improvement (IQI) Committee is comprised of appropriate Partnership department directors, managers, and staff that track progress towards successful completion of quality initiatives, surveys, audits, and accreditation. The IQI Committee under the leadership of the Chief Medical Officer, Medical Director for Quality, and Senior Director of Quality and Performance Improvement, meets 10 times per year, with the option to add additional meetings if needed, and reviews external-facing policies owned by the various Health Services department, including QI, and a few non-HS departments (i.e., Credentialing, Network Services, Provider Relations, Member Services, and Grievance & Appeals). IQI also considers QI initiatives spearheaded by Performance Improvement staff; reviews annual evaluations of the various Quality Incentive Programs (QIPs) and hears annual "Grand Analysis" presented by various Health Services departments. IQI is also the initial committee to receive and provide feedback on the monitoring of Initial Health Assessment trends and actions, site review results, and trends in potential quality of care issues. Multidisciplinary improvement teams may be designated to complete analysis and intervention recommendations for quality improvement issues and activities. The IQI Committee serves to integrate quality activities organization wide. Activities and progress are reported to the Quality and Utilization Advisory Committee (Q/UAC) and then the Physician Advisory Committee (PAC). The IQI Committee met 10 times during FY 2025-2026. Partnership's IQI Committee agenda remained heavy throughout the year, due to the volume of policy changes related to NCQA Accreditation and DHCS requirements. Partnership timely addressed all agenda items. The IQI Committee membership remained stable, consisting of a multi-departmental team that included the necessary level of leadership across departments impacted by policies and procedures moving through the IQI Committee. The meeting structure included a policy pre-review process and dedicated policy review time during the meeting, both of which ensure there is adequate time for policy discussion. Discussion topics were presented to the committee, and Partnership leveraged these presentations and reports for IQI Committee members to provide input and qualitative feedback. Overall, the IQI

Committee structure has been sufficient to provide adequate oversight and support in tracking quality initiatives and providing health plan and/or clinical expertise into policy and procedure review.

Partnership's IQI Committee agenda was heavy this fiscal year, not least because some detailed attention was made to whether policies must be edited or new ones created to accommodate the new Dual-eligible Special Needs Plan "Partnership Advantage" program anticipated to go-live in eight of our counties, effective Jan. 1, 2027. Go-live has been postponed to Jan. 1, 2028, so this level of review will continue. Additionally, adding Regulatory Affairs & Compliance review to the update of policies, effective August 2026, will pose challenges as this will greatly impact schedules and staff time across the organization as a whole.

Quality and Utilization Advisory Committee

The Quality and Utilization Advisory Committee's (Q/UAC) role is to assure that quality, comprehensive health care and services are provided to Partnership members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. This responsibility includes providing significant input on the QI Program Description, Annual Evaluation, and Work Plan. The committee is required to meet at least 10 times per year, with the option of adding meetings if needed. Present Q/UAC voting membership includes two consumer representatives and 10 external clinicians whose specialties are internal medicine, family medicine, pediatrics, OB/GYN, neonatology, or behavioral health, among others. Our one Public Health Officer member resigned in May 2026. The Partnership CMO (chair of the committee), Medical Director for Quality (vice-chair), and leadership from the Health Service departments (i.e., QI, CMO Office, Utilization Management, Care Coordination, Pharmacy, Population Health, Health Equity, Behavioral Health, and Enhanced Health Services) and non-HS departments (e.g., Member Services and Grievance & Appeals) regularly attend Q/UAC meetings. Q/UAC activities and recommendations are reported monthly to PAC and at least quarterly to the Commission.

Q/UAC met 10 times during FY 2025-2026. Partnership's Q/UAC agenda remained heavy due to the volume of policy changes related to maintaining NCQA Accreditation and new DHCS requirements largely associated with California Advancing & Innovating Medi-Cal (Cal-AIM) and other All Plan Letters. Furthermore, Partnership's addition of 10 new counties to its service area, effective January 2024, continued to impact the QI Program at large and Q/UAC discussions particularly.

Quorum was met each meeting. Partnership was able to address all agenda items timely, although at times, reports on QI initiatives had to move from verbal presentation to directing committee members to refer to written reports in their meeting packets in soliciting feedback. This was a result of accommodating the increased discussion corresponding to the growing policy load. (See Internal Quality Improvement (IQI) Committee above for details.) Overall the Q/UAC committee structure was sufficient and provided adequate oversight and support to the Quality Improvement program and sufficient clinical expertise to support informing policy and procedure. Moreover, the medical expertise of Q/UAC's clinicians is deemed sufficient to meet Medicare's requirements, that those whose practices care for the elderly and disabled are involved.

Physician Advisory Committee Oversight Program

Physician Advisory Committee (PAC) and voting membership included external PCPs, board certified high-volume specialists, and advanced practice clinicians such as certified nurse midwives, nurse practitioners, or physician assistants. A voting provider member of the committee chaired PAC. Per Partnership policy, the

committee met monthly, at least 10 times during FY 2025-2026. PAC monitored and evaluated all Health Services activities and was directly accountable to the Commission for the oversight of the QI Program. The parameters for membership and meeting frequency were met for the FY 2025-2026, and activities including review and approval of policies and procedures, QI activities, and evaluations of projects and programs were addressed by an appropriate mix of Primary Care and Specialty physician members who attended. Quorum requirements were met for ten of the ten convened meetings. The Partnership CMO, Medical Director for Quality, Clinical Director of Behavioral Health, and leadership from QI, Provider Relations, Utilization Management, Care Coordination, and Pharmacy Departments attended PAC meetings regularly.

Quality Incentive Program Advisory Groups

As detailed later, Partnership has several incentive programs called Quality Incentive Programs (QIPs). QIP Advisory Groups are made up of appropriate Partnership staff and representative provider network staff to ensure ongoing collaboration in Partnership's value-based program offerings. Each year they review and recommend measures for the QIPs in which they participate. The QIP Team manages the Advisory Group member list and is responsible for inviting new participants at the conclusion of their period. Advisory Group meetings are held once per quarter throughout a measurement year for most QIPs and less frequently but no less than twice per measurement year for smaller programs.

Physician Advisory Committee (PAC) oversees the QIP Advisory Groups and the QIP Team is responsible for hosting the meeting and creating the Advisory Group meeting agenda in collaboration with the Partnership Chief Medical Officer. Each QIP Advisory Group formulates recommendations generated by internal QIP Technical Working Groups, in the form of draft measures which are released to their respective provider networks during a "public comment period." Feedback from the public comment period is shared with the QIP Advisory Groups, who assimilate them into a set of measure recommendations that are forwarded to PAC for review and approval. The current committee structure supports the QIPs and allows for valuable feedback from appropriate stakeholders, in a fashion that helps Partnership meet its goals. The QIP Advisory Group includes representation from all Partnership regions, including invitees from smaller organizations to diversify feedback and increase stakeholder buy-in.

Quality Improvement Leadership Engagement & Commitment

Partnership HealthPlan of California's executive leadership team provides essential oversight, accountability, and strategic guidance to support the Quality Improvement (QI) Program. Through active participation in key committees, workgroups, and strategic initiatives, these leaders ensure alignment between organizational priorities and quality goals. Each executive brings unique expertise and plays a distinct role in advancing quality management, supporting NCQA accreditation, meeting regulatory requirements, and driving performance improvement initiatives that enhance member care. The following describes the roles and contributions of executive leaders key to the governance and success of the QI Program.

Chief Executive Officer

The Partnership Chief Executive Officer's (CEO) primary roles in quality management and improvement were four-fold:

- Maintained a working knowledge of clinical and service issues targeted for improvement
- Provided organizational leadership and direction
- Participated in prioritization and organizational oversight of quality improvement activities
- Ensured availability of resources necessary to implement the approved QI Program

The CEO is a member of the Internal Quality Improvement (IQI) Committee and is a standing attendee and presenter at the Physician Advisory Committee (PAC). Along with other members of the Executive Team, the CEO further supports the QI Program through participation in the NCQA Steering Committee and Executive Quality Measure Score Improvement meetings. The Executive Team provides oversight, accountability and support for NCQA, HEDIS®, and related quality improvement initiatives.

In recognition of the need to better engage provider executive leadership at practice sites primarily responsible for driving quality measure performance, the CEO and CMO (or their senior leadership designees) meet with the executive and senior leadership of our largest primary care provider sites. One (1) to three (3) meetings are held annually with each of the participating provider organizations. These meetings have been an effective engagement strategy over the past several years and will continue in the next FY. The CEO was also a member of the Board Quality Advisory Group and partnered with the CMO in the consideration of topics and areas to gain further insights and recommendations from Board members who are also leaders at some of our largest participating network provider sites. The CEO's level of involvement in quality improvement activities was appropriate to ensure executive level accountability in support of the department and organizational wide goals and responsibilities.

Chief Operating Officer

The Chief Operating Officer (COO) provides strategic leadership and guidance in all health plan operations. The COO has purview over the Member Services, Claims, Configuration, Grievance and Appeals, Transportation, Provider Relations, Contracting, Network Services, and the Regional Leadership departments and ensures that these departments incorporate and prioritize quality improvement work and processes in coordination with standing work. The COO is a regular attendee and ad hoc member of PAC and an engaged participant at NCQA Steering Committee and Executive Quality Measure Score Improvement meetings. The COO's level of involvement fulfilled the need for executive support and accountability for operations key to successful quality improvement interventions, initiatives, and related organization-wide goals and responsibilities.

Chief Medical Officer

The Chief Medical Officer (CMO), with the assistance of the members of the PAC, Q/UAC, and IQI Committees, is responsible for providing professional judgment regarding matters of quality of care, peer review, clinical services, and medical procedures. The CMO is the chair of the IQI Committee and Q/UAC and has significant involvement in all QI, Pharmacy, Population Health Management, and Health Services activities. The CMO

facilitates the Board Quality Advisory Group and presents a report on quality at each Board of Commissioners meeting.

The CMO and the QI Program senior leadership team provide oversight for QI programs on a day-to-day basis. The team is comprised of:

- Associate Medical Directors - Assists CMO with utilization management review, review of appeal decisions, and review of Potential Quality Issues (PQI). The level of involvement of the associate medical directors was sufficient for reconciliation of PQIs via the peer review process.
- Medical Director for Quality - Assists CMO by providing physician support for varying activities within the Department, including Performance Improvement, Member Safety, Peer Review, and the Quality Improvement Programs, as well as assisted with utilization management review activities. This role also has management oversight of the Member Safety Teams within the Quality Department. The time allocated and scope of responsibilities of the Medical Director for Quality is set appropriately to meet the evolving needs of the QI Department.
- Regional Medical Directors - Works closely with respective counties on quality improvement activities including: liaison to physician leaders, serve as medical leadership at community meetings, support process improvement activities, author/ edit provider and member QI newsletter articles, drive improvements on adult and child quality measures and foster further collaboration and engagement with providers through regional meetings.
- Medical Director of Medicare Services – This new role was added in 2023-2024 to assure physician leadership in preparations for implementing the Medicare Dual Special Needs Plan (D-SNP). This medical director works closely with the CMO and Quality Department to develop policy, strategy, and tactical activities with Medicare leads designated in other departments across the organization. As D-SNP is implemented, this role will provide medical leadership for Partnership's Medicare activities, including utilization management, quality, care coordination, pharmacy, grievances, and compliance activities. Also assists CMO, as requested, in supporting broader needs to oversee appropriateness and quality of care delivered through Partnership and for the cost-effective utilization of services.
- Senior Director of Quality and Performance Improvement - Works collaboratively with the CMO to define strategy, develop programs and services, and evaluate the effectiveness of the QI Program. Together with the QI management team, including the Medical Director for Quality, provides oversight of Facility Site Reviews, investigation of potential quality issues, compliance with NCQA standards, HEDIS® and other performance measure data collection and performance reporting, value based payment programs (QIPs), performance improvement initiatives and programs, external and internal QI training, provider education on the QIPs and HEDIS®, grant application and grant management. This role works to foster greater cross collaboration of QI staff and strategic involvement of other departments to support the execution of tactics defined and maintained under Partnership's 5-Star Quality Strategy.

The number of associated Health Services staff and level of involvement of the CMO was appropriate for meeting the objectives of the Quality Improvement Program.

Chief Health Services Officer

The Chief Health Services Officer (CHSO) works closely with leaders in Utilization Management to provide accountability for delegates to meet necessary NCQA accreditation requirements and provide strategic leadership and guidance in the review and revision of provider contracts to ensure QI reporting requirements and value-based program contingencies are met. The CHSO also has purview over the Care Coordination, Utilization Management, Enhanced Health Services, Behavioral Health, and Health Equity Departments and ensures that these departments incorporate and prioritize quality improvement work and processes in coordination with standing work. The CHSO's level of involvement fulfills the need for executive support and accountability for improvements with data quality, and coordination of activities between QI and these departments. Collaborates with the Chief Medical Officer and members of PAC, Q/UAC, and IQI in matters involving quality of care, clinical, and medical procedures.

Chief Strategy & Government Affairs Officer

The Chief Strategy and Government Affairs Officer (CSGAO) reports to the Chief Executive Officer and is a peer to the other executive team members. The CSGAO leads the overall strategic direction of the HealthPlan in consultation with the CEO and Governing Board.

This position is responsible for the operations and executive management of Communications, Government Affairs, and Project Management/Operational Excellence (PMO) departments. This executive leader is also overseeing the organizational implementation of the Partnership Advantage product, a Medicare Duals Special Needs Plan (D-SNP).

Quality Improvement Departmental Changes

The structure of the QI Department, including committee structure (inclusive of leadership and practitioner participation), position changes, staff and team roles and responsibilities, are periodically assessed. The results of these assessments can lead to major operational and structural changes to the department or related QI functions. Consideration is given to new state directives, local and national events, general business needs, staff growth and development and fiscal responsibility when making a determination on whether to make structural or operational changes.

Based on the considerations noted above and the evaluation and assessment of the 2024-2025 QI Program, the following changes were made during FY 2025-2026:

Changes within QI Department

Key personnel changes and Program restructuring in FY 2025-2026:

Director of Quality Measurement
The responsibilities of the Director of Quality Measurement were expanded to include oversight and management of the NCQA, DSNP, and HEDIS teams. Along with this change, a Data Quality Validation Analyst was added to the team to help maximize the impact of all data sources.

HEDIS
As the requirements of the HEDIS team have grown, so too has the size of the team. This year they added additional temporary workers to assist with growing requests for data analysis and insight.

Member Safety Investigations
The volume of PQIs and their associated investigations has grown considerably over the last several years. This year, an additional PQI nurse was added to the team to accommodate the increase in workload. New nurses on this team have been selected from various backgrounds and specialties to provide a more thorough investigation.

Quality Improvement Executive Summary

QI TRILOGY

Executive Summary

Partnership has identified three (3) strategic priorities in its 2024-2027 Strategic Plan – 1) Champion Local Partnerships, Provide Statewide Leadership, 2) Be a Catalyst for Health Equity and Quality and 3) Extend Our Reach, Transform Our Role.

Partnership HealthPlan of California's Quality Improvement Program remained effective and adaptable during FY 2025-2026, continuing to support quality, safety, member experience, and accountability across a complex 24-county service area. This summary highlights the most important themes that frame our report. Overall, the year reflected steady execution of core quality priorities, meaningful progress in selected performance areas, continued investment in data and reporting capabilities, and preparation for future operational and regulatory demands.

- **Accreditation and readiness remained a major strength.** The organization sustained strong focus on NCQA-related work, successfully achieved Health Outcomes Accreditation, and continued structured preparation for upcoming accreditation surveys. This reflects a mature quality infrastructure and strong cross-department accountability.

- **Quality strategy remained aligned with external accountability.** The QI Program continued to organize its work around DHCS Managed Care Accountability Set (MCAS), NCQA, CAHPS, and related priorities, helping ensure that improvement efforts, provider incentives, and internal monitoring all supported the same strategic goals.

- **Provider-focused improvement work continued to mature.** Performance improvement teams, regional support models, coaching, improvement workgroups, and incentive programs remained central to Partnership's approach. These efforts helped advance targeted work in preventive care, chronic disease, behavioral health, women's health, and pediatric measures.

- **Data and analytics capabilities continued to strengthen.** The organization made further progress in data quality, supplemental data use, dashboard development, governance, and preparation for future system transitions. These investments are increasingly important for accurate reporting, performance monitoring, and decision-making.
- **Member experience and health equity remained important priorities.** Work continued to improve access, transportation, communication, and disparity analysis, while reinforcing that better experience and more equitable outcomes require sustained multi-year effort across departments and provider partners.

- **Preparation for future demands accelerated.** The report also reflects continued work to prepare for Partnership Advantage (D-SNP), evolving regulatory expectations, and HealthRules Payer implementation. These efforts added complexity during the year but also helped clarify future infrastructure and oversight needs.

In summary, this evaluation shows a Quality Improvement Program that is stable, capable, and increasingly integrated across the organization. Our full document provides detail on how Partnership supported accreditation, strengthened provider improvement efforts, improved data infrastructure, advanced member experience and equity priorities, and positioned itself for the next phase of quality oversight and program growth.

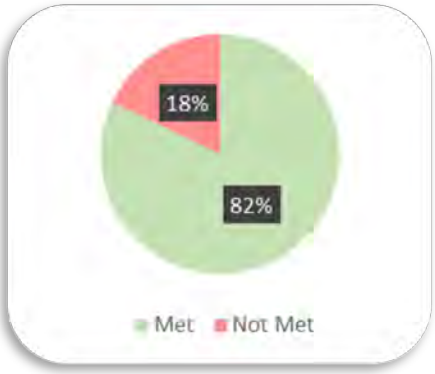
2025-2026 QI Work Plan Summary

Background

Background: The QI Work Plan is designed to track progress on key Quality Improvement (QI) activities and initiatives throughout the year. Approved by our Board of Commissioners and quality committees, it includes progress updates on planned activities and objectives for improving quality of clinical care, safety of clinical care, quality of service and members' experience. The Work Plan is set on a FY 2025-2026 schedule. This update includes progress on activities included in the FY 2025-2026 QI Work Plan from July 1, 2025, to June 30, 2026.

Of the 72 goals outlined in the QI Work Plan, 59 were complete, 9 were terminated, and 4 were delayed or incomplete.

Goal Status July 1, 2025 – June 30, 2026		
Status	**Total Number:**	**%**
Met	59	82%
Not Met	13	18%



QI Major Milestones and Activities

This year's quality improvement activities focused heavily on strengthening the systems, data processes, and program infrastructure needed to support performance monitoring, incentive program administration, HEDIS reporting, and evolving data exchange requirements. Major efforts included expanding the use of clinical data through partnership with DataLink for MY2025 HEDIS rate generation, increasing participating practices from six to more than 30, and preparing the provider network for continued movement toward Electronic Clinical Data Systems (ECDS) reporting and the CMS Interoperability Framework. Incentive program infrastructure was also advanced through Perinatal QIP provider onboarding and ECDS implementation, successful data extraction for most participating providers, updates to the PCP QIP Data Validation Framework, and revisions to the Palliative Care QIP Data Validation Framework to support payment accuracy, timeliness, and new measure implementation. Additional operational improvements included updates to Member Safety corrective action monitoring tools, an upgrade to the Potential Quality Issue documentation system, new Initial Health Appointment tracking processes, development of a Medi-Cal Dental provider directory, and pharmacy review of latent tuberculosis infection treatment gaps.

The year also included broad, targeted work to improve measure performance through cross-functional collaboration, provider coaching, and regionally tailored interventions. The Quality Measure Score Improvement initiative engaged measure-specific workgroups across behavioral health, chronic disease, women's health and perinatal care, and pediatrics, with activities focused on monitoring performance, identifying improvement

opportunities, and completing defined deliverables. Behavioral health work included collaboration across Behavioral Health, Care Coordination, Population Health, Pharmacy, Quality Improvement, county partners, and hospital-based Community Health Workers to support follow-up after emergency department visits and peer support service utilization. Chronic disease efforts emphasized diabetes management evaluation, colorectal cancer screening education, blood pressure monitoring, kidney health evaluation for patients with diabetes, and collaboration with UC Davis on county-level colorectal cancer improvement strategies. Women's health and perinatal efforts focused on prenatal care timeliness, HPV self-collection, chlamydia screening, adolescent reproductive health education, and Tribal Perinatal Program participation. Pediatric activities included preventive care webinars, identification of best practices from high-performing providers, developmental screening education, well-child visit monitoring, and a newborn pilot project to improve early visit completion.

Provider engagement, network education, and member-facing interventions were another major theme of the year. The Performance Improvement team partnered with local consortia and high-volume primary care practices across regions to support priority measures such as breast cancer screening, cervical cancer screening, lead screening, topical fluoride application, chlamydia screening, childhood immunizations, controlling high blood pressure, and well-child care. Regional quality meetings created opportunities for peer learning and sharing successful local strategies, while Improvement Academy offerings expanded provider education through six virtual trainings on priority MCAS measures, three in-person ABCs of Quality Improvement sessions, microlearning evaluations, and a QI Project Toolkit and Training Program that moved from pilot to full-scale implementation. Member outreach and access-focused initiatives also supported measurable improvement, including Healthy Kids Growing Together outreach for well-child visits, Your Partner in Prevention Women's Wellness Days, and 109 Mobile Mammography event days that resulted in 2,465 completed breast cancer screenings and contributed to regional PCP QIP benchmark achievement. Collectively, these activities reflect a coordinated year of building quality improvement capacity, strengthening data-driven program oversight, improving provider support, and advancing preventive and clinical outcomes for members across Partnership regions.

Please see Appendix (G) 2025-2026 QI Work Plan Summary for a complete list of activities.

FY25/26 Final Goal Status: Delayed/Terminated

Project or Program	Goal	Status Details	Next Steps
2.h. Enterprise Information Management	**Goal #1:** By June 30, 2026, integrate the HRP® version of the HEDIS® project data into the Enterprise Data Warehouse and use this data to create the HRP® version of the HEDIS® PQD modules.	Terminated	The priority of this task has changed, now working towards implementing automated solution on the Inovalon Data Lake.
2.h. Enterprise Information Management	**Goal #2:** By June 30, 2026, Plan, Develop, Test, and have the files ready for Wakely to integrate the test data to their	Delayed	Delayed due to postponement of D-SNP program. Deliverables will be resumed in the 26-27 FY.

Project or Program	Goal	Status Details	Next Steps
	environment to help build STAR measures dashboard for Medicare LOB		
2.h. Enterprise Information Management	**Goal #4:** By June 30, 2026, Plan, Develop, Test, and have the test files ready for PCP QIP project to support Medicare Line of Business (LOB). Integrate the necessary datasets to Cozeva platform to support QIP measures.	Terminated	This goal is terminated due to postponement of D-SNP program to 1/1/28 and Cozeva contract termination. The PCP QIP program for D-SNP line of business will be addressed later
2.j. HEDIS Reporting to Support D-SNP Data Collection and Analysis	**Goal #1:** By August 29, 2025 provide first set of data for DSNP Monthly MY2025 data to the QI DSNP Team and, send data monthly thereafter after each data refresh.	Terminated	This goal has been terminated due to the decision to report DSNP data collection and analysis using a new third party vendor, Wakely.
3.a. Primary Care Provider Quality Improvement Program (PCP QIP)	**Goal #1:** By June 30, 2026, the PCP QIP Program will be leveraged to support existing and newly added low performing providers in the Modified QIP measure set. This support will include provider education and encouragement to increase on-line data platform usage and monitoring which results in improved engagement and performance improvement activities.	Terminated	As of 1/1/2026, MQIP program was discontinued due to the Federal Ruling contract agreements requirements. The Enhanced Provider Engagement program has been created to support low performing providers in the PCP QIP. The PCP QIP team continues to collaborate with Performance Improvement Advisors to engage and train these specific providers as needed through Partnership's Enhanced Provider Engagement strategy which is owned by the Performance Improvement team.
3.b. Hospital Quality Incentive Program (H-QIP)	**Goal #2:** By June 30, 2026, develop Partnership's Hospital Quality Symposium for the 2026-2027 H-QIP measurement year.	Terminated	This goal has been terminated due to programmatic changes caused by new federal regulations that necessitate the HQIP transitioning from a fiscal year program to a calendar year program. These changes do not

Project or Program	Goal	Status Details	Next Steps
			make it feasible or practical to hold the event this year. The Hospital Quality Symposium will not be held in 2026 but will be held in 2027.
3.f. Dual Eligible Special Needs Plan (D-SNP) Quality Incentive Program (QIP) Development	**Goal #1:** By October 31, 2025, complete the Advance Care Planning and Annual Wellness Visit (AWV) measure development for inclusion in the 2027 D-SNP QIP measurement year.	Delayed	The Annual Wellness Visit (AWV) goal has been delayed due to the Medicare DSNP go-live date being postponed to January 1, 2028. The proposed AWV measure will still require approval from the Executive team before it can be included in the 2028 DSNP QIP measures.
3.f. Dual Eligible Special Needs Plan (D-SNP) Quality Incentive Program (QIP) Development	**Goal #2:** By October 31, 2025, obtain a signed contract agreement with Partnership HealthPlan of California and our selected D-SNP system vendor, Cozeva.	Terminated	After careful consideration, leadership has chosen to take a more streamlined approach to our DSNP QIP in the first year of our Medicare product, and as a result, will not be utilizing Cozeva's services at this time. We will maintain open communication with Cozeva and may consider partnering with them in the future if our needs evolve.
3.f. Dual Eligible Special Needs Plan (D-SNP) Quality Incentive Program (QIP) Development	**Goal #3:** By June 30, 2026, develop a detailed implementation plan and timeline (Project kick-off, Pre-Implementation phase, Implementation phase) with internal PHC teams and Cozeva.	Terminated	After careful consideration, leadership has chosen to take a more streamlined approach to our DSNP QIP in the first year of our Medicare product, and as a result, will not be utilizing Cozeva's services at this time. We will maintain open communication with Cozeva and may consider partnering with them in the future if our needs evolve.
3.f. Dual Eligible Special Needs Plan (D-SNP) Quality Incentive Program (QIP) Development	**Goal #4:** By June 30, 2026, the D-SNP Quality Incentive Program (QIP) will prepare Cozeva systems for the anticipated 2027 go-live.	Terminated	After careful consideration, leadership has chosen to take a more streamlined approach to our DSNP QIP in the first year of our Medicare product, and as a result, will not be utilizing Cozeva's services at this time. We will maintain open

Project or Program	Goal	Status Details	Next Steps
			communication with Cozeva and may consider partnering with them in the future if our needs evolve.
4.c. Mobile Mammography Program	**Goal #2:** By June 30, 2026, complete at least 3 wellness days as part of the new Your Partner in Prevention Program (YPIP).	Terminated	The YPIP Team has decided to organize strategy meetings in collaboration with the Performance Improvement Team to develop strategies on executing Kid and Adolescent Wellness Days. Note that Mobile Mammography-focused events continues to be supported by other teams in QI and population health.
9.a. Compliance with NCQA HOA and Sustain Performance	**Goal #1:** By June 30, 2026, departments will maintain compliance of all assigned NCQA Health Outcomes Accreditation (HOA) Standards and Guidelines, following the 2026 HOA Standards and Guidelines once available, as measured by the three (3) deliverables listed.	Delayed	NCQA Program Management Team will continue to work with the selected department(s) to complete their annual HOA Workbook and 2026-2028 HOA Report Schedule. NCQA will ensure there are no issues identified due to the incomplete submission. The NCQA Program Management Team will host meetings with the Consultant and the department(s), to clarify the NCQA standards, understand the operation workflows, explore new processes, and then define roles and responsibilities to comply with the Renewal Survey requirements. No immediate risks or issues identified at this time. Will be completed in the next FY.

National Committee for Quality Assurance (NCQA) Accreditation

QI TRILOGY

NCQA Overview

(National Committee for Quality Assurance)

Partnership strives to improve the health status of members and their care experience to become one of the highest quality health plans in California. The NCQA Health Plan Accreditation (HPA) and Health Outcomes Accreditation (HOA) support Partnership's vision, mission, and strategic goals and fulfill Partnership's contractual obligations with the Department of Health Care Services (DHCS).

NCQA Health Plan Accreditation (HPA) and Health Outcomes Accreditation (HOA) Key Activities

During FY 2025-2026, Partnership focused on advancing key activities and achieving important goals related to NCQA Accreditation. Including:

1) Maintaining compliance of all assigned NCQA Health Plan Accreditation (HPA) Standards and Guidelines, in preparation for the HPA Renewal Survey on September 15, 2026.
2) Preparing for readiness and maintaining compliance of all assigned NCQA Health Outcomes Accreditation (HOA) Standards and Guidelines, in preparation for the HOA Renewal Survey on May 16, 2028.
3) Report HEDIS® and CAHPS® results to NCQA for HPA requirements by June 2026.

Compliance with NCQA Survey Standards

Per the 2024 DHCS contract, all Managed Care Plans (MCPs), including Partnership, will be mandated to achieve both NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation (HEA) by January 1, 2026.

On September 30, 2025, NCQA released a statement stating that Health Equity Accreditation will be renamed Health Outcomes Accreditation (HOA), effective January 15, 2026. Partnership ensured all material and communications moving forward are compliant with this name change.

Partnership successfully achieved NCQA HPA reaccreditation on December 28, 2023. NCQA requires health plans to undergo reaccreditation every three (3) years, and Partnership's next HPA Renewal Survey is scheduled for September 15, 2026. In preparation for Partnership's HPA Renewal Survey in 2026, Partnership conducted a Mock Renewal Survey in October 2025. The Mock Renewal Survey served as a full-scope review of all "Year 1" evidence by our NCQA Consultant, who provided recommendations and addressed findings on the evidence submitted. Business Owners also had the opportunity to clarify issues and seek guidance during this time. A final report and scoring, along with the Action Plan, were distributed to Business Owners after the conclusion of the Mock Renewal Survey. Business Owners continued to work with the NCQA Program Management Team to address the findings and assess the recommendations to align the survey deliverables in accordance with NCQA's look-back period, timelines, and/or expectations. Activities are currently underway in FY 25-26 to prepare for the Formal HPA Renewal Survey. As a result of continuous partnership among departments, leadership and the NCQA Program Management Team, all standard categories (QI, PHM, NET, UM, CR, and ME) achieved 80 percent of the applicable points as of May 2026, including Standards/Elements with a shorter look-back period based on the 2026 HPA Standards and Guidelines. Opportunities for improvement were identified under a subset

Must-Pass file review Elements. The impacted departments implemented interventions tied to the identified causes and will continue ongoing monitoring to ensure their effectiveness.

NCQA HOA is another accreditation program, focusing on high-quality care based on understanding and addressing the unique or specific needs of our member populations. The HOA Program structure mimics that of the HPA Program structure, which has proven to be successful in achieving accreditation. Partnership successfully obtained its first NCQA HOA on August 7, 2025. Due to a delay in the release of the 2026 HOA Standards and Guidelines, which took place in December 2025 instead of August 2025, the NCQA Management Team re-adjusted the key activities and timeline of the program deliverables for FY 25-26. In addition, a three (3)-year HOA Renewal Survey timeline has been developed which outlines all key activities to achieve HOA in 2028. The NCQA Program Management Team worked closely with Partnership's NCQA Consultant, and key stakeholders across the organization to estimate Partnership's current performance and its readiness to achieve the next NCQA HOA by May 2028. Percentage compliance at the start of the 24-month look-back period, May 2026, was at 34.3%. This percentage is based on evidence documentation provided by Business Owners by April 2026, including documented processes for NCQA Consultant's assessment and screenshots from online resources and websites. The NCQA Program Management Team continues to work with the key stakeholders in assessing gaps based on changes from 2026 HOA Standards and Guidelines. This assessment includes collaboration between departments, clarifying functions by different business units, and determining roles and responsibilities for NCQA HOA requirements.

The NCQA Program Management Team strives to maintain up-to-date knowledge of the NCQA HPA and HOA Standards and Guidelines, and monitors NCQA's public comment, triannual policy updates and monthly FAQs closely, notifying Business Owners of any impact to their standards and/or approved evidence. The NCQA Program Management Team also maintains a compliance dashboard, which outlines key reporting accreditation metrics, and tracks plan-wide compliance rates. Communications provided by the NCQA Program Management Team were shared via different forums, including newsletters, business owner check-in meetings, and Steering Committee meetings with the executive leadership. Input and direction received from the executive leadership help to define Partnership's NCQA program vision and success for accreditation.

Preparation for HPA and HOA Renewal Survey

The plan-wide NCQA-related HPA and HOA key activities were approved by the NCQA Steering Committee for FY 2025-2026. The HPA key activities included six (6) milestones aimed at ensuring continuous compliance with HPA requirements in preparation for Partnership's next HPA Renewal Survey, scheduled for September 15, 2026. For the HOA key activities, there were three (3) milestones aimed at readiness of all assigned HOA Standards and Guidelines for the HOA Renewal Survey, scheduled for May 16, 2028. A summary of the key activities and outcomes towards obtaining NCQA HPA and HOA Renewal Survey are presented below. The HPA and HOA key activities were met, and all milestones were completed.

HPA Key Activities: Departments will maintain compliance with all assigned NCQA HPA Standards and Guidelines, following the most up-to-date Standards and Guidelines once available, as measured by six (6) milestones:

Milestone 1: Milestone 1 was achieved by Business Owners submitting evidence accurately and timely. Business Owners submitted all annotated evidence for the Mock Renewal Survey based on the dates listed in the Evidence

Submission Library for Year 1 of the look-back period, and the submission guidelines provided by the NCQA Program Management Team.

Milestone 2: Milestone 2 was achieved by Business Owners completing the annual HPA Workbooks. This included:

1. Review of the HPA Work Plan, identifying new Business Owners, Business Sponsors, and Contributors as needed.
2. Review of the Evidence Submission Library, confirming evidence documents and planned target production dates.
3. Obtaining attestations, discussing questions, and evaluating impact among Business Owners and Contributors, as needed.

Milestone 3: Milestone 3 was achieved by Business Owners submitting edits to the HPA Report Schedule and providing their analysis reports timely. All edits were incorporated, and the analysis reports were deemed compliant by the NCQA Consultant.

Milestone 4: Milestone 4 was achieved by Business Owners participating in the HPA Mock Renewal Survey. For any identified gaps, Business Owners completed additional steps. These included:

1. Submitting an Action Plan (AP) to address any applicable recommendations.
2. Correcting evidence by the applicable look-back period, timelines, and/or expectations by NCQA. Any revised or new evidence was submitted to the NCQA Consultant for review and approval.

After the Mock Survey, Business Owners were instructed to share any modifications to approved evidence that affect NCQA requirements, including documented processes, with the NCQA Program Management Team for review and further assessment prior to the effective/production date.

Milestone 5: Milestone 5 was achieved by applicable departments completing the three (3) components related to file review and oversight.

1. Applicable departments participated in a Mock File Review with our NCQA Consultant in August 2025 and February through May 2026. Audit findings and recommendations were shared with Business Owners and Action Plans were completed and submitted timely by the Business Owners. Risks identified and next steps were presented to the NCQA Steering Committee .
2. Applicable departments conducted quarterly file review audits of Partnership files. The audits were completed timely with no or minimal issues identified. When issues were identified, Business Owners provided an action plan to address the findings. Utilization Management implemented daily monitoring of denial letters (including Utilization Management hospital delegates letters) and upheld appeal letters.
3. The Network Services and Utilization Management teams continue ongoing monitoring of non-NCQA accredited delegates. The annual delegation audits for credentialing delegates took place in February-March 2026. The annual delegation audits for Utilization Management delegates took place in March-April 2026. Corrective Action Plans were issued to three (3) credentialing delegates, where a key finding was identified. Two (2) delegates submitted example documentation showing the issue had been corrected, and an ad hoc audit is scheduled with one delegate to ensure a new process is in place and will operate effectively. No issues identified from Utilization Management delegates.

Milestone 6: Milestone 6 was achieved by Business Owners submitting bookmarked and annotated evidence accurately and timely for the HPA Formal Survey Renewal. In a few instances, documentation was not available by the assigned deadline. Impacted Business Owners worked closely with the NCQA Program Management team for an adjusted timeline.

HOA Key Activities: Departments will prepare readiness and maintain compliance of all assigned NCQA Health Outcomes Accreditation (HOA) Standards and Guidelines and prepare for the HOA Renewal Survey in May 2028, as measured by three (3) milestones:

Milestone 1: Milestone 1 was achieved by Business Owners completing the annual HOA Workbooks. This included:

1. Review of the HOA Work Plan, identifying new Business Owners, Business Sponsors, and Contributors as needed.
2. Review of the Evidence Submission Library, confirming evidence documents and planned target production dates.
3. Obtaining attestations, discussing questions, and evaluating impact among Business Owners and Contributors, as needed.

Milestone 2: Milestone 2 was achieved by Business Owners submitting edits to the HOA Report Schedule and providing their analysis reports timely. All edits were incorporated, and the analysis reports were deemed compliant by the NCQA Consultant.

Milestone 3: Milestone 3 was achieved by Business Owners completing the two (2) components timely:

1. All Business Owners confirmed Documented Processes were in compliance prior to the start of the look-back period. Any edits that were required to bring Documented Processes in compliance were completed by April 2026.

   2. 2. All Business Owners submitted their applicable screenshots prior to the established due dates. All screenshots were reviewed and deemed compliant by the NCQA Consultant. Overall, the activities outlined above, along with staff that serve as the NCQA Program Management Team, were sufficient and provided strong oversight to achieve the FY 2025-2026 key activities and objectives for NCQA HP and HO Accreditation included in the QI Work Plan.

CAHPS® and HEDIS® Reporting for Health Plan Accreditation

Partnership was required to formally report MY2025 HEDIS® and CAHPS® for HPA by June 2026. HEDIS® and CAHPS® reporting is a requirement that must be fulfilled annually by accredited health plans in order to maintain their accredited status. A health plan may choose the results of the CAHPS® survey to be reported: Adult CAHPS® or Child CAHPS®. For MY2025/RY2026, Partnership chose to submit the Child CAHPS® rates. Partnership also successfully reported HEDIS® HPA rates by the May 22, 2026, mandated deadline. Additionally, Partnership submitted the NCQA Healthcare Organization Questionnaire (HOQ) for the required CAHPS® surveys by the December 29, 2025, required deadline.

NCQA uses the annual HEDIS®/CAHPS® reporting to calculate the Health Plan Rating (HPR) that is released on NCQA's website every September. The HPR is the weighted average of a plan's HEDIS® and CAHPS® measure ratings, plus bonus points for plans with current Accreditation status.

During the next fiscal year, Partnership will continue to work on sustaining compliance of all Renewal Survey requirements through key defined activities, as well as its NCQA Program Management and NCQA Steering Committee structure to assure our readiness for Renewal Survey Accreditation in September 2026.

Partners in Quality

As of November 2021, Partnership became an NCQA Recognition Program Partner in Quality (PIQ) and has been awarded the PIQ stamp by NCQA. The PIQ program recognizes organizations that provide financial incentives or support services to practices seeking recognition through a subset of NCQA programs, including Patient-Centered Medical Home (PCMH) Recognition. This distinction was awarded to Partnership based upon the incentive payment offered to practices who are PCMH providers as well as technical assistance provided for gap analysis or assessment to assist practices with identifying areas to focus transformation. As of November 2021, Partnership is also listed on NCQA's Resource Directory of Incentives website as a PIQ organization. NCQA will reassess our PIQ status on a yearly basis via survey shared with our organization, and update their database accordingly based on our response.

As a result of this recognition, provider practices that are first time applicants and are supported by Partnership will also be eligible for a 20% discount for NCQA Recognition programs. Partnership offers support and motivation for the Provider network to achieve and maintain the Patient Centered Medical Home (PCMH) recognition is the PCMH Unit of Service measure included in the PCP QIP. Each measurement year, the Provider network has the chance to earn $1,000 per PCP site for achieving or maintaining PCMH accreditation from NCQA, or equivalent from Accreditation Association for Ambulatory Health Care (AAAHC) or The Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Key Benefits of Being a Partners in Quality (PIQ) Recognized Organization:

- NCQA will grant automatic-credit on a small subset of HPA Standards and Guidelines
- NCQA offers provider quality data at a discounted rate to organizations seeking to integrate validated quality ratings into their information tools.
- Provider Practices supported by Partnership that are first time applicants will be eligible for a 20% discount off the initial Recognition submission fee when submitting their NCQA application.

Preparations for Partnership Advantage (D-SNP)

QI TRILOGY

Preparations for Partnership Advantage (D-SNP)

During FY 2025-2026, Partnership dedicated significant effort to preparing for the launch of its Medicare Dual-Eligible Special Needs Plan (D-SNP), known as Partnership Advantage, whose go-live date is planned for eight or more counties in January of 2028. These preparations focused on meeting regulatory requirements, establishing a comprehensive Model of Care (MOC), and integrating Medicare-specific goals and structures into existing Quality Improvement (QI) processes. The work reflects a coordinated, organization-wide commitment to ensuring that Partnership Advantage delivers high-quality, patient-centered care while aligning with CMS Star Rating expectations and other federal and state performance requirements. The following section highlights key activities and initiatives undertaken by the QI Department in preparation for a successful D-SNP launch and ongoing performance monitoring.

Model of Care

Partnership is required by DHCS to implement an Exclusive Aligned Enrollment (EAE) Dual-enrollment Special Needs Plan (D-SNP). Each D-SNP is required to draft a Model of Care (MOC) document which specifies how members receive care, how that care is coordinated, and how the plan intends to ensure that care is accessible, efficient and patient-centered. The MOC was drafted according to NCQA and DHCS guidelines, however, it was not formally submitted due to the postponement of the launch of Partnership Advantage from 2027 to 2028. Pending approval for the 2027 submission, Partnership Advantage is anticipated to launch within the following eight counties: Del Norte, Humboldt, Lake, Marin, Mendocino Napa, Solano and Sonoma. The MOC addresses four specific areas: 1) identifying and defining the needs of our most vulnerable population, 2) care coordination, 3) the primary care and specialty care network, and 4) quality improvement and monitoring. The QI Department assumed the lead in continuously updating and formatting the MOC for future submissions by the Regulatory and Compliance Department.

Within the Quality section of the MOC, Partnership defines the processes for monitoring and evaluating D-SNP performance. This process aligns closely with the annual QI Program Description in terms of existing committee structure, quality improvement program structure and overlapping data reporting needs. This structure and additions to the QI Program will supplement Partnership's overall efforts to achieve a high CMS Star Rating.

Integrating Partnership Advantage D-SNP

The QI Department integrated Medicare focused goals throughout the department. The Quality team has specifically focused on adapting to needs in the Quality Incentive Program, HEDIS and CAHPS data monitoring and Potential Quality Issues. Continuing building the program based on the Operational Gap Analysis previously conducted, the QI Department continued to build resources and programs for effective monitoring and performance improvement in the D-SNP program. Several projects were executed this fiscal year to supplement existing QI work, including:

- Developing the structure and vendor support for a D-SNP Quality Incentive program
- Data sharing and configuration to generate baseline Medicare HEDIS rates from our existing Medi-Cal population
- Generating QI-specific D-SNP training materials for internal staff members
- Developing methods for data capture and analysis for HEDIS as part of a larger Medicare Star Strategy

Additionally, new projects included developing the structure and internal support to address overall Medicare Quality reporting needs, including; CMS Stars, DHCS and MOC reporting. Overall, the QI Department has focused significant efforts to ensure a successful program launch and the ability to monitor and analyze Medicare program data to optimize the quality of member care.

HealthPlan Quality Performance

QI TRILOGY

Overall Summary

In addition to HEDIS® reporting, updates on the following activities were presented to the IQI and physician committees annually: CAHPS®, summary results from specific access studies, Grievances & Appeals, Initial Health Assessments, facility site and medical record reviews, potential quality issues, targeted improvement projects, and the Partnership Improvement Academy. Project measures were reviewed during improvement team meetings. Partnership completed a robust, comprehensive evaluation annually for major programs and quality improvement projects and initiatives.

Partnership HEDIS Reporting Populations – MY2025

In MY2025, Partnership continued to host two (2) required separate audits:

- DHCS / MCAS required reporting: Health Service Advisory Group Auditor
- NCQA HEDIS® Health Plan Accreditation / HPA: Advent Advisory Auditor

Starting in MY2024, Partnership reported one Plan-Wide rate for all 24 counties in its network for the MCAS measure set to its DHCS auditor, Health Services Advisory Group (HSAG).

Starting in MY2024, Partnership also reports county-wide rates for all MCAS measures and their respective sub-measures to DHCS directly. DHCS uses county-wide rates to calculate outcomes for multiple accountability programs that are described below. County level rates for hybrid measures are calculated using a county-level oversample populations (minimum size of 100 members).

For NCQA reporting, Partnership also reported one Plan-Wide rate for all 24 counties in its network. Rates for each HPA measure are reported to Partnership's NCQA auditor, Advent Advisory.

In MY2025, Partnership observed slight decrease in overall membership by approximately 1.3%, to 895,339 assigned members in December 2025.

The impact of population shifts in Partnership's network from the 10 new counties joining the Partnership network in January 2024 continues to impact HEDIS measure reporting populations differently, depending on each measure's continuous enrollment requirements as defined in the NCQA HEDIS MY2025 Technical Specifications. One measure, Breast Cancer Screening, ECDS (BCS-E), requires continuous enrollment greater than one year for a member to be included in the measure's eligible population, which meant that very few members from incoming counties met the criteria to be included in the measures' plan-wide rates in MY2025. All other MCAS measures in the 10 incoming counties have eligible populations that reflect the current membership.

DHCS Accountability Programs

Since 2019, DHCS has introduced multiple MCP accountability programs that align plan MCAS measure performance with DHCS's Comprehensive Quality Strategy and Bold Goals Initiative. The table below outlines DHCS accountability programs that are driven by MY2025 measure performance, and each program is described in ***Appendix E: HEDIS® MY2025 / RY2026 Annual Summary of Performance Report (MCAS).***

DHCS Accountability Programs Driven by MCAS Measure Performance, MY2025

Program	Description	Geographic Impact	Financial Impact	Financial Impact Trigger
Quality Withholds and Incentive Program	MCP's earn back withheld revenue with high regional performance or improvement on subset of MCAS measures Incentive earnback with closing regional disparities on WCV measure	Quality Rating Regions	1% of MCP's annual revenue earned back	<67th percentile performance AND <25% YoY improvement
Clinical Efficiencies	Performance on clinical efficiency measures (mostly inpatient) impact MCP rate setting	Plan Wide	Plan rates	Main driver: low performance Ambulatory Sensitive Admissions
Community Reinvestments Quality	5% annual net income automatically invested in county community projects, Quality Factor is an additional investment amount based on quality measure performance	County	Additional 7.5% of annual net income - prorated by county membership	2+ measures <50th percentile in a measure domain
Quality Sanctions	Fines for performance below 50th percentile on all MCAS measures	County	Measure population not served is main factor	<50th percentile
Quality Factor Score	Composite MCAS measure score used to compare MCP performance state-wide	Plan Wide	None	None

Supplemental Data Within MY2025 HEDIS Annual Project

Partnership was able to use several new supplemental data sources in the MY2025 HEDIS Annual project:

Electronic Clinical Data Systems (ECDS) Vendor: Partnership expanded its use of Datalink, an NCQA Certified Data Aggregator software, in MY2025, and received auditor approval to include records in the MY2025 HEDIS Project. The use of clinical data towards HEDIS measure rate calculation is an important step towards readiness for NCQA's planned transition of hybrid measures to ECDS measures by 2029, which require structured clinical data for measure rate generation; and towards readiness for CMS's Interoperability Framework.

Records from over 30 practices within Partnership's provider network were included in the MY2025 HEDIS Annual Project. Partnership continues to make progress with leveraging Datalink as a supplemental data source:

- Even without full implementation across the Partnership network, Datalink made a significant positive impact on administrative rates for MCAS Accountable measures. To summarize, the impact of Datalink on measure rates includes:
    - 23% of total care gaps closed for the Controlling Blood Pressure (CBP) administrative measure, plan-wide
    - 17% of total care gaps closed for the Glycemic Status for Diabetes (GSD) administrative measure, plan-wide
    - 18% of total care gaps closed for the Breast Cancer Screening (BCS-E) ECDS measure, plan-wide
    - 12% of total care gaps closed for the Cervical Cancer Screening (CCS-E) ECDS measure, plan-wide

- Partnership is preparing for the addition of three (3) Depression Screening measures to the MCAS measure set in MY2026: Depression Screening for Adolescents and Adults (DSF-E-SC); Prenatal Depression Screening (PND-E-SC); and Postpartum Depression Screening (PDS-E-SC). Datalink will be the sole source of data for these three measures.

Year Round Medical Record Review for Well-Child Visits in the First 30 Months of Life (W30) and Prenatal and Postpartum Care (PPC) measures: In MY2024, the QI department identified a systems issue with newborns' temporary member ID's that caused underreporting of newborn visit rates for the W30 measure. To address this, the HEDIS team completed a supplemental Medical Record Review of the entire W30 measure eligible population in early 2025, which was accepted as a supplemental data source by HSAG's auditor. The supplemental Medical Record Review made a dramatic impact on the rates for both W30 submeasures, and both W30 submeasure rates scored above the 50th percentile for MY2024.

In MY2025, the HEDIS team repeated the Medical Record Review as a year-round effort, which allowed the team more time to collect and review charts for the W30 eligible population. The team also expanded the scope of the year-round Medical Record Review to allow the Prenatal and Postpartum Care (PPC) submeasures to benefit from the extended review period.

Electronic Record on Demand (ERD) Clinical Data retrieval pilot: Partnership piloted an additional clinical data retrieval methodology supported by the plan's HEDIS certified software vendor, Inovalon. The pilot was focused on retrieving clinical records for measures that were not included in the ECDS Datalink scope which resulted in a slight increase in rates across 22 measures in the MCAS and NCQA Health Plan Accreditation measure sets. Further assessment is underway to determine the potential to expand this effort.

SacValley MedShare (SVMS): SVMS is a Health Information Exchange used by practices and health systems throughout Northern California. In MY2025, Partnership received auditor approval to use Encounter, Lab, and Measurement (i.e., blood pressure readings) records towards the HEDIS Annual Project, which had a significant impact on several MCAS measures in MY2025. SVMS's Immunization records did not receive auditor approval to be included in the MY2025 HEDIS rate generation.

Root cause analysis of fluoride varnish services: Partnership worked with DHCS in 2024 - 2025 to better understand how it receives fluoride varnish claims and encounters that can be counted towards the Topical Fluoride for Children (TFL) MCAS measure, most of which are billed to Denti-Cal from Federally Qualified Health Center (FQHC), Rural Health Center (RHC), and Tribal Health Dental Centers and then sent to Partnership. In 2025 Partnership actively worked with DHCS and Dental Centers throughout its network to standardize and spread dental fluoride varnish coding that would accurately capture completed services towards the MY2025 measure. The plan also created a Dental Liaison role on the Quality Improvement team to promote pediatric dental care and ensure that the Partnership network has high quality dental directory resources and referral pathways for pediatric members. This has resulted in significant improvements to Partnership's ability to accurately report pediatric fluoride varnish application rates.

DHCS MCAS Accountable Measures

In MY2025 / RY2026 HEDIS® Annual Final Reporting, DHCS announced that it is planning to hold managed care plans (MCPs) accountable for performance on 18 selected Hybrid and Administrative measures. The same 18 MCAS accountable measures from MY2024 continued into MY2025. These measures are subject to DHCSs multiple accountability programs described above.

Results of an additional 10 MCAS measures were reported but were not part of the accountability measure set in MY2025 ("reporting only measures"). The full list of MY2025 MCAS measures can be found on the DHCS

website: https://www.dhcs.ca.gov/dataandstats/reports/Documents/Medi-Cal-Accountability-Set-Reporting-Year-2026.pdf

The measure performance analysis that follows is based on the performance of the 18 accountable MCAS measures per NCQA Quality Compass 2025 Benchmarks, developed using MY2024 performance for Medicaid plans nation-wide.

MY2025 MCAS Plan-Wide Rates

The table below shows Partnership's MY2025 rates for the MCAS measure set at the Plan-Wide level.

Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
Below MPL (minimum performance level, based on NCQA's Quality Compass Medicaid 50th percentile)

Measure Name	Plan-Wide Rate	YoY Change	50th	90th
(AMR) Asthma Medication Ration - Total 5 - 64 Ratios > 50%	73.33%	8.62%	63.66%	76.25%
(BCS-E) Breast Cancer Screening - Non Medicare Total	53.43%	-2.86%	55.87%	66.31%
(CBP) Controlling Blood Pressure - Non Medicare Total *	67.40%	-2.19%	67.88%	75.43%
(CCS-E) Cervical Cancer Screening - Total	48.08%	-11.04%	52.32%	64.21%
(CHL) Chlamydia Screening in Women - Total	58.98%	3.40%	56.30%	70.67%
(CIS-E) Child Immunization Status - Combo10	26.74%	-1.48%	23.89%	34.79%
(DEV) Developmental Screening in the First Three Years of Life - All Ages Total *	39.42%	9.77%	37.40%	0.00%
(FUA-30) Follow Up after ED Visit for Alcohol and Other Drug Abuse or Dependence - 30 Day Rate	41.35%	8.08%	39.10%	53.27%
(FUM-30) Follow Up After ED Visit for Mental Illness - 30 Day Rate	50.26%	21.25%	57.13%	74.67%
(GSD>9) Glycemic Status Assessment for Patients with Diabetes - GMI Poor Control > 9 *	27.74%	-4.86%	30.41%	23.60%
(IMA-E) Immunizations for Adolescents - Combo 2	39.39%	-1.00%	34.14%	47.16%
(LSC) Lead Screening in Children *	74.94%	3.16%	69.96%	82.86%
(PPC-Post) Prenatal and Postpartum Care - Postpartum Care *	90.02%	0.48%	82.48%	88.32%
(PPC-Pre) Prenatal and Postpartum Care - Prenatal Care *	87.10%	1.70%	86.37%	91.97%
(TFL-CH-1) Topical Fluoride for Children - Dental or Oral Health Services	21.07%	8.67%	21.60%	0.00%
(W30-2+) Well Child Visits in the First 30 Months of Life - Well Child Visits for Age 15-30 Months	76.64%	4.42%	72.32%	82.12%
(W30-6+) Well Child Visits in the First 30 Months of Life - Well Child Visits in the First 15 Months	64.64%	-2.41%	63.38%	71.71%
(WCV) Child and Adolescent Well-Care Visits - Total	52.57%	3.74%	55.41%	67.63%

** Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population.*
Notes: (1) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (2) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (3) GSD is an inverted measure: a lower rate results in better performance. (4) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. (5) Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

MY2025 MCAS Quality Rating Region Rates

The table below shows Partnership's MY2025 rates for the MCAS measure set at the Quality Rating Region (QRR) level:

North Bay Area: Marin, Napa, Solano, Sonoma, Yolo Counties
Rural Upper Central: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba Counties
Rural Upper North: Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Trinity Counties

Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
Below MPL (minimum performance level, based on NCQA's Quality Compass Medicaid 50th percentile)

Measure Name	North Bay Area	Rural Upper Central	Rural Upper North	50th	90th
(AMR) Asthma Medication Ration - Total 5 - 64 Ratios > 50%	77.30%	70.67%	71.02%	63.66%	76.25%
(BCS-E) Breast Cancer Screening - Non Medicare Total	56.98%	41.29%	48.78%	55.87%	66.31%
(CBP) Controlling Blood Pressure - Non Medicare Total *	72.23%	60.90%	69.34%	67.88%	75.43%
(CCS-E) Cervical Cancer Screening - Total	52.57%	39.61%	52.38%	52.32%	64.21%
(CHL) Chlamydia Screening in Women - Total	65.51%	54.34%	55.30%	56.30%	70.67%
(CIS-E) Child Immunization Status - Combo10	36.59%	24.12%	17.04%	23.89%	34.79%
(DEV) Developmental Screening in the First Three Years of Life - All Ages Total *	43.50%	36.90%	34.35%	37.40%	0.00%
(FUA-30) Follow Up after ED Visit for Alcohol and Other Drug Abuse or Dependence - 30 Day Rate	39.88%	40.55%	43.70%	39.10%	53.27%
(FUM-30) Follow Up After ED Visit for Mental Illness - 30 Day Rate	49.29%	48.70%	53.13%	57.13%	74.67%
(GSD>9) Glycemic Status Assessment for Patients with Diabetes - GMI Poor Control > 9 *	29.26%	29.95%	28.09%	30.41%	23.60%
(IMA-E) Immunizations for Adolescents - Combo 2	53.78%	31.13%	31.53%	34.14%	47.16%
(LSC) Lead Screening in Children *	72.10%	67.34%	75.17%	69.96%	82.86%
(PPC-Post) Prenatal and Postpartum Care - Postpartum Care *	94.60%	86.54%	87.99%	82.48%	88.32%
(PPC-Pre) Prenatal and Postpartum Care - Prenatal Care *	92.51%	81.84%	83.30%	86.37%	91.97%
(TFL-CH-1) Topical Fluoride for Children - Dental or Oral Health Services	27.70%	22.40%	10.55%	21.60%	0.00%
(W30-2+) Well Child Visits in the First 30 Months of Life - Well Child Visits for Age 15-30 Months	79.15%	75.82%	74.30%	72.32%	82.12%
(W30-6+) Well Child Visits in the First 30 Months of Life - Well Child Visits in the First 15 Month	71.19%	55.63%	67.13%	63.38%	71.71%
(WCV) Child and Adolescent Well-Care Visits - Total	55.57%	50.81%	50.90%	55.41%	67.63%

** Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population.*
Notes: (1) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (2) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (3) GSD is an inverted measure: a lower rate results in better performance. (4) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. (5) Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

Some highlights of MY2025 MCAS performance include:

Measures above the High-Performance Level (90th percentile):

- One (1) measure, Prenatal and Postpartum Care: Postpartum Care, scored above the 90th percentile at the Plan-Wide level, and above the 75th percentile in all three Quality Rating Regions.

Measures above the Minimum-Performance Level (50th percentile) :

- Partnership performed above the 50th percentile Plan-Wide and in all three Quality Rating Regions on four (4) MCAS measures:
  - Glycemic Status Assessment for Patients with Diabetes (GSD)
  - Well Child Visits in the First 30 Months of Life – 2+ Visits 15-30 Months (W30-2)
  - Follow-up After Emergency Department (ED) Visit for Substance Use (FUA-30)
  - Asthma Medication Ratio (AMR) rates improved significantly in MY2025. All three Quality Rating Regions performed above the 75th percentile. This measure will be retired in MY2026.
- Partnership performed above the 50th percentile Plan-Wide on two (2) additional measures:
  - Childhood Immunization Series (CIS-10) performed above the 50th percentile in two of three Quality Rating Regions.
  - Chlamydia Screening for Women (CHL) - measure retired in MY2026

Measures with Regional Performance Opportunities:

- Partnership has prioritized five (5) measures as the highest priority for improvement in specific counties and Quality Rating Regions, to make the maximum positive impact on the DHCS Accountability programs described above:
  - Controlling High Blood Pressure (CBP)
  - Immunizations for Adolescents – Combination 2 (IMA-2)
  - Prenatal and Postpartum Care – Timeliness of Prenatal Care (PPC-Pre)
  - Well-Child Visits in the First 30 Months of Life – 6+ Visits 0-15 Months (W30-6)
  - Child and Adolescent Well-Care Visits (WCV)
- Four (4) additional measures are also improvement opportunities in 2026 onward in specific counties and Quality Rating Regions:
  - Cervical Cancer Screening (CCS-E)
  - Developmental Screening in the First Three Years of Life (DEV)
  - Lead Screening in Children (LSC)
  - Topical Fluoride for Children (TFL)

Measures with Data Completeness and Measure Limitation Issues

- Breast Cancer Screening (BCS): The Breast Cancer Screening measure transitioned its age range from 52-74 years to 42-74 years. This has resulted in a misalignment of the MY2025 measure (42-74 years), with the NCQA benchmark applied, that was based on MY2024 national outcomes (52-74 years). Once NCQA creates a national benchmark based on the new age range (later in 2026), this measure limitation issue will no longer exist. Partnership has recommended to DHCS that Medi-Cal MCP's be held accountable for the 52-74 years sub-measure, which does align with the MY2024 NCQA benchmark. In most counties, Partnership's performance would be above the 50th percentile in MY2025 for DHCS accountability programs if this recommendation is acted upon by DHCS.

Because the measure has long continuous enrollment requirements for members to be included in the measure, MY2025's measure still included very few members from the Rural Upper Central Rating Region.

- Follow-up After Emergency Department (ED) Visit for Mental Illness (FUM-30): Partnership's plan-wide rate for FUM-30 increased over 20 percentage points in MY2025. Partnership benefited from a revised NCQA measure definition that expanded the scope of services counting as a follow-up visit, as well as sustained focus on maximizing data capture opportunities from DHCS's data feed. While the plan also made significant gains in data capture from DHCS data feeds, Partnership is still not receiving a full year's worth of data from County DBH's to apply to this measure during the HEDIS project timeline. Partnership is actively working with DHCS to improve the quality of our data feed and exploring other opportunities to receive clinical data from County DBH EMR's to improve the completeness of our data.

NCQA Health Plan Accreditation (HPA) – Health Plan Rating (HPR) Methodology

As an NCQA-Accredited Health Plan, Partnership is required to report HEDIS® and CAHPS® data annually. This reporting started in June 2022 for MY2021. Reporting for MY2025/RY2026 will be formally assessed by NCQA for Partnership's publicly reporting Health Plan Rating (HPR).

- Health Plans are given the option to choose to report the Adult CAHPS® survey results or Child CAHPS® survey results.
- Partnership chose to report the Child CAHPS® survey results for MY2025.
- In addition to CAHPS measures, there were 42 clinical HEDIS® measures requiring plan-wide level reporting for the HPA Annual Project.
- As of June 2026, Partnership awaits NCQA's formal assessment and final HPR for MY2025.

NCQA has released the current Health Plan Rating Methodology: (Plan-wide)

- NCQA ratings are based on three (3) types of quality measures:
  - Measures of clinical quality from NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®); and
  - Health Outcomes Survey (HOS); measures of patient experience using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®); and
  - Results from NCQA's review of a health plan's health quality processes (NCQA Accreditation). NCQA rates health plans that choose to report measures publicly.
- The overall rating is the weighted average of a plan's HEDIS®, HOS, and CAHPS® measure ratings added to any Accreditation bonus points (if the plan is accredited by NCQA), which is then rounded to the nearest half point and displayed as stars.
- The overall rating is based on performance tied to dozens of measures of care. The rating is calculated on a 0–5 scale including half points with five (5) being the highest. Performance includes three (3) subcategories (also scored 0–5 in half points):
  1. Patient Experience
  2. Rates for Clinical Measures
  3. NCQA Health Plan Accreditation

MY2024 HPA Star Rating Results

NCQA's MY2024 HPA Star Rating Results with the Child CAHPS® Survey Results is the most recent NCQA Star Rating result published. The MY2025 NCQA HPA Star Rating results with the Child CAHPS Survey Result will be published by NCQA in Fall 2026.

MY2024 NCQA Star Rating with Child CAHPS® Survey Results: 3.0 Stars

HEDIS HealthPlan Accreditation Star Rating Scoring MY2024 With Child CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2024	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points overall
Overall Rating (CAHPS + Accreditation Measures)	60	135	164.5	2.741666667	3.0
Patient Experience	7.5	12	18	2.400	2.5
Prevention and Population	19.5	52	61.5	3.154	3.0
Treatment	33	71	85	2.576	2.5

MY2024 NCQA Star Rating with Adult CAHPS® Survey Results: 3.0 Stars

HEDIS HealthPlan Accreditation Star Rating Scoring MY2024 With Adult CAHPS Survey Results	MY 2024 Final Rate	TOTAL Weight	TOTAL ACCRD Score MY2024	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)		60	133	161.5	2.691666667	3.0
Patient Experience		7.5	10	15	2.000	2.0
Prevention and Population		19.5	52	61.5	3.154	3.0
Treatment		33	71	85	2.576	2.5

For Partnership's full HPA performance, refer to MY2025 Health Plan Accreditation Annual Summary of Performance, Appendix (F).

Summary of HEDIS Measures in the Primary Care Provider Quality Incentive Program (PCP QIP)

The table below provides a summary of Measures Managed Care Accountability Sets (MCAS) for Medi-Cal Managed Care Plans Measurement Year 2025 | Reporting Year 2026 included in Partnership's Quality Incentive

Program (QIP) measure sets.

HEDIS® Measures	MCAS Accountable/Reporting	MY2024 QIP Measure	MY2025 QIP Measure	QIP Program
Asthma Medication Ration (AMR)*	Accountable			None
Breast Cancer Screening (BCS-E)*	Accountable	X	X	PCP QIP Ages 52-74 years – Clinical Ages 40-51 years – Monitoring
Cervical Cancer Screening (CCS-E)	Accountable	X	X	PCP QIP
Childhood Immunization Status (CIS-E) – Combo 10	Accountable	X	X	PCP QIP
Chlamydia Screening (CHL)	Accountable		X	PCP QIP Monitoring
Colorectal Cancer Screening (COL-E)	Reporting	X	X	PCP QIP
Controlling High Blood Pressure (CBP)	Accountable	X	X	PCP QIP
Developmental Screening in the First Three Years of Life (DEV)	Accountable			None
Eye Exam for Patients with Diabetes (EED)	Reporting	X	X	PCP QIP
Glycemic Status Assessment for Patients with Diabetes—Glycemic Status (>9%), Poor Control (GSD)	Accountable	X	X	PCP QIP QIP uses the inverse of this measure: Good Control, HbA1c Good Control <9%
Immunizations for Adolescents (IMA-E) – Combo 2	Accountable	X	X	PCP QIP
Lead Screening in Children (LSC)	Accountable	X	X	PCP QIP
Postpartum Depression Screening (PDS-E)	Reporting	X	X	Perinatal QIP
Prenatal Depression Screening (PND-E)	Reporting	X	X	Perinatal QIP
Prenatal and Postpartum Care (PPC) – Postpartum Care	Accountable	X	X	Perinatal QIP
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	Accountable	X	X	Perinatal QIP
Prenatal Immunization Status – combo (PRS-E)	Reporting	X	X	Perinatal QIP
Topical Fluoride for Children (TFL)	Accountable		X	PCP QIP Ages 1-5 years - Monitoring
Well-Child Visits in the First 30 Months of Life—15 to 30 Months—Two or More Well-Child Visits (W30-2)	Accountable		X	PCP QIP
Well-Child Visits in the First 30 Months of Life—0 to 15 Months—Six or More Well-Child Visits (W30-6)	Accountable	X	X	PCP QIP
Child and Adolescent Well-Care Visits (WCV)	Accountable	X	X	PCP QIP

PCP QIP Measurement Set: http://www.partnershiphp.org/Providers/Quality/Pages/PCPQIPLandingPage.aspx

For Partnership's full summary of HEDIS® MY2024 performance, please refer to Appendix (E) and Appendix (F).

Quality in Data Governance

QI TRILOGY

Data Governance, Stewardship, and Analytics Integration

Partnership continues to strengthen its data and analytics infrastructure through the combined efforts of its Data Governance framework, Data Stewardship program, and Analytics Center of Excellence (ACE). Together, these initiatives ensure that organizational data is reliable, well-managed, and strategically applied to support quality improvement activities.

The Data Governance and Stewardship functions provide oversight, accountability, and structure for managing critical data assets, while ACE builds on this foundation to advance analytics maturity, promote data literacy, and drive innovation through cross-department collaboration. This integrated approach supports Partnership's goal of delivering data-driven insights to improve member care and organizational performance.

Data Governance

The QI, IT, and Health Analytics Departments play a key role in supporting the Data Governance framework across the organization. Data Governance involves the planning, oversight, and management of data and related resources to ensure they are used effectively and responsibly.

The main goal of Data Governance is to make data available, more reliable, well-understood, and easy to use. There is an important emphasis on partnering with each department to solve data related problems.

The Enterprise Data Warehouse (EDW) Team, within IT, has made significant progress in building a data warehouse system that integrates data from HealthRules Payer® (HRP®) (the new claims system), bringing together member, claims, and provider data into the Data Warehouse and DataMarts. Departments across the organization, including QI, rely on this data to support critical applications and processes.

Following the development of this infrastructure, the Provider Quality Dashboard (PQD) for the Quality Incentive Program (QIP) was developed and tested using data sourced from HRP®. Building the PQD database was successful, and this data was able to be fed into the HRP® version of the dashboards. Going forward into the next year the data will continue to be thoroughly tested in preparation for HRP® go live.

Data Stewardship

The Data Stewardship program is one key process under the Data Governance framework. In preparation for the introduction of HRP®, the team partnered with several departments to identify the data stewards for some of the data domains and established roles and responsibilities.

The goals and deliverables set for FY 2025-2026 included the following:

- Plan, Develop, Test, and have the files ready for Wakely, Partnership's vendor for D-SNP Star measure rate generation, to integrate the test data to their environment to help build STAR measures dashboard to support D-SNP program

- Develop, test, and have the 2025 HEDIS® monthly project live in production with the data available to users via the HEDIS® PQD modules.

The EDW Team was able to successfully integrate data from the new claims system, HRP®, into all QI processes. This included the HEDIS® project, the PQD, and EDW DataMart's which are provided to end users to use for reporting and analyzing data. By doing this it will allow for the QI processes to seamlessly switch sources of data for their projects, dashboards, and reporting when the new claims system goes live. Multiple iterations of testing have been performed to ensure the data from the new system will meet quality standards and the EDW Team will continue to oversee this as the go live date approaches.

The EDW team was able to plan, develop and test the claims, membership, Pharmacy, and clinical data feeds to Wakely to support the D-SNP program. The initial development work was completed along with the Unit and QA testing. We worked closely with Wakely to define the data elements needed for STAR measures and initial round of testing is completed.

The HEDIS and EDW team worked closely to successfully implement the 2025 PQD HEDIS monthly project in Production. The data was made available to the downstream users via the tableau dashboard.

Analytics Center of Excellence

Partnership's Analytics Center of Excellence (ACE) was established in January 2024 as a virtual, cross-functional entity designed to integrate IT, business, and analytics functions across the organization. Its purpose is to align analytics initiatives with organizational strategy and to guide the development of analytics maturity, governance, and innovation.
ACE was created with the following core objectives:

- Operationalize the organization's analytics strategy
- Drive data governance and promote data literacy
- Identify and coordinate cross-functional analytics projects
- Standardize data management practices and data products
- Foster innovation in analytics
- Enhance collaboration across departments and reduce duplication of effort

ACE comprises several interconnected groups, each playing a distinct role:

- Analytics Steering Committee: Oversees the activities of the ACE groups and reports to the existing Data Governance Council. It is formed by representatives of the business units, IT and the Lead Team, and meets every other month, or as needed.

- Analytics Council: Cross-departmental forum for analysts to discuss data issues, inform of new data or tools, contribute to the development of data standards, identify training, knowledge sharing, and prevent duplication of effort.

- Data Governance Council: Involved in developing and maintaining the data stewardship program.

Despite organizational constraints, ACE has delivered several important achievements:

- Data Literacy: Launched learning modules via the Learning Management System (LMS), supporting a foundational goal of improving data fluency across departments.
- Develop Advanced Analytics Capability: Established a Data Science function to support complex analysis, such as applying machine learning to provider network gap analysis and using RAND's Bayesian surname geocoding to address missing demographic data—critical for improving equity analysis.
- Cross-Team Integration: The integration of 2 Care Coordination (CC) Data Analysts into the Health Analytics (HA) team, along with the continued contributions of a Quality Improvement (QI) Analyst brought on several years ago, has enhanced collaboration between CC, QI, HA, and Enterprise Information Management (EIM), has improved both operational efficiency and the integrity of analytics across projects.
- Data Standardization: Initiated a data catalog and glossary while also defining consistent classifications for race and ethnicity across datasets.
- Data Transparency: The HA team developed an inventory dashboard that enables users to easily search for reports and provides centralized links to all dashboards, improving visibility, accessibility, and reuse of analytics assets across teams.
- Analytics Council Engagement: With active participants from departments including IT, Finance, Grievance and Appeals, Quality Improvement, Care Coordination, and Population Health, the Council has become a key platform for sharing projects, addressing data quality concerns, and promoting standard practices.

While progress has been made, ACE's development has been hindered by several structural and cultural challenges. Leadership turnover and loss of key Lead personnel have stalled strategic momentum, and proliferation of several key initiatives requiring organizational priority have reduced the attention and resources available for ACE activities.

To ensure long-term success and impact, the following recommendations are proposed at the close of FY 2025-2026:

1. Update the ACE charter to reflect lessons learned, redefine the roles of each group with clarified deliverables, and consider more agile, outcome-oriented governance practices. Through this charter update, re-establish executive sponsorship given changes in executive leadership and immense organizational growth since the original charter was developed and adopted.
2. Enhance communications and visibility by improving internal awareness of ACE activities through regular updates, success stories, and shared outcomes.
3. Implement a structured framework to evaluate and prioritize ACE initiatives, ensuring alignment with organizational priorities and focusing limited resources on the highest-impact work.
4. Develop clear, measurable outcomes and assign ownership to track progress, demonstrate value, and maintain momentum despite leadership or staffing changes.

5. Secure dedicated resources (analytics, project management, and operational leads) to reduce reliance on ad hoc support and ensure consistent execution of ACE initiatives.

Partnership Quality Dashboard

The Partnership Quality Dashboard (PQD) is one of many dashboard projects that can be accessed on Partnership's Tableau server landing page. This page houses multiple healthcare quality measure data dashboards and supports Partnership's data and analytics objectives. Dashboards visualize key performance indicators for multiple Partnership department stakeholders, including behavioral health, population health, care coordination, data quality, cost avoidance, member access and utilization projects. The PQD dashboards focus their scope on visualization of source data maintained by the Quality Improvement (QI) Department, HEDIS®, and Quality Incentive Program (QIP). These dashboards enable providers and Partnership staff to prioritize, inform, and evaluate quality improvement efforts. PQD supports year-over-year performance trending and enables analysis across geographic regions and demographic aggregates.

The PQD is maintained by staff in Partnership's QI, IT, and Finance departments. Annual dashboard development involves evaluation of project data needs, documentation of business requirements, data and dashboard development, and user acceptance testing. Data Governance principles are applied throughout the development and maintenance process to ensure accuracy, consistency and responsible use of the data. Ongoing maintenance of dashboards throughout the year involves monthly warehousing of both HEDIS® and QIP source data and issue resolution. PQD training is a key project activity conducted throughout the year.

The majority of PQD project goals and deliverables outlined under the 2025-2026 QI Department Work Plan were successfully accomplished during the fiscal year. Due to dependencies on the HealthRules Payer® (HRP®) integration several PQD enhancements initiated in FY24-25 continued into FY25-26. While final dashboard updates remain tied to HRP timing, meaningful progress was made during this evaluation period to ensure a smooth transition once implementation is complete.
Key FY 25-26 progress includes:

- Defined and validated business rules for mapping primary care provider identification numbers under the new HRP® provider data structure were identified and shared with stakeholders.
- Several HEDIS dashboards have migrated to Inovalon Data Lake as their data source, which minimizes publication delays; migration of HEDIS dashboards will continue in 2026-27.
- Other business rules defining data linkages were identified for source data projects (eReports, Inovalon) and tested, to help minimize delays during implementation.
- Source data validation and user acceptance testing was completed and continues, where needed.
- PQD dashboards are expected to be updated based on HRP® source data, following implementation. (Note, exact timing of refreshing PQD dashboards is contingent on the final implementation timing of HRP®, which remains pending as of the close of 2025-2026.)

A health disparity dashboard was soft launched internally in November 2024. The dashboard allows various internal stakeholders to easily see the disparities by measure and by region. This dashboard is a critical step toward changing systems and decreasing disparities. The health disparity dashboard was launched to external stakeholders in March 2025 and continues to be refreshed with the normal PQD development cycle.

Summary of FY 25-26 PQD Dashboards

Dashboard Name	Data Source	Brief Description	Reporting Enhancements
MY2025 HEDIS® Annual Static -Summary of Performance	HEDIS® Annual Measurement Year 2025	MCAS measure performance by Planwide, Financial Regions and County and color-coded against NCQA benchmarks; MCAS Accountable measures included.	Measurement Year 2025 HEDIS® Final Performance
MY2025 HEDIS® Annual Exploratory	HEDIS® Annual Measurement Year 2025	MCAS measure performance by Sub-Region, County and Provider. Color-coded against benchmarks. Stratification by member demographics such as race and gender. Member-level drilldown reports by measure.	Measurement Year 2025 HEDIS® Final Performance (MY 2025 dashboard expected Q3, 2026)
MY2025 NCQA Health Plan Accreditation (HPA) Annual Static – Summary and Star Rating Estimation	HEDIS® Annual Measurement Year 2025	HPA measure performance (including 2025 Child and Adult CAHPS scores) by Plan-Wide and County, including year-over-year measure performance. Star Rating calculations displayed based on HPA scoring methodology.	New Tableau dashboard. Displays Star Rating using Child and Adult CAHPS scoring scenarios. (MY2025 dashboard expected Q3, 2026)
MY2026 HEDIS® Monthly Exploratory – Internal View	HEDIS® Monthly 2026	MCAS and NCQA Health Plan Accreditation measure performance by various geographic and demographic aggregates, color-coded against NCQA benchmarks. Member-level drilldown reports by measure.	2026 Rolling Year and Year-to-Date Performance (MY2026 dashboard implemented in Q1 2026)
PCP QIP Internal and Provider View	Monthly eReports Clinical data and QIP Non-Clinical calculated data	Payout by measure for the PCP QIP program, with gaps to target, member drilldown, performance against targets and regional averages.	December-2025 final PCP QIP performance. The QIP Stoplight and Final Statement dashboards are also available on PQD.
Disparity Analysis	PCP QIP Monthly Clinical Data	Breakout of QIP performance by measure at the plan-wide level and stratified by ethnicity group. View top 10 providers	December-2025 Geographic View dashboard to display measure performance

Dashboard Name	Data Source	Brief Description	Reporting Enhancements
		with largest population size for selected ethnicity groups	across updated categories for race and ethnicity. Dashboard is available to the provider network through eReports.
Maximizing Visibility of Quality Data	PCP QIP Year-end Score	Rank PCPs year-end QIP total score by county and display population size, increase or decrease over previous year score.	December-2025 PCP QIP Final Data PCP-level stars ratings added to ranked performance chart.
QIP Stoplight Dashboard	PCP QIP Monthly Data	Member gap-to-target analysis, color coded against benchmarks at the parent organization level.	December-2025 PCP QIP Final Data.
PCP QIP Final Statement	PCP QIP Year-end Score	Payment, points and performance by measure for individual providers. Used for PCP QIP payment.	December-2025 PCP QIP Final Data.
Perinatal QIP Dashboard	Perinatal QIP supplemental measure data and custom claims and membership calculations	Perinatal QIP measure performance is updated quarterly for provider statements.	
Hospital QIP (HQIP) Final Statement	Supplemental HQIP Performance data	Calculates payment for the Hospital QIP year-end provider payment.	FY 2024-2025 performance
PQD User Activity	Monthly HEDIS® and QIP dashboard clicks, internal and external (PCP QIP)	Monitors internal and external provider user clicks in HEDIS® and QIP PQD dashboards.	N/A
Well Care Dashboard – Internal View	Custom table for well-care claims for members in measure age ranges	Reports by provider for well visit dates of service for assigned and special members. Internal staff access through PQD.	N/A
Preventive Care Reports – Provider View	Custom table for well care claims and CIS and IMA claims and California	Member-level contact information includes all well care, IMA and CIS DOS for assigned members. Priority	Daily refresh starting in January of each measurement year.

Dashboard Name	Data Source	Brief Description	Reporting Enhancements
	Immunization Registry (CAIR) data	flags for member outreach based on age.	

Provider Network Quality Improvement Support and Initiatives

QI TRILOGY

Quality & Performance Improvement Initiatives and Projects

Overview

In 2025-2026, our Quality Improvement (QI) Team continued to focus on priority measures for Partnership HealthPlan of California, guided by performance indicators from the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) and the National Committee for Quality Assurance (NCQA) accreditation measures. DHCS encouraged prioritized improvement efforts related to Health Equity, as well as measures where significant financial incentives/penalties were introduced or enforced.

We made significant strides in understanding Health Equity (HE) and achieved Health Equity Accreditation. Additionally, we began developing a Dual Eligible Special Needs Plan (D-SNP) product line, its accompanying Model of Care (MOC), as well as its associated Quality Incentive Program (QIP). Due to the size of the projected member volume, the QIP for D-SNP was reduced in size to better reflect statewide trends.

Considerable efforts were dedicated to building relationships, understanding gaps, and updating data related to Partnership's geographic expansion. With a year of baseline data under our belts, the QI and Regional cross-functional staff engaged with providers in the Auburn and Chico Operational Regions to continue improvement efforts.

California's health care system braced for significant change associated with HR1, including considerable impacts on services provided to the UIS (Uncertain Immigration Status) population. As member volume has begun to decrease, the QI team has looked at options to scale interventions appropriately. Partnership focuses on quality measures and initiatives that move us in the direction of meeting state goals, with some seeing significant improvement, in large part due to data quality enhancements. Other measures such as vaccination rates, continue to decline due to shifting public messaging on efficacy and importance.

Our QI Team and Partnership leadership continued efforts related to engagement of lower performing providers. This included changing our modified measure-set intervention back to a full measure-set, accompanied with improvement plans and leadership signoff and buy-in. We assessed, supported, and coached lower-performing sites, developing tailored interventions designed to address foundational issues. Some of these efforts included financial support to purchase equipment, increase access, and reduce disparities. Our commitment to the Improvement Academy trainings, joint leadership meetings with major provider organizations, practice coaching, mandated work collaborations, and other ad hoc support increased to meet provider needs. The focus of this support was on closing care gaps through clinical and operational workflows, fostering a culture of quality within provider leadership, and building capacity for quality improvement within provider teams.

Internally, QI collaborated closely with key stakeholders, including Population Health, Pharmacy, Behavioral Health, Medical Directors, Health Equity and regional leadership on strategic efforts, such as direct member engagement. Additional success occurred as the Local Engagement Teams (LETs) met to better understand local issues and share region-specific intelligence within each Operational Region. Collaboration with Population Health led to alignment and improvement of the CHA/CHIP goals established by counties within the Partnership footprint.

Quality Measure Score Improvement (QMSI) workgroups were expanded and optimized to address evolving DHCS MCAS and NCQA Health Plan Accreditation (HPA) measure sets and anticipated Medicare STARs measures. The QMSI workgroups focused on measure domains specific to Pediatrics, Chronic Diseases, Medication Management, Behavioral Health, Women's Health, and Perinatal Care. These workgroups evaluated opportunities under priority measures included in the DHCS Quality Withholds and Incentive Program, as well as those subject to DHCS sanctions, such as Topical Fluoride for Children and well-child visit measures. Through collaboration with internal staff and external partners, such as Aliados, the Health Alliance of Northern California (HANC), and North Coast Clinics Network (NCCN) consortia, we piloted, scaled, and spread improvements across measures including breast cancer screening, childhood immunizations, adolescent immunizations, and well-child visits.

Partnership incentivized improved performance and the adoption of best practices through Quality Incentive Programs (QIPs), targeting Clinical and Non-Clinical measures aligned with NCQA Health Plan Accreditation (HPA) and DHCS Managed Care Accountability (MCAS) sets. Enhancements to data tools improved visibility and transparency into QIP performance gaps. Financially, Partnership paid out more incentives within the QIPs than any previous year.

These combined efforts have positioned Partnership HealthPlan of California and our provider network to deliver high levels of care and support to our members, amidst challenging national headwinds and potential budget cuts.

Quality Measure Score Improvement (QMSI)

The Quality Measure Score Improvement (QMSI) effort continues to better coordinate service and performance across the organization and to raise Partnership's overall performance in quality measures, as defined under DHCS MCAS and NCQA Health Plan Accreditation (HPA). This effort involved team formation under QMSI to encompass all current and potentially future accountable measures by measure family within each workgroup team: Pediatric, Chronic Diseases (including medication management), Behavioral Health, Women's Health and Perinatal Care. Each workgroup monitored and reviewed all measure performance where data was available, assessed current improvement efforts, identified gaps and initiated new performance improvement activities.

QMSI workgroups consisted of cross-functional teams led by Quality and included representation from across the organization, such as: Care Coordination, Claims, Health Education, Office of the CMO, Pharmacy, Population Health, Provider Relations, Health Equity, Quality and/or regional leadership. The following summaries include what each measure-family QMSI Workgroup Team achieved in 2025-2026.

QMSI Improvement Workgroups

Chronic Disease

Expand Exact Sciences Cologuard Care-gap Orders Offering

In 2023 Partnership conducted a pilot project with Exact Sciences who produces the Cologuard Fit DNA colorectal cancer screening product. During the pilot Partnership observed notable improvements in colorectal cancer screening rates with participating providers. Partnership has turned this effort into an ongoing offering and has worked closely with Exact Sciences to spread awareness and access to care gap orders. Partnership has created a Cologuard Care-gap Orders page with information and resources.

Partnership's Quality team has monthly check-ins with Exact Sciences to review-data and collaborate on upcoming facilitated orders. Exact Sciences has a minimum number of patients required for care gap orders since it is resource intensive for them to do outreach and messaging for patients with an order. Partnership has offered to help facilitate group for smaller practices who do not have large enough denominators to initiate care gap orders on their own. Facilitated orders are offered twice a year in the Spring and Fall.

The Chronic Disease workgroup will continue to monitor colorectal cancer screening rates, and specifically modalities to track screening rates by screening type to look for opportunities where Cologuard bulk order may be appropriate based on availability of other screening methods.

Three-year lookback**:** Colorectal cancer screening performance has improved over the past three years, increasing from 37.93% in MY2023 to 38.30% in MY2024 and reaching 41.82% in MY2025. This reflects a total improvement of 3.89 percentage points over the three-year period, with the strongest year-over-year gain occurring between MY2024 and MY2025. Key drivers of improvement include the expansion of the Exact Sciences Cologuard care-gap orders offering following a successful 2023 pilot, ongoing monthly collaboration to review data and coordinate facilitated orders, and targeted support for smaller practices through grouped outreach efforts. Additional momentum has come from the 2025 collaboration with the UC Davis Comprehensive Cancer Center, which has focused on clinic engagement, workflow improvement, staff education, technical assistance, and community outreach in Tehama County. Together, these efforts demonstrate steady progress and a strengthened infrastructure to support continued improvement in colorectal cancer screening rates.

	MY2023	MY2024	MY2025*
Colorectal Cancer Screening	37.93	38.30	41.82

UC Davis Cancer Comprehension Collaborative

In the summer of 2025, the Quality Improvement team and Partnership's Regional Medical Director began work with the UC Davis Comprehensive Cancer Center on an initiative to advance colorectal cancer screening improvement strategies.

Using county-level data to identify needs, gaps, and opportunities, Partnership is engaging clinics by providing targeted support, education, and technical assistance aimed at strengthening clinical workflows and improving screening processes. The collaborative team that includes Partnership, UC Davis, Tehama County Public Health and five Partnership primary care clinics within Tehama County meet monthly and discuss opportunities for future events within the community. To-date, the team has done one major outreach event at a local rodeo Chili Cook off, which was very successful in educating the community on the need for Colorectal Cancer Screening and the different modalities at hand.

Additionally, the Partnership is currently partnering with four clinics in Tehama County to support workflow refinement, enhance staff knowledge, and promote sustainable practice changes intended to improve colorectal cancer screening performance over time. Current clinics participating: Greenville Rancheria, Lassen Medical Clinic (Dignity health), Tehama County Public Health Service and Rolling Hills Clinic.

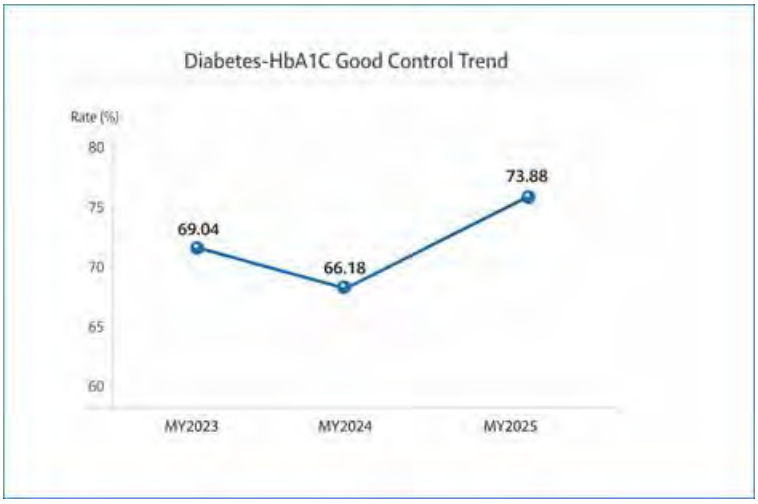
Next steps for the UC Davis Comprehensive Cancer Center collaborative include continuing monthly meetings with participating partners and clinics to review county and clinic-level screening data, identify workflow barriers, and prioritize improvement actions. Partnership provide ongoing technical assistance to participating clinics to

strengthen screening registries, standing order processes, patient recall workflows, and documentation practices. The collaborative will also continue staff education to improve knowledge of colorectal cancer screening guidelines, available screening modalities, and follow-up processes. In addition, Partnership plans to expand community outreach efforts in Tehama County through local events and trusted community partners to increase awareness of colorectal cancer screening and connect members to available services. As the initiative matures, the team will assess lessons learned from the current participating clinics and explore opportunities to spread successful strategies to additional counties and communities.

Diabetes Management Offerings From Telemed2U

Starting in 2025 through the current measurement year, the workgroup monitored, evaluated, and enhanced utilization of the TeleMed2U diabetes management program through analysis of utilization and engagement data to assess program effectiveness, identify participation gaps, and inform decisions regarding the continued prioritization of this intervention relative to other strategies.

The workgroup partnered with Provider Relations and supported outreach and member education efforts by promoting available nutrition services as an integral component of diabetes management, developing and disseminating fax communications to the provider network to increase program awareness and encourage referrals The collaboration also extended to engagement with Care Coordination to further expand awareness of the program among members and providers who may benefit from additional diabetes support services.



Three-year look back: Diabetes-HbA1C Good Control performance shows an overall improvement across the past three years, moving from 69.04% in MY2023 to 66.18% in MY2024 and then increasing to 73.88% in MY2025. Although there was a decline of 2.86 percentage points between MY2023 and MY2024, performance rebounded strongly in MY2025 with a 7.70 percentage point increase over MY2024, resulting in a net three-year improvement of 4.84 percentage points. This recent progress aligns with ongoing work to monitor and strengthen the TeleMed2U diabetes management program, evaluate utilization and engagement trends, and expand awareness of available diabetes support services. Additional outreach through Provider Relations, member education, nutrition service promotion, provider fax communications, and collaboration with Care Coordination has helped build broader visibility and support for diabetes management resources. Together, these efforts position the program for continued improvement in diabetes good control outcomes.

Next Steps: TeleMed2U has been experiencing internal changes, which include how they are able to aggregate this program data from their utilization reporting. In 2025 you will notice Nutrition spiked in utilization from years prior due to the outreach and engagement with providers and members noted above. TeleMed2U continues to expand their Nutrition offerings, including Perinatal Nutrition Services. Partnership will continue outreach, monitoring data and work with TeleMed2U as they continue their work in identifying the programs data for members. Because of the continued awareness of the program and TeleMed2U offerings, not only has the utilization grown, but the number of utilizing providers has grown immensely.

Promotion Of at Home Blood Pressure Monitoring

The Partnership Medical Equipment Distribution Services (PMEDS) program distributes medical devices to eligible members based on diagnosis of related conditions. This program has been distributing blood pressure monitors to members with diagnoses of hypertension and other related conditions since 2020. Research from the Million Hearts Self-Monitored Blood Pressure Program (SMPBP) indicates blood pressure monitors can be effective in reducing blood pressure rates when used alongside patient education, timely monitoring, medication control, and related nutrition, smoking or lifestyle interventions.

The workgroup analyzed data from CY2024 comparing end of year Controlling Blood Pressure (CBP) measure compliance (values less than 140/90) for members with and without blood pressure monitors. Evaluation of this data presented barriers in documentation, availability of useable data from multiple sources, manual adjustments to data, and data volume. Upon analyzing data from PQD (Partnership Quality Dashboard) and a more comprehensive data set from electronic data warehouse (EDW), a significantly higher number of members without blood pressure monitors had numerator compliance for the CBP measure compared to a sample population of members who have blood pressure (BP) monitors. The workgroup identified and collaborated with a PCP who has experienced success in this measure by utilizing the PMEDS program. Their workflows and interdisciplinary care approach have been documented and will be ongoing throughout 2025. The workgroup will consider piloting a similar interdisciplinary approach with interested PCP Quality Incentive Program (QIP) organizations to increase measure success annually. This may increase measure success by implementing workflow best practices alongside the PMEDS program.

Next Steps: The workgroup will continue to meet with this provider on best practices as they will continue to audit quarterly to see the success between the PMEDS program, as well as what they are implementing around new and improved workflows when the patient is coming in for a visit and has hypertension. New processes and best practices consist of re-checking blood pressure if they are presented with a value of 140/90, requesting a follow up appointment as soon as one month after being seen if medication is increased at the given appointment and making sure at every appointment contact information is being updated to prevent missed opportunities.

Creating Best Practices with a Low Performing Site Around Blood Pressure Control

Mountain Valley Health Center's Tulelake site was identified as a low-performing site for blood pressure control in measurement year 2024 and was selected for focused quality improvement support. Located in a very rural area, the site faces common barriers that can affect hypertension outcomes, including limited resources, workflow variation, and challenges with timely patient follow-up.

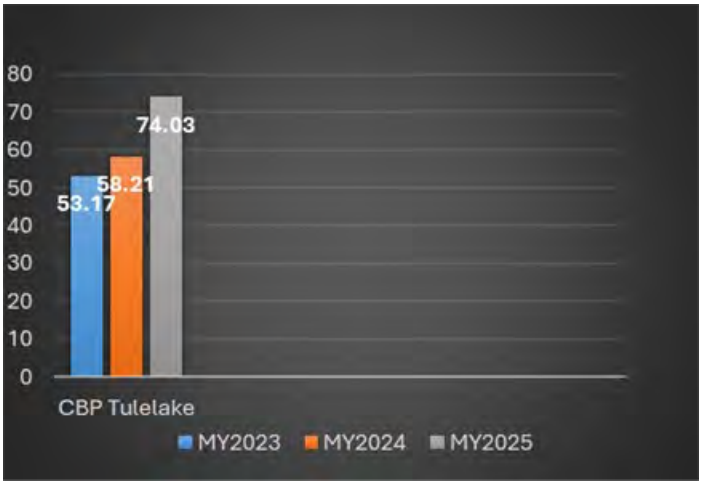
In response, the Quality team partnered directly with clinic leadership and providers to review existing processes, identify practical opportunities for improvement, and research evidence-based toolkits and resources to support a best practice workflow. Key resources that informed this work included the *CDC Hypertension Management*

Program Toolkit, and the *AMA MAP BP framework*. These resources consistently emphasize accurate blood pressure measurement, team-based care, timely follow-up, treatment intensification when indicated, and patient partnership through self-measured blood pressure monitoring. By adapting those principles into a small-site, low-cost workflow, the Tulelake clinic was able to implement changes that were realistic, sustainable, and appropriate for its rural practice setting.

The resulting workflow focused on several high-impact process changes. Staff were trained to obtain and document blood pressure accurately at every eligible visit and to repeat readings during the same encounter when the initial value was 140/90 or higher, helping reduce missed numerator opportunities caused by isolated elevated readings or measurement technique variation. Providers and staff also standardized follow-up expectations by scheduling return visits promptly, including follow-up as soon as one month after a medication adjustment when clinically appropriate. In addition, the clinic strengthened basic panel management activities by updating patient contact information at each visit to support outreach and reduce missed follow-up opportunities. The clinic also reinforced patient education and use of home blood pressure monitoring when available, consistent with national best practice resources supporting self-measured blood pressure monitoring with clinical support. These small but intentional adjustments did not require major new infrastructure or high-cost interventions, yet they improved consistency in care delivery and closed gaps in documentation, rechecking processes, and follow-up.

Outcomes and Next Steps: Program evaluation findings indicate that this targeted, workflow-centered approach was highly effective. Mountain Valley Health Center's Tulelake site moved from not exceeding the minimum performance level in 2024 to exceeding the 90th percentile in measurement year 2025. This improvement demonstrates that meaningful gains in blood pressure control can be achieved in a rural, resource-constrained clinic when evidence-based tools are translated into simple operational changes and supported through provider engagement. The Tulelake experience now serves as a practical model for spread: start with accurate measurement, recheck elevated readings during the visit, ensure timely follow-up after uncontrolled readings or medication changes, maintain reliable patient contact information, and incorporate home blood pressure monitoring and team-based support whenever feasible. Continued monitoring will help determine which components have the strongest effect over time and inform replication of this best practice workflow with additional clinic providers.

Three-year Lookback:



Behavioral Health

DHCS Mandated Non-Clinical PIP: Improving Provider Notifications and Follow-Up for Members with Serious Mental Health Diagnoses

The Department of Health Care Services (DHCS) has mandated a non-clinical Performance Improvement Project (PIP) to improve the timeliness and consistency of provider notifications for members with Serious Mental Health (SMH) diagnoses following emergency department (ED) visits. The goal is to increase notifications sent within seven days to support timely follow-up care.

Timely, accurate notifications help bridge the gap between emergency and outpatient care. Increasing the use of alert systems ensures providers can respond within the critical 30-day window, with a focus on delivering ED alerts in real time or daily.

In 2024, Partnership Health Plan of California's (Partnership's) QI team identified PointClickCare as a tool to enhance notifications. This platform provides real-time Admission, Discharge, and Transfer (ADT) messages, including ED events, member demographics, PCPs, and SMH diagnoses.

Partnership implemented a targeted intervention in the Northwest region, sending daily reports to a large provider organization identifying members with recent ED visits for SMH diagnoses. The organization is developing workflows for outreach, appointment scheduling, and follow-up within 30 days. This approach supports engagement for members less likely to seek care due to stigma or other barriers. It was first piloted with Open Door in Humboldt and Del Norte counties, using a tracking tool and weekly data exchanges to improve coordination. The pilot will continue through 2026, with expansion planned based on promising results.

Process Measure	Count	Rate/Comment
Total ED Visit (SMDs)	66	
Provider Notifications	66	66/66 =100%
# of ED Visits after exclusions (-21)	45	
Total outreach attempts	45	45/45 =100%
Total Scheduled	31	31/45= 69%

SacValley MedShare Data Exchange

To improve data sharing capabilities between Behavioral Health Plans (BHPs) and Partnership collaborated with SacValley MedShare (SVMS) was expanded to include county participation. Over the course of a 12-month collaboration, Partnership and SVMS successfully onboarded all participating counties into a unified data exchange, significantly strengthening regional data-sharing infrastructure.

The project achieved its core objectives, including the implementation of real-time hospital data feeds capturing admissions, discharges, and transfers (ADT). This advancement enhances visibility into member care events, supporting more timely coordination between physical and behavioral health systems. Broader county participation has improved cross-system communication and laid the foundation for more integrated care delivery.

All project deliverables have been completed, and the initiative is now in the closeout phase, with final documentation and administrative processes underway. Ongoing functions such as data integration maintenance and vendor relationship management will continue as part of standard operations beyond the project scope.
The key next step is to clarify regulatory guidance related to substance use disorder (SUD) data, which remains an important consideration for further advancing data sharing and ensuring compliance. Overall, the project demonstrates strong collaboration, successful system implementation, and meaningful progress toward improved care coordination through enhanced data exchange.

Community Health Worker (CHW) & Emergency Department

To strengthen substance, use interventions and promote sustainable care models, Partnership implemented a grant-funded initiative to integrate Substance Use Navigators (SUNs) into Emergency Departments, with the goal of transitioning services to Community Health Worker (CHW) billing over time. Through this effort, Partnership provided grants of up to $100,000 to contracted hospitals to support the implementation of CHW-aligned services in emergency care settings.

Over the course of the project, CHWs were successfully embedded within Emergency Departments to support patients with substance use needs, offering immediate engagement and linkage to follow-up services. Strong interest was demonstrated, with 24 hospitals initially expressing participation; of these, 17 successfully completed the full grant year, reflecting meaningful adoption across participating sites. The project achieved its primary objective of expanding CHW presence in acute care settings and concluded at the end of calendar year 2025. It also advanced the foundation for longer-term sustainability by aligning services with CHW billing pathways.

As the project transitions out of the implementation phase, the next critical step is to work collaboratively with hospitals and their electronic health record (EHR) vendors to improve documentation practices. Strengthening documentation will support accurate billing, enable reimbursement for CHW services, and ensure the long-term sustainability of this model of care.

Overall, the project demonstrated strong provider engagement, successful implementation of CHW-supported interventions in Emergency Departments, and clear progress toward sustainable integration of these services within routine care delivery.

DHCS 2025–27 DMC ODS Clinical and Non-Clinical Performance Improvement Projects (PIPs)
The California Department of Health Care Services (DHCS) requires all Drug Medi-Cal Organized Delivery System (DMC-ODS) plans to conduct two Performance Improvement Projects (PIPs) per contract period—one clinical and one non-clinical. The current PIP cycle began in 2025, with annual submissions due each July, and will conclude in 2027 (final submission due July 2028). Participating counties include Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano.

Within this framework, Partnership is implementing PIPs focused on improving follow-up after Emergency Department (ED) visits for substance use and increasing the number of members receiving Peer Support Services. Together, these efforts aim to strengthen engagement and continuity of care for members with behavioral health and substance use needs.

The Clinical PIP focuses on improving follow-up rates after ED visits for substance use. Root cause analysis is underway to identify barriers to timely follow-up, and targeted interventions are being implemented and monitored for effectiveness. Findings from this work will inform process improvements for upcoming reporting periods.

The Non-Clinical PIP focuses on expanding access to Peer Support Services. To support this, counties have been offered up to $10,000 per individual through HCAI funding to train and develop Peer Support Specialists, increasing workforce capacity.

Across both projects, shared outreach strategies are in place targeting members identified through PointClickCare data feeds, particularly those with recent ED visits related to mental health or substance use. Outreach calls are conducted to connect members to follow-up care and peer support services. In addition, claims data is reviewed to confirm service delivery when direct member contact is not successful, supporting more comprehensive monitoring.

A key challenge across both efforts is difficulty reaching members following ED visits, which can limit engagement in services. As a result, the primary next step is to validate and improve member contact information to enhance outreach effectiveness and increase successful linkage to care.

Overall, these projects demonstrate a comprehensive approach to improving care transitions and access to support services through targeted outreach, workforce investment, and data-driven quality improvement, with continued focus on strengthening member engagement and outcomes.

Datalink Initiative to Improve Data Capture for Required Screening and Follow ups
To strengthen clinical data capture and improve performance on HEDIS measures, Partnership implemented the Datalink initiative to enhance data exchange between provider networks and health plan systems. This effort focuses on improving the completeness and timeliness of screening and follow-up data, supporting both quality measurement and broader interoperability goals across counties.

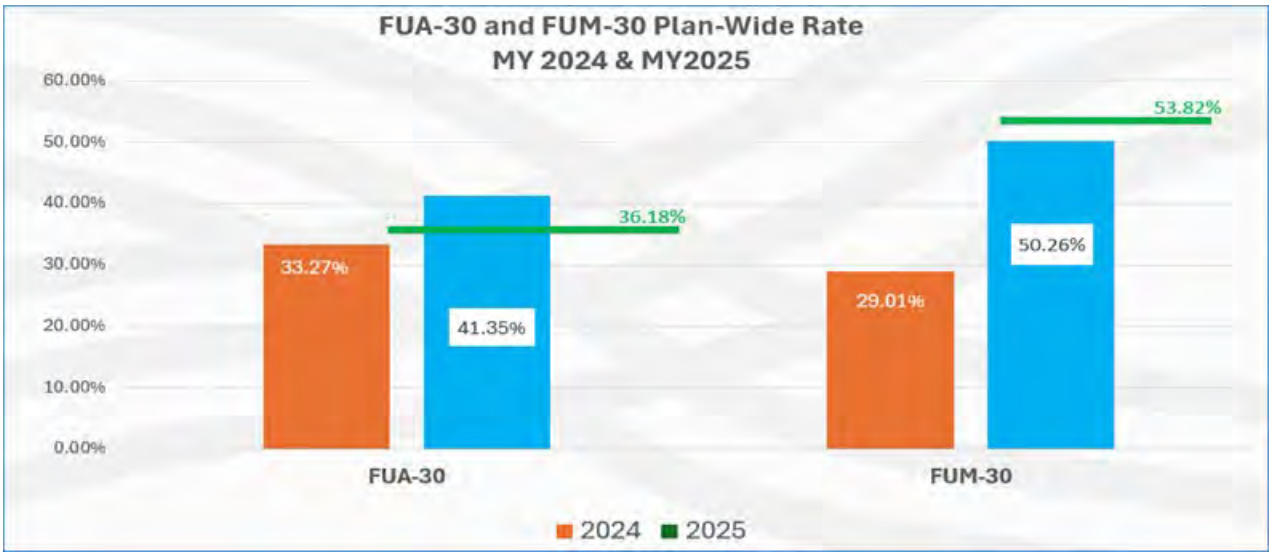
The initiative demonstrated significant impact during the MY2025 HEDIS cycle, which included approximately 274,000 member charts across more than 30 primary care provider (PCP) organizations. Datalink served as the sole source of data for new depression screening measures (DSF-E), with 15 of 24 counties exceeding the

Minimum Performance Level (MPL), highlighting its critical role in capturing previously underreported clinical activity.

Notable improvements were also observed in key follow-up measures. Follow-Up After Emergency Department Visit (FUM-30) increased by 21.25 percentage points to 50.26% (33rd percentile), with 5 of 24 counties exceeding MPL. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-30) increased by 9.07 percentage points to 42.34% (50th percentile), with 15 of 24 counties exceeding MPL and overall performance rising above MPL.

These results reflect meaningful progress in data completeness and quality performance, demonstrating the effectiveness of enhanced data integration and provider engagement strategies.
Pending budget approval, the next phase of the initiative includes expanding Datalink to provider organizations in all 24 counties. Continued efforts will focus on improving data completeness for FUM-30 and FUA-30, increasing emphasis on service completion in counties performing below MPL, and prioritizing these measures beginning in MY2026.

Overall, the Datalink initiative represents a scalable and impactful approach to improving data-driven quality performance, strengthening reporting accuracy, and advancing care coordination through enhanced clinical data exchange.



Pediatric Preventative Care

Improving Measure Outcomes Webinars

Measure Focus: This initiative focused on improving performance across HEDIS and PCP QIP measures through the Improving Measure Outcomes (IMO) Webinar Series, specifically targeting preventive care measures for children ages 0–30 months and 3–17. These measures are tied to MCAS accountability and DHCS withhold performance, making them a priority due to identified gaps in well-child visit completion and disparities in access to preventive care among underserved populations. The work aligns with organizational and Quality Improvement goals to enhance preventive care delivery, improve measure performance, and advance health equity by supporting providers with best practices and actionable strategies. Additionally, this initiative responds to external drivers,

including DHCS and NCQA (HEDIS) requirements and Health Equity Accreditation priorities, by promoting equitable care and improved clinical outcomes across the network.

Baseline Performance and Opportunity: This improvement effort focuses on MY 2024 and MY 2025, targeting pediatric members eligible for preventive care and immunization-related HEDIS and PCP QIP measures, including Well-Child Visits (WCV), Childhood Immunization Status Combination 10 (CIS-10), Immunizations for Adolescents (IMA), Lead Screening in Children (LSC), and Well-Child Visits in the First 30 Months of Life (W30: 2+ and 6+ visits).

Measure	MY 2024 Rate (%)	MY 2025 Rate (%)
WCV (3–17 years)	55.48	59.27
CIS-10	24.11	24.31
IMA	35.42	39.22
Topical Fluoride	Data not available	9.53*
W30 (2+ visits)	Data not available	73.06
W30 (6+ visits)	54.22	57.41
***Data is inaccurate due to incomplete Medical Claims files for Denti-Cal encounters**		

Baseline data indicates ongoing gaps in preventive care and immunization performance relative to established benchmarks, particularly in measures requiring multiple touchpoints (e.g., W30 6+ visits and CIS-10). These gaps represent opportunities to improve timely well-child visit completion, immunization adherence, and overall preventive care utilization.

Interventions Implemented

IMO Webinar Series (Two Targeted Sessions): Implemented two separate webinars focused on PCP QIP preventive care measures (one for children ages 0–30 months and one for ages 3–17). The sessions translated pediatric measures for each age group into actionable workflows, emphasizing best practices to increase well-child visit completion and close identified care gaps.

- *SME-Led Facilitation Model*: Each 60-minute webinar was co-facilitated by a Medical Director and an Improvement Advisor, often aligned with QMSI Lead assignments, to ensure clinically relevant, measure-specific guidance and strong provider engagement.
- *Cross-Functional Collaboration*: Partnered with the QIP team during sessions to address measure specification questions in real time, reinforcing alignment between quality improvement efforts and incentive structures.
- *Health Equity Integration*: Embedded strategies to address disparities in preventive care access, including focused outreach approaches for underserved populations and culturally responsive care practices.

Outcomes, Equity, and Current Performance

- *Reach and Engagement Outcomes*: The IMO Webinar Series demonstrated strong provider engagement across both sessions. The webinar focused on Preventive Care for Children Ages 0–30 Months had 67 external attendees representing 41 organizations, while the webinar on Preventive Care for Children and Adolescents Ages 3–17 had 54 external attendees representing 36 organizations, reflecting broad participation across the provider network.

- *Participant Feedback and Satisfaction*: Evaluations were sent out to participants after each webinar. Below are the results.

	IMO 1: 0-30 Months (n=22)	IMO 2: 3-17 (n=14)
The topics covered were relevant and useful.	Strongly Agreed: 81.82% Agreed: 18.18%	Strongly Agreed: 92.86% Agreed: 7.14%
The content was clearly communicated by the presenters	Strongly Agreed: 77.27% Agreed: 22.73%	Strongly Agreed: 92.86% Agreed: 7.14%
Overall, how would you rate this educational session?	Strongly Agreed: 86.36% Agreed: 13.64%	Strongly Agreed: 85.71% Agreed: 14.29%

- *Application of Best Practices*: In response to the question, "How do you plan to implement the best practices outlined in today's webinar?", participants shared the following themes:
    - Ages 0-30 Months
        - Becoming more proactive with scheduling appointments.
        - I plan to update our current workflows to be more proactive and work toward gap prevention instead of how we have been operating, at a more gap filling. Some best practices will be adopted completely, like data pulls each month with weekly working, some may be adjusted, like the vaccine talk near the end. I enjoyed the mention of health equity as well. There are places where my clinic can grow here.
        - As a QI Coordinator, I plan to review our current pediatric workflows and implement the best practices discussed to improve immunization tracking and compliance. I will also collaborate with our care team to strengthen pre-visit planning and parent education to ensure timely care for our pediatric patients.
    - Ages 3-17
        - Use strategies mentioned in outreach work as well in clinic and sharing the knowledge with others to continue to provide the best quality patient care as possible.
        - Try to schedule more well child visits from sick visit.
        - Staff education on measures and best practices, turn on CRAFFT screening in EMR, possibly schedule lead screening training.
        - Definitely changing and updating some established workflows. Lots of staff turnover has been making what we have almost unusable. There were some great ideas and info in this webinar.

<u>Key Learnings, Barrier Analysis, and Next Steps</u>

- *Key Learnings*: The IMO Webinar Series was well received, with participants reporting that content was relevant, useful, and applicable to their practice. Attendees were able to articulate intended workflow changes and strategies to improve preventive care delivery, indicating strong comprehension and immediate applicability of the material.
- *Barrier Analysis*:
    - Despite positive feedback and stated intent to implement best practices, a key limitation identified is the inability to assess whether changes are being consistently implemented at the practice level.
    - There is limited visibility into whether knowledge gained during the webinars is being shared beyond attendees to broader care teams and organizational leadership, which may impact scalability and sustained improvement.

- *Next Steps*: Planned next steps include evaluating the overall effectiveness of the IMO Webinar Series as a quality improvement strategy and determining whether modifications to the training model are needed. This may include enhancing follow-up processes and exploring alternative training strategies.

Well Child Visits and Adolescent Immunizations Interviews

Measure Focus

This work was prioritized this fiscal year to address key performance gaps in QIP and HEDIS measures, particularly Well-Child Visits (WCV) and Immunizations for Adolescents (IMA), which impact MCAS, Withhold, and Sanction outcomes. Performance across these measures has been inconsistent across regions, highlighting both overall quality gaps and potential equity concerns in access, outreach, and care delivery. In alignment with organizational and Quality Improvement department goals to improve preventive care outcomes and reduce variation in performance, structured interviews were conducted with high-performing providers across diverse healthcare settings. These interviews focused on understanding effective workflows, care team utilization, outreach strategies, and feedback mechanisms; specifically identifying what works, what does not, and how success is sustained. This approach is also responsive to external drivers, including California Department of Health Care Services and National Committee for Quality Assurance priorities under HPA and HEA, which emphasize closing care gaps and advancing equitable outcomes. Insights gathered will be used to develop and disseminate best and next practices to support underperforming regions and improve overall measure performance.

Baseline Performance and Opportunity

Performance in these two measures demonstrates year-over-year improvement; however, rates remain below internal targets and external benchmarks. WCV increased from 55.48% in MY2024 to 59.27% in MY2025, and IMA increased from 35.42% to 39.22%.

Measure	MY2024	MY2025	Change
WCV	55.48%	59.27%	+3.79%
IMA	35.42%	39.22%	+3.80%

Review of performance data and provider-reported barriers prior to the interviews identified key drivers of underperformance. For WCV, contributing factors include large denominator populations and limited access to preventive care appointments. For IMA, lower completion rates for the second dose of the HPV vaccine were identified as a primary barrier. These findings indicate opportunities to improve access, strengthen outreach and recall processes, and support care coordination to close identified gaps.

Interventions Implemented

This year, a strategic shift in intervention design was implemented to address persistent gaps in WCV and IMA, following limited improvement from prior targeted efforts such as HPV second-dose reminders and WCV-focused outreach campaigns. A three-pronged approach was adopted to identify, analyze, and scale effective practices from high-performing providers.

1. The first prong focused on the identification of high-performing and consistently improving providers across regions using performance trend data. This step enabled targeted selection of provider sites demonstrating sustained success in WCV and IMA measures.
2. The second prong involved conducting structured interviews with care teams and Q) staff at selected sites. These interviews explored workflows, care team roles, outreach strategies, and mechanisms used to sustain performance, with the goal of identifying practical and replicable strategies.

3. The third prong centers on systematic analysis and dissemination of findings. Interview insights are being synthesized to identify best and next practices, which will be translated into actionable guidance and shared with underperforming sites through technical assistance and practice transformation support. This phase is ongoing and extends into the next fiscal year.

Outcomes, Equity, and Current Performance

This initiative primarily generated qualitative insights rather than immediate measurable improvements, as it focused on identifying and scaling effective practices. The identification of high-performing and improving provider sites enabled targeted learning from organizations demonstrating sustained success in WCV and IMA, helping clarify practical drivers of higher performance and opportunities to reduce variation across the network. The project remains ongoing with structured interviews still being scheduled. The third phase, focused on synthesizing and disseminating findings, along with translating insights into actionable strategies for broader implementation, is in progress and will continue into the next fiscal year. Preliminary findings indicate that high-performing sites rely on proactive outreach and clearly defined care team roles for their success. Overall, the work reinforces that sustainable improvement is driven by reliable systems and consistent execution rather than isolated interventions, highlighting the value of leveraging best practices from high-performing providers to inform targeted practice transformation and drive longer-term improvements in WCV and IMA performance.

Key Learnings, Barrier Analysis, and Next Steps

Well-Child Visits (WCV)

To-date take-aways: Both clinics succeed in WCV performance because they rely on tight MA teamwork, proactive scheduling, and strong relationships with families.

Core Cross Clinic Themes (Best Practices):

- Continuity of care — Both clinics emphasize long-term relationships with families, which increases trust and makes scheduling easier.
- Proactive scheduling — Visits are booked during unrelated encounters, reducing future gaps.
- Embedded pre visit planning — MAs scrub charts ahead of time to ensure accurate screening and vaccine needs.
- Strong MA culture — Whether MCC's "braiding hair" model or Santa Rosa's structured huddles, both rely on MAs who communicate constantly and support each other.
- Child centered communication — Staff adjust tone, pace, and approach based on the child's mood and comfort.

Across both clinics, WCV success is rooted in relationships and workflow consistency. MCC benefits from being a small, tight knit pediatric team with long standing staff who know families well. Santa Rosa, though larger, reinforces consistency through structured huddles and standardized outreach roles. Both rely heavily on MAs who communicate fluidly, anticipate needs, and proactively schedule future visits. Pre visit planning, especially chart scrubbing, ensures that no opportunities are missed. Challenges tend to be operational (new providers, documentation gaps) rather than cultural, and both clinics show strong adaptability. These early findings suggest that team cohesion + proactive planning are foundational to high WCV performance.

Immunizations for Adolescents (IMA)
To-date takeaways: Both clinics succeed in IMA through clean data, persistent outreach, and clear, confident vaccine communication.

Core Cross Clinic Themes (Best Practices):

- Accurate care gap lists — Santa Rosa uses Relevance; MCC uses eReports + internal tracking. Both stress the importance of clean data.
- Phone first outreach — Calls remain the primary outreach method; both clinics revisit non-responders.
- Presumptive vaccine language — Both clinics present vaccines as the expected plan, not an optional add on.
- Education forward approach — HPV is framed as cancer prevention; staff explain why mild illness doesn't preclude vaccination.
- Consistent QI visibility — Monthly meetings, dashboards, and staff recognition keep teams aligned and motivated.

IMA workflows at both clinics revolve around data accuracy and persistent outreach. Santa Rosa uses Relevance to generate clean, targeted lists, while MCC supplements denominator lists with manual tracking, especially for HPV. Both clinics rely on phone calls as their primary outreach method and revisit non-responders over time. During visits, clinicians and MAs use presumptive language and emphasize the "why" behind vaccines, especially HPV. Vaccine hesitancy is addressed through repetition, reassurance, and clear expectations ("We will ask at every visit"). Both clinics also maintain strong QI cultures with regular meetings, visible QI staff, and recognition systems that reinforce performance. These shared practices point to a model where clean data + confident communication + steady outreach drive strong IMA rates.

Clinic availability barriers — Many clinics are not responding or have limited bandwidth due to competing priorities, making it difficult to secure interview time.

Next Steps:

- The workgroup will continue to conduct interviews. Current findings reflect early themes from only two clinics. As more interviews are conducted, patterns may shift or deepen. The goal remains to identify replicable best practices that can reliably increase WCV and IMA rates across diverse clinic settings.
- The workgroup will synthesize findings into actionable best practices that can be disseminated to the wider network.

Newborn Pilot Project for W30 +6

<u>Measure Focus</u>

This initiative focused on improving performance in the Well-Child Visits in the First 15 Months of Life measure (W30+6) by implementing a Newborn Pilot Project in Siskiyou County in partnership with Fairchild Medical Center. The pilot builds on a previously successful model in Solano County aimed at increasing timely newborn visits through enhanced care coordination, hospital collaboration, and targeted outreach to new parents.

The work was prioritized due to persistent performance gaps in W30+6 rates. This measure is tracked across QIP and HEDIS domains and is tied to MCAS performance, with implications for withhold and sanction outcomes. The initiative also aligns with organizational and Quality Improvement goals focused on improving pediatric preventive care and reducing disparities in underserved communities. Additionally, this effort supports external

drivers, including DHCS priorities under Health Equity and Population Health frameworks and NCQA HEDIS performance expectations for early childhood care.

Baseline Performance and Opportunity

MY2024 performance for W30+6 shows a plan-wide compliance rate of 54.22%, while Siskiyou lags significantly at 26.53%, reflecting a gap of nearly 28 percentage points and a clear opportunity for improvement. Interpretation of these rates is complicated by persistent data capture challenges, particularly in the first two months of life. Historically, infants were not assigned a CIN until after two months, resulting in visits being billed under the mother's CIN and limiting accurate attribution; although the implementation of Gateway has improved timely CIN assignment, newborns are still often recorded as "unknown baby," making it difficult to link mother-infant records. Findings from the original pilot further indicated that many parents were unaware of the number and timing of required well-baby visits, suggesting a gap in caregiver education that may also contribute to missed or delayed care.

Intervention Implemented

- Partnered with Fairchild Medical Center, the primary labor and delivery hospital serving the target population, to implement a centralized intervention aimed at improving early well-baby visit compliance.
- Launched a Phone Outreach Pilot from September 5th- February 28th focused on supporting Medi-Cal enrollment, facilitating newborn PCP selection, and reinforcing the importance of timely well-baby visits.
- Implemented a coordinated workflow in which hospital staff informed mothers at discharge about upcoming outreach, provided program materials, and shared weekly delivery reports with Partnership; PHC staff then conducted outreach calls within one week of discharge to assist with next steps and appointment readiness.

Outcomes, Equity, and Current Performance

Implementation of the outreach pilot with Fairchild Medical Center experienced lower-than-expected reach participation. Out of the 25 unique members, only 44% agreed to participate, which is lower than the 51.5% participation rate observed in our original pilot in Solano County. Overall impact on well-baby visit compliance and the performance gap cannot yet be measured, as outcomes for this measure are only assessable once the child reaches 15 months of age, with results anticipated next year.

Key Learnings, Barrier Analysis, and Next Steps

Key Learnings:

- Overall, findings suggest that while the intervention model has potential, its effectiveness is highly dependent on consistent operational execution, data-sharing infrastructure, and strong partner accountability.

Barrier Analysis:

- While early engagement with Fairchild leadership was strong and agreement on workflow requirements was established, execution challenges significantly limited impact.
    - Delays and inconsistencies in receiving lists of newly delivered mothers resulted in many members being routed through the standard postpartum outreach workflow instead of the pilot, reducing exposure to the enhanced intervention components.
    - Fairchild staff did not inform patients about the upcoming outreach, contributing to lower engagement rates.

- A data quality issue involving inclusion of a patient who had experienced a miscarriage highlighted gaps in list validation processes.

- Despite follow-up discussions and commitments to retrain staff and improve data accuracy, ongoing barriers, including inability to send secure emails and lack of follow-through on alternative solutions, led to cessation of list sharing before the pilot could be fully executed.

Next Steps:

- The workgroup is interested in testing this pilot again with a different partner to see if the results could be replicated with the results observed in Solano County. Given that Butte County also has notably low W30+6 completion rates, a labor and delivery unit in this region would be ideal. The team is coordinating a meeting with Enloe Health in Butte County to explore interest in partnering to test this pilot with their patient population.
- The workgroup is collaborating with PointClickCare to develop an L&D discharge report, which will allow independent access to the data needed rather than relying on partner provided lists, increasing overall self sufficiency.

Evaluation of GTP Registration for W30-2+

Measure Focus

Last year the team focused on improving performance in the Well Child Visit in the First 30 Months of Life measure (W30+2) by increasing Partnership's promotion of the Growing Together Program (GTP). This program provides structured support and care coordination for families, with the goal of increasing timely visit completion (see table below). This year, the aim is to continue this activity and more importantly, evaluate the outcomes of the project team's efforts.

Campaign Outcome	Members (% of Total)	Members who completed all recommended visits (% of outcome)
Engaged	1551 (23%)	1033 (67%)
Declined	1090 (16%)	593 (54%)*
Left Message	2698 (41%)	1415 (52%)*
Unable to Reach	1282 (19%)	588 (46%)*
Total	6621	3629
Not Referred	12,689	3141 (25%)*

***Indicates statistically significant result.**

This table was retrieved from the June 2025 Population Health grand analysis.

Improving W30+2 performance directly supports organizational goals related to early childhood health, preventive care engagement, and health equity. Additionally, the initiative aligns with DHCS and NCQA (HPA/HEA) expectations emphasizing early developmental screenings, continuity of care, and reduction of disparities in maternal and child health outcomes.

Baseline Performance and Opportunity

The 2024 GTP data shows that among those eligible for the program, only 34% were referred, and of those referred, just 23% agreed to register, with the remaining individuals either declining or being unreachable. Despite these challenges, the data indicates that participants in GTP are more likely to complete their well child visits compared to those who do not participate' highlighting the need to strengthen outreach and promotion efforts. Notably, the engaged White population demonstrated a significantly lower completion rate for well child visits (57%) compared with Hispanic participants (72%).

QIP monitoring of the W30+2 measure began in MY2025, allowing providers to track their progress in this measure. The plan-wide completion rate by the end of 2025 stood at 73.06%. While the current completion rate is encouraging, it also makes clear that there is meaningful room to improve. This underscores the value in leveraging W30+2 monitoring in eReports to promote more consistent preventive care participation.

Interventions Implemented

- Integrated Growing Together Program (GTP) information, including program overview, member benefits, and registration instructions, into external facing meetings and trainings such as QI Regional Meetings, IMO webinars, and partner education sessions.
- Provided clear guidance to providers on how to refer eligible patients to GTP, including referral pathways.
- Improvement Advisors distributed GTP flyers and referral forms to all assigned providers to support consistent messaging and increase awareness.
- Added W30+2 as a monitoring measure within QIP to increase visibility of the measure, encourage active tracking, and promote performance improvement efforts.

Outcomes, Equity, and Current Performance

Early qualitative feedback suggests an increase in awareness of the Growing Together Program (GTP) among providers and partners following expanded promotional efforts. The 2024 data shows that increased GTP engagement was associated with higher well child visit completion overall; however, because monitoring of visits occurring between 15 and 30 months (W30+2) only began recently, continued assessment is needed to determine whether these improvements extend to this specific measure as well.

GTP Registration (Healthy Babies)	
2024	2,484
2025	6,890
Jan-April 2026	2,443

Overall, the interventions have strengthened provider awareness, improved referral consistency, and enhanced visibility of the W30+2 measure through QIP monitoring. Continued tracking and partner feedback will guide next steps to reduce disparities and support improved outcomes.

Key Learnings, Barrier Analysis, and Next Steps

Key Learnings:

- Promotion of the Growing Together Program during provider trainings, QI meetings, and distributed materials successfully increased registration compared to 2024 baseline levels.
- Adding W30+2 to QIP monitoring increased visibility and accountability, even though measure level impact cannot be assessed until MY2026.

Barrier Analysis:

- Outdated or inaccurate phone numbers limited successful outreach, reducing opportunities to engage eligible families in the program.
- Many families did not return calls even after multiple messages, creating inconsistent follow up and hindering timely enrollment and support.

Next Steps:

- Continue to reinforce GTP messaging through ongoing QI touchpoints, partner education, and regional meetings.
- Continue monitoring GTP registration trends and prepare for MY2026 evaluation of W30+2 to assess long term impact on well child visit completion.
- Determine how to increase registration rates among Partnership's white population in order to close disparities between groups.

Educating Practices about Developmental Screening in the First Three Years of Life

Measure Focus

This initiative focused on improving completion of three developmental screenings in the first three years of life by conducting one-on-one training for PCP practices with scores significantly below the MPL. The Pediatric QSMI workgroup reviewed MY2025 HEDIS rates and worked with an Associate Medical Director to set up one-on-one interventions for select practices with especially low scores and larger denominators. This work was prioritized due to persistent performance issues across the entire Partnership footprint. Additionally, the measure is MCAS accountable.

Baseline Performance and Opportunity

In MY2023, the MPL for Developmental Screening in the First Three Years of Life was 28.83%, however in MY2024, the MPL increased to 37.50%, so although Partnership's overall plan-wide score increased by 1.26% Year over Year, the gap to MPL increased by 5.61%.

For MY2025, the MPL dropped by 0.10% to 37.40% and based on preliminary HEDIS data, Partnership achieved a plan-wide rate of 36.11%, an overall improvement of approximately 6.5%.

	MY2023	MY2024	MY2025*
Developmental Screening in the First Three Years of Life	28.39%	29.65%	36.11%
Gap to MPL	0.44%	6.05%	1.29%
			***Rate Estimated**

Review of individual practices within the network showed a wide range with some practices performing near 100% and others with 0% compliance. Performance in this measure is almost entirely reliant on claims submitted with CPT code 96110, so accurate and complete data capture is a significant barrier to rate improvement.

Interventions Implemented

- Analyzed MY2025 November and December HEDIS rates to identify practices with screening completion rates of 0.0% - 9.9%, practices with completion rates over 50%, and practices 10% or less away from MPL.
- Reached out to high-performing practices with completion rates at 50% and higher to discuss their workflows and processes.
- Reviewed and updated best practices for conducting developmental screenings, documentation, and billing practices.
- Started outreach to the lowest performing sites to schedule one-on-one discussions to identify and remediate performance issues.

Outcomes, Equity, and Current Performance

One-on-one coaching for low performing practices only recently started so there has not been enough time to evaluate outcomes. Practices that receive coaching will be monitored and offered additional training if their scores do not improve after 3 months.

Key Learnings, Barrier Analysis and Next Steps

Key Learnings:

- The current data set relies on claims submitted with code 96110. Six of the lowest performing practices were compared against a list of site audits by the Medical Record Review team and two of those sites had fully compliant charts during their last site visit so it appears at least some practices are conducting screenings but not billing correctly for them.
- Some practices discuss elements of the screenings during the actual visit and document those discussions in the EHR but may not complete the actual screening tool or correctly bill for the screening.
- Even among pediatric-only practices, some are performing well and others are far below the MPL. Proper billing and documentation appears to be an issue regardless of practice type.

Barrier Analysis:

- Some EHRs limit the number of codes that can be attached to a claim, and others are limited in the code sets they can use.
- Billing workflows vary widely between practices. Some practices have billers review the chart notes and apply all the relevant codes while other practices have clinicians select procedure codes while charting. If billers and providers are unaware of the developmental screening code 96110, it will not be added to the chart.
- Clinical workflows vary between practices and sometimes even between different sites of the same parent organization.

Next Steps:

- Continue one-on-one training with low performing practices throughout CY2026.
- Work with Claims department to determine whether practices can resubmit claims for visits where a developmental screening was completed but the right codes were not used.
- Repeat the Developmental Screening webinar last conducted in 2025. Record and post to the Partnership Improvement Academy website so practices can refer to the information as needed.
- Develop a written best practice guide with a focus on billing to help practice submit the necessary codes.

- Continue Monthly HEDIS rate review to track whether practices who received coaching improve in their rates.

Women's Health and Perinatal Care

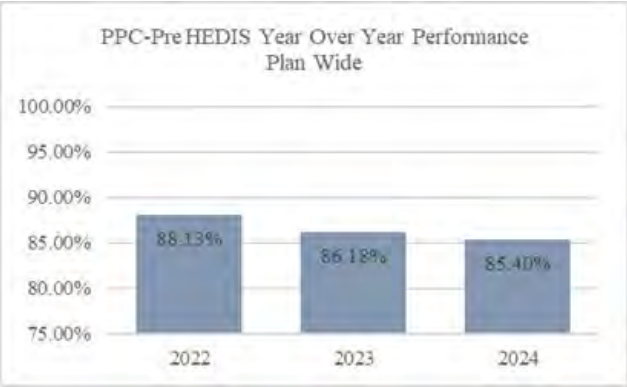
PPC Pre Timeliness of Prenatal Care Alignment

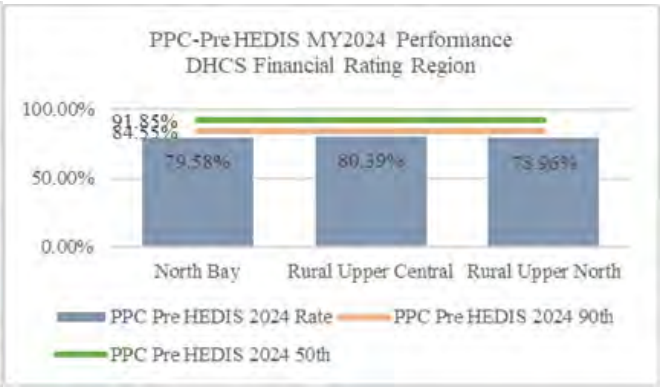
Measure Focus

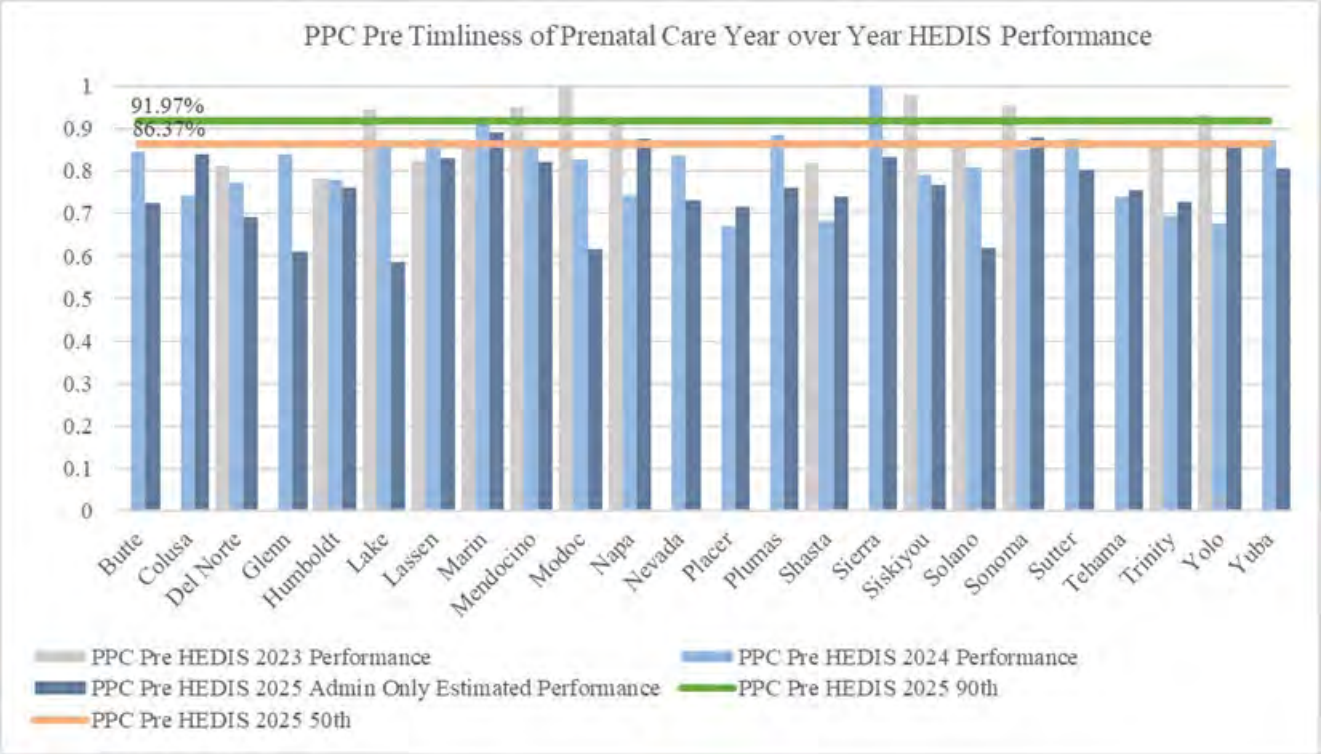
This initiative focused on alignment across Partnership's Perinatal Quality Incentive Program (P-QIP), Primary Care Provider Quality Incentive Program (PCP QIP), HEDIS, and Clinical Compliance for Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre). PPC-Pre is a Department of Health Care Services (DHCS) withhold measure in the Managed Care Accountability Set (MCAS) held to the minimum performance level (MPL). Additionally, PPC-Pre is an annually reported measure for Partnership's National Committee for Quality Assurance (NCQA) Health Plan Accreditation, Health Plan Rating, QI3 Care Coordination audit, and Health Outcomes Accreditation. PPC-Pre reporting methodology is Hybrid/Admin and must be stratified by race/ethnicity per NCQA categorizations. The work was prioritized due to impact on members and financial risk from withholds, sanctions, and Quality achievement community investment.

Baseline Performance and Opportunity

PPC-Pre HEDIS plan wide performance has shown a slight decline year over year. During an investigation into the MY2024 PPC-Pre rate decline conducted by the HEDIS team, it was identified that a prenatal visit code was not included in the claims data loaded for the MY2024 Annual Regulatory project resulting in an observed decrease. PPC-Pre HEDIS MY2024 Performance by DHCS financial rating region showed that no region met the 50th percentile benchmark. County performance varies year over year, with 14 counties falling below the 50th benchmark in MY2024. Administrative only data as of December 2025 shows an estimated 19 counties below the 50th benchmark in MY2025.







A multidisciplinary team review identified opportunities to improve consistency of PPC-Pre measurement support across the organization. The initiative focused on reducing variation in coding and documentation practices, standardizing best practices for qualifying perinatal encounters, and identifying allowable care models (telehealth pathways) that support timely access to prenatal care. This was a multifaceted quality improvement effort that included targeted research, root-cause analysis, claims review, cross-departmental meetings, workflow and policy document review, and implementation of standardized guidance to improve organizational alignment and measure performance.

Interventions Implemented

- Updated FY25/26 P-QIP VSD to include HEDIS validated codes for PPC-Pre.
- Developed a Perinatal Care measure best practices resource to support providers in prenatal care, postpartum care, depression screenings, and prenatal immunization status.
- Explored telehealth options for PPC-Pre that meet HEDIS requirements and may result in timely in person prenatal care and early entry to care coordination.
- Initiated a PPC-Pre monitoring measure proposal for PCP QIP inclusion.
- Planned the 2026 Fostering Connections series with a focus on timely access to perinatal care among priority providers.

Outcomes, Equity, and Current Performance

- A review of FY24/25 P-QIP's VSD identified the PPC-Pre measure was not included. Timely prenatal visits are not captured in claims in the P-QIP payment dashboard, so HEDIS codes have not been added in the past. The P-QIP program manager, Director of Quality Measurement, HEDIS Clinical team, and Dr. Townsend Regional Medical Director updated the FY25/26 P-QIP Value Set Directory to include

validated HEDIS codes for PPC-Pre. This addition ensures providers receive clear guidance on documentation and coding needed for numerator compliance.

- Annually, the Improvement Academy develops measure best practice resources to support the PCP QIP measure set that aligns closely with the MCAS established by DHCS. This year perinatal care was added outlining best and promising practices to support timely care, reduce barriers, and strengthen measure compliance, with additional information on outreach, equity, coding, and documentation.
- Met with HEDIS Clinical team to explore PPC-Pre telehealth visit options that meet HEDIS requirements and may address access barriers supporting timely care, early connection to care coordination, and improved maternal and infant health outcomes.
- A 2025 claims analysis on positive pregnancy test results indicated the majority of first visits following a positive pregnancy test were with a Federally Qualified Health Center Provider, Rural Health Provider, or Tribal Health Provider. Inclusion of PPC-Pre in the PCP QIP measure set would allow primary care providers visibility on measure performance and requirements, encourage quality department engagement, and incentivize providers to connect patients to prenatal care in the first trimester. The PPC-Pre measure proposal was presented at the PCP QIP Tech Workgroup and is currently under review for consideration.
- Ownership of Partnership's 2026 Fostering Connections series transitioned to the WHP QMSI workgroup. The series provides P-QIP participating providers with education on prenatal care, women's health preventive services, current recommendations and guidelines, performance data, measure best practices, and an open discussion around barriers. The 2026 series focus is on improving timely access to perinatal care. Priority providers have been identified, content has been developed, and scheduling is underway.

<u>Key Learnings, Barrier Analysis and Next Steps</u>

Key Learnings:

- Adding validated HEDIS codes to the P-QIP Value Set Directory improves clarity, reduces variation in prenatal care coding and documentation, and supports more reliable HEDIS performance monitoring.
- The PPC-Pre measure best practice resource provides a standardized, evidence-based framework for improving perinatal care delivery and operational performance. Translating measure requirements into actionable workflows can improve quality of care and patient outcomes without organizations reinventing the wheel.
- PPC-Pre Telehealth visits in both administrative and hybrid data collection methods are eligible for use in HEDIS reporting. The visit must be with an appropriate provider, within the applicable timeframe, and include a confirmation/diagnosis of pregnancy, and a visit component such as discussion of screening or lab results or last menstrual period with Obstetric (OB) history.
- Primary care, FQHC, rural, and Tribal health providers play a critical role in early pregnancy and should be included in performance visibility and improvement strategies.
- Integrating provider education efforts into existing structures strengthens the program allowing wider visibility, the prioritizing of providers based on performance data, and inclusion of improvement advisors.

Barrier Analysis:

- PPC-Pre was not previously included in the P-QIP Value Set Directory, requiring cross-team review and validation before updated coding guidance could be added.
- No two health centers are the same. Perinatal care measure best practices may work at one health center, but not at another.

- Telehealth requirements for PPC-Pre are complex and will require careful interpretation and implementation.
- PCP QIP PPC-Pre inclusion depends on formal review and approval processes.
- Fostering connection series is not a requirement and providers may choose not to participate.
- During an investigation into the MY2024 PPC-Pre rate decline conducted by the HEDIS team in November 2025, it was identified that the homegrown local code Z1032, which maps to CPT 99215 for prenatal visits, was not included in the claims data loaded for the MY2024 Annual Regulatory project. This missing mapping is the primary driver of the observed decrease in the PPC-Pre rate when compared to the Monthly YTD December 2024 results, which explains the significant variance between the two projects.

Next Steps:

- Reinforce annual P-QIP VSD dissemination and provider reminders through the Fostering Connection series.
- Continue annual updates and communication of PPC-Pre best practices.
- Continue evaluation of telehealth models that meet requirements and operationalize referral/hand-off processes to timely in-person prenatal care.
- Pending PPC-Pre measure proposal approval, a defined implementation and communication plan will need to be developed for participating practices.
- Continuing scheduling of fostering connection series with priority providers.

High-risk Human Papillomavirus Self-Collect Support and Education

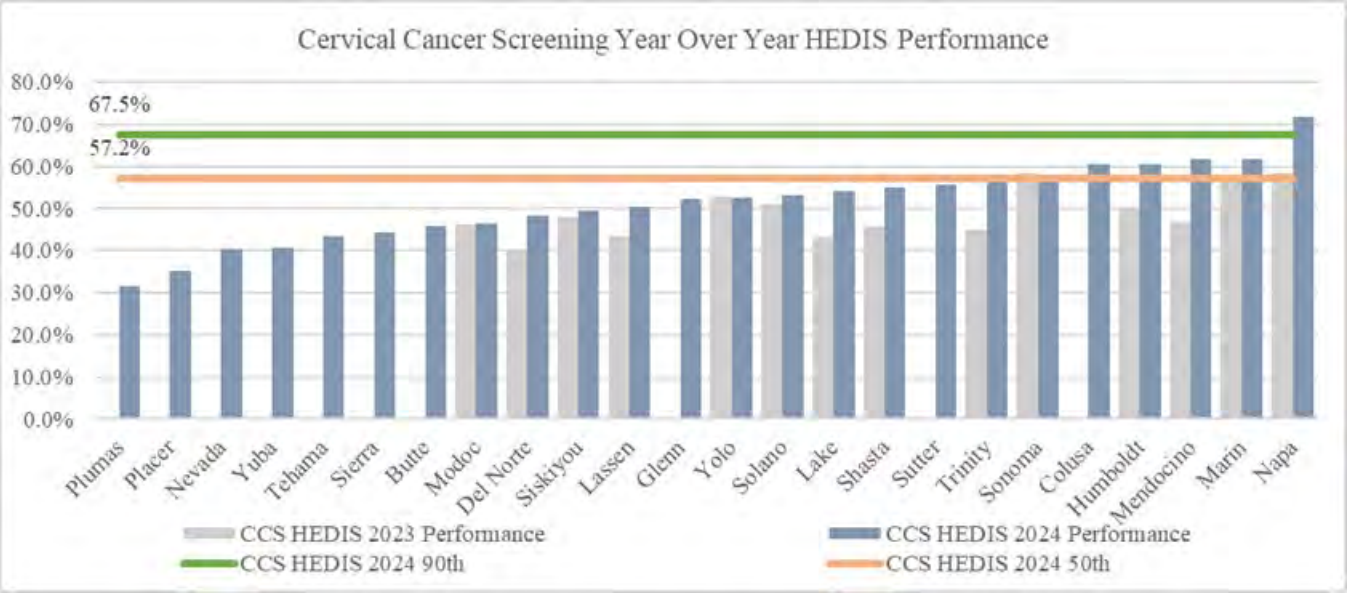
Measure Focus

This initiative focused on improving performance in the Cervical Cancer Screening measure by expanding and standardizing use of the high-risk HPV (hrHPV) self-collect option in healthcare settings. Work centered on strengthening network-wide awareness, updating best-practice guidance, and ensuring clinics had consistent instructions and education materials to support appropriate implementation.

Cervical Cancer Screening reporting methodology was retired by NCQA starting MY2025 and only Cervical Cancer Screening- Electronic Clinical Data Systems (CCS-E) is reported. CCS-E is a DHCS MCAS measure held to the MPL and in the MY2026 PCP QIP Core Measurement Set under the Clinical Domain for Family Medicine and Internal Medicine. Additionally, it is a component of Partnership's NCQA Health Plan Accreditation and Health Plan Rating. CCS-E must be stratified by race/ethnicity per NCQA categorizations. The work was prioritized due to impact on members and financial risk from sanctions and Quality achievement community investment.

Baseline Performance and Opportunity

CCS HEDIS performance in legacy counties shows gradual improvement from 2023 to 2024. Despite overall progress, 18 counties remained below the MY2024 CCS 50th percentile benchmark, 6 counties met or exceeded the benchmark, and Napa was the only county to meet the MY2024 CCS 90th percentile benchmark.



In May 2024, the U.S. Food and Drug Administration expanded approval of two hrHPV tests to allow self-collected vaginal samples for screening in a healthcare setting. In FY24/25, the workgroup supported network wide implementation by standardizing internal workflows to support HEDIS and PCP QIP compliance and partnering with laboratories to ensure test availability. Adoption was driven through coordinated internal and external education, communications, and provider implementation support. Ongoing monitoring of provider implementation of hrHPV self-collect identified variation in clinic adoption. This informed the decision to prioritize implementation guidance, targeted coaching for low-performing providers, and development of a year-over-year performance tracker to monitor improvement.

Interventions Implemented

Reviewed, updated, and developed CCS patient and provider education materials on hrHPV self-collection. Identified low-performing providers and collaborated with Improvement Advisors to deliver targeted 1:1 education through coaching sessions. Developed a site-level performance tracker to monitor year-over-year improvement and identify year over year PCP QIP CCS performance.
Partnered with analytics to assess availability of hrHPV self-collection data and determine best use for ongoing monitoring and reporting.

Outcomes, Equity, and Current Performance

- CCS patient and provider education materials with the inclusion of hrHPV self-collect have been approved and published. Equity considerations were incorporated through review of health education materials to ensure patient instructions are accessible and usable across Partnerships threshold languages.
- Completed provider education with PCP QIP participating providers at 31 parent organizations across 117 provider sites. Deployment of a performance tracker to support ongoing PCP QIP performance monitoring. Estimated 2025 PCP QIP CCS data shows 28 of the 31 providers who received one on one provider education and resources experienced a rate increase.
- A structured interview with a rural health provider following a successful hrHPV self-collect pilot identified effective workflows, care team utilization strategies, and outreach approaches. Key insights into these successful practices have been incorporated into a quality improvement storyboard. Additionally,

these insights will be used to develop best practices to support underperforming providers and improve CCS measure performance.

- In 2025, the American Medical Association introduced CPT Code 87626 that separately reports high-risk types and high-risk pooled results. This CPT code is used for the hrHPV Self Collect and clinician collect. During a claims review of cervical cancer screenings, it was discovered both methods use the same CPT codes and diagnosis codes, limiting the ability to distinguish between collection methods.

Key Learnings, Barrier Analysis, and Next Steps

Key Learnings:

- Provider and patient education materials are foundational for scaling hrHPV self-collect consistently across the network.
- Equity-centered material review is important to ensure patient instructions are accessible across threshold languages and usable by patients with different literacy levels and care access needs.
- Targeted provider education informed by site level performance data and improvement advisor insights was an efficient way to prioritize education.
- hrHPV self-collect can be integrated successfully when clinics have clear instructions, laboratory access, and practical examples of staffing, outreach, and visit workflows.

Barrier Analysis:

- Provider hesitancy on hrHPV self-collect remained an important barrier and additional education was needed on screening guidelines, eligibility, workflow, and the growing evidence base showing self-collection is an effective option when used as recommended in a healthcare setting.
- Clinic adoption has varied, reflecting differences in workflows, priorities, and readiness to operationalize a new screening approach.
- Staff familiarity with hrHPV self-collect eligibility, patient instructions, specimen handling, and follow-up processes varies across sites, creating risk for inconsistent implementation.
- Current claims-based reporting does not distinguish self-collect from clinician-collect because both methods use the same CPT and diagnosis coding, limiting baseline measurement and ongoing evaluation.
- Some counties and regions continue to perform below benchmark, indicating a need for more focused support.

Next Steps:

- Disseminate updated CCS best practices and hrHPV self-collect education materials across the network, with emphasis on clear clinic workflows, patient instructions, and staff training.
- Continue targeted one-on-one provider education with a focus on Tribal Health, Rural Health, and low performing providers. Continue use of the site-level tracker to monitor year over year CCS improvement.
- Partner with analytics, laboratories, and internal stakeholders to validate available data sources and define a practical approach for monitoring hrHPV self-collect implementation and impact.
- Identify and close remaining gaps in multilingual, low-literacy, and culturally responsive materials to strengthen equitable access and patient understanding.

Sexual and Reproductive Health Education and Resources

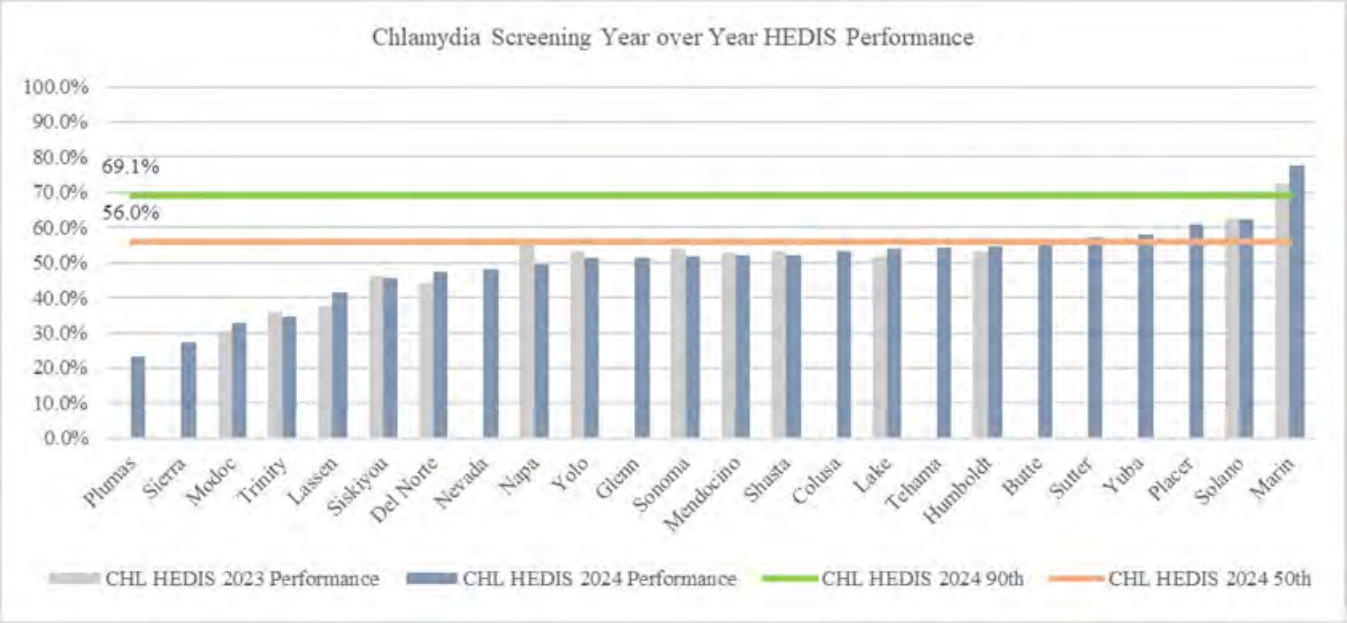
Measure Focus

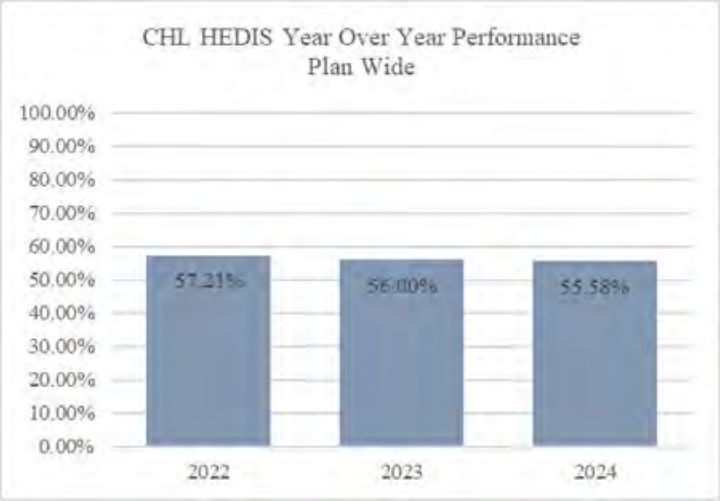
This initiative focused on improving performance in the Chlamydia Screening (CHL) measure by increasing provider awareness, engaging high performing providers in best practice discussions, offering one on one coaching to low performing providers, developing best practice guidance, and equipping clinics with education and implementation resources to integrate CHL screening into routine adolescent workflows. The work also supported broader adolescent sexual and reproductive health education to strengthen consistent screening offers, appropriate counseling, confidential care, and documentation practices.

CHL was a DHCS MCAS measure for MY2025 in the reproductive health domain. CHL was removed from the DHCS MCAS and HPA beginning of MY2026. In MY2025 CHL was introduced into the PCP QIP as a monitoring measure for family and internal medicine provider types, and in the core measurement set under the clinical domain for pediatric providers. CHL remained in the MY2026 PCP QIP and moved to the core measurement set for all provider types. The work was prioritized due to impact on member outcomes, low HEDIS performance, and the introduction of a new MY2025 PCP QIP measure.

Baseline Performance and Opportunity

CHL HEDIS plan wide performance declined slightly year over year. In MY2023, 12 of 14 counties were below the 50th percentile benchmark, while Marin County met the 90th percentile benchmark. In MY2024, 19 of 24 counties were below the 50th percentile benchmark, and Marin again met the 90th percentile benchmark. County performance varies widely, showing significant performance gaps with counties ranging from 23.3% to 77.6%.





Addressing low CHL HEDIS performance and county-level variation highlighted opportunities to strengthen screening practices in routine care settings. Missed screening opportunities were identified in visits that did not present primarily as sexual or reproductive health concerns, particularly in the adolescent and pediatric populations. Variation in provider comfort, confidentiality practices, clinic workflows, and documentation processes created an opportunity to standardize education, reinforce clinical guidance and minor consent services, and integrate screening into routine care. These findings informed a multifaceted approach that prioritized provider education and resources, gathering insights and resources from high-performing practices, and targeted support for lower-performing providers to improve workflow adoption, patient communication, and overall screening performance.

Interventions Implemented

- Developed a chlamydia screening measure best practices resource to support providers.
- Restructured the Improvement Academy 2026 IMO series by developing a new reproductive and sexual health topic and featuring The Sex Ed Justice Project, a Northern California based non-profit.
- Identification of high-performing and consistently improving providers using HEDIS CHL performance trend data enabling targeted selection of provider sites demonstrating sustained measure success.
- Planned/initiated engagement with two CHL high-performing practices to identify best and promising practices for the pediatric/adolescent population.
- Identified consistently low-performing providers and collaborated with Regional Medical Directors to deliver targeted one on one education.
- CHL measure focus for February 2026 Santa Rosa Regional Quality Meeting and March 2026 Santa Rosa Regional Small Health Center Quality Meeting.

Outcomes, Equity, and Current Performance

- Annually, the Improvement Academy develops measure best practice resources to support the PCP QIP measure set that aligns closely with the MCAS established by DHCS. This year CHL was added to support providers with a universal/opt-out screening approach, reduce stigma and barriers to care, and strengthen measure compliance with additional information on outreach, equity, and documentation.
- Incorporated adolescent sexual and reproductive health topic into the Improvement Academy through the 2026 Improving Measure Outcomes series featuring the Sex Ed Justice Project to broaden the discussion

beyond measure performance and support systems-level thinking about sexual and reproductive health. The Sexual and Reproductive Health IMO hosted 59 attendees representing 32 unique organizations

- Planned and initiated engagement with two high-performing practices to identify best and promising practices for broader dissemination. Early insights planned to support development of resources that may help lower-performing providers improve workflow adoption and patient communication.
- Four consistently low-performing providers were identified, and targeted education was initiated with support from Regional Medical Directors to enable more focused outreach and discussion of barriers.
- The Santa Rosa Small Health Center Regional Quality Meeting focused on CHL screening, including opt-out versus risk-based screening approaches, clinical recommendations and guidelines, promising practices, and a driver diagram quality improvement activity. Key drivers identified for Marin and Sonoma County providers included screening workflows, confidentiality, and staff comfort.
- Chlamydia screening was also featured at the Santa Rosa Regional Meeting through a "Voices from the Field" discussion with two providers: Marin Community Clinics and Santa Rosa Community Health Centers. Marin shared strategies that have supported consistently high performance over time, while Santa Rosa discussed expansion of opt-out or universal screening at additional pediatric-focused sites. Both organizations shared workflows, resources, and approaches to maintaining confidentiality throughout the visit.

<u>Key Learnings, Barrier Analysis, and Next Steps</u>

Key Learnings:

- Integrating chlamydia screening into routine visits, including well-child workflows, is critical to reducing missed opportunities and improving adolescent screening rates.
- The Sexual and Reproductive Health IMO shifted away from a CHL measure focus and instead emphasized practical workflow strategies, including screening approach, confidentiality processes, patient communication, and normalizing screening in routine care. This reinforced that improving CHL performance depends on stronger care systems, not only measure-specific education.
- Hearing directly from high-performing organizations provided practical, credible examples of workflows that can be adapted in other settings.
- Meetings with lower-performing providers were important for identifying unique barriers to screening. Performance data also helped prioritize outreach, while increased provider comfort and clarity on CHL workflows supported more consistent screening.
- The driver diagram quality improvement activity identified three primary drivers: screening workflows, confidentiality, and staff comfort, and, together with peer discussion, helped surface real-world challenges and solutions. These meetings also created opportunities to share promising practices from the field and translate measure requirements into actionable clinic workflows.
- Differences between HEDIS and PCP QIP measure definitions can undermine provider engagement.

Barrier Analysis:

- Differences between the CHL PCP QIP and HEDIS measure created confusion about screening eligibility. Many providers associate screening with sexual activity or risk factors which reduced provider engagement and increased the need for best-practice guidance that supported opt-out/universal screening approaches.
- Successful performance in the PCP QIP CHL measure often required providers to make substantial workflow changes. Many providers were unable to operationalize these changes because of limited capacity, staffing constraints, insufficient leadership support, and competing organizational priorities.

- No two health centers are the same. CHL measure best practices may work at one health center, but not at another.
- Clinic workflows, limited time during visits, and discomfort initiating sexual and reproductive health conversations may contribute to missed screening opportunities.
- Lower-performing sites may face operational, staffing, or workflow barriers that require more individualized support, and some providers remained resistant to changing screening practices despite engagement from Regional Medical Directors.
- Confidentiality requirements can be difficult to implement consistently across clinic settings and electronic medical records, creating operational barriers to reliable execution.

Next Steps:

- Incorporate CHL screening into well-child workflows for ages 16–17 in collaboration with the Pediatrics workgroup.
- Document and disseminate best practices identified from the CHL high-performing practices, Sex Ed Justice Project, and CHL driver diagram.
- Continue using regional and small health center meetings to elevate provider voices, share promising practices, and support discussion of operational barriers and solutions.
- Anticipated changes to the PCP QIP MY2027 measure set include removal of CHL. Although chlamydia screening will remain important for improving health outcomes, it will no longer be prioritized as a workgroup focus for MY2026–2027.
- Prepare to implement home testing, particularly for rural populations, now that the FDA has approved home testing kits. Continue collaborating with eligible laboratories to integrate home hrHPV testing as it becomes available.

Increase PPC Pre Timeliness of Prenatal Care Awareness

Measure Focus

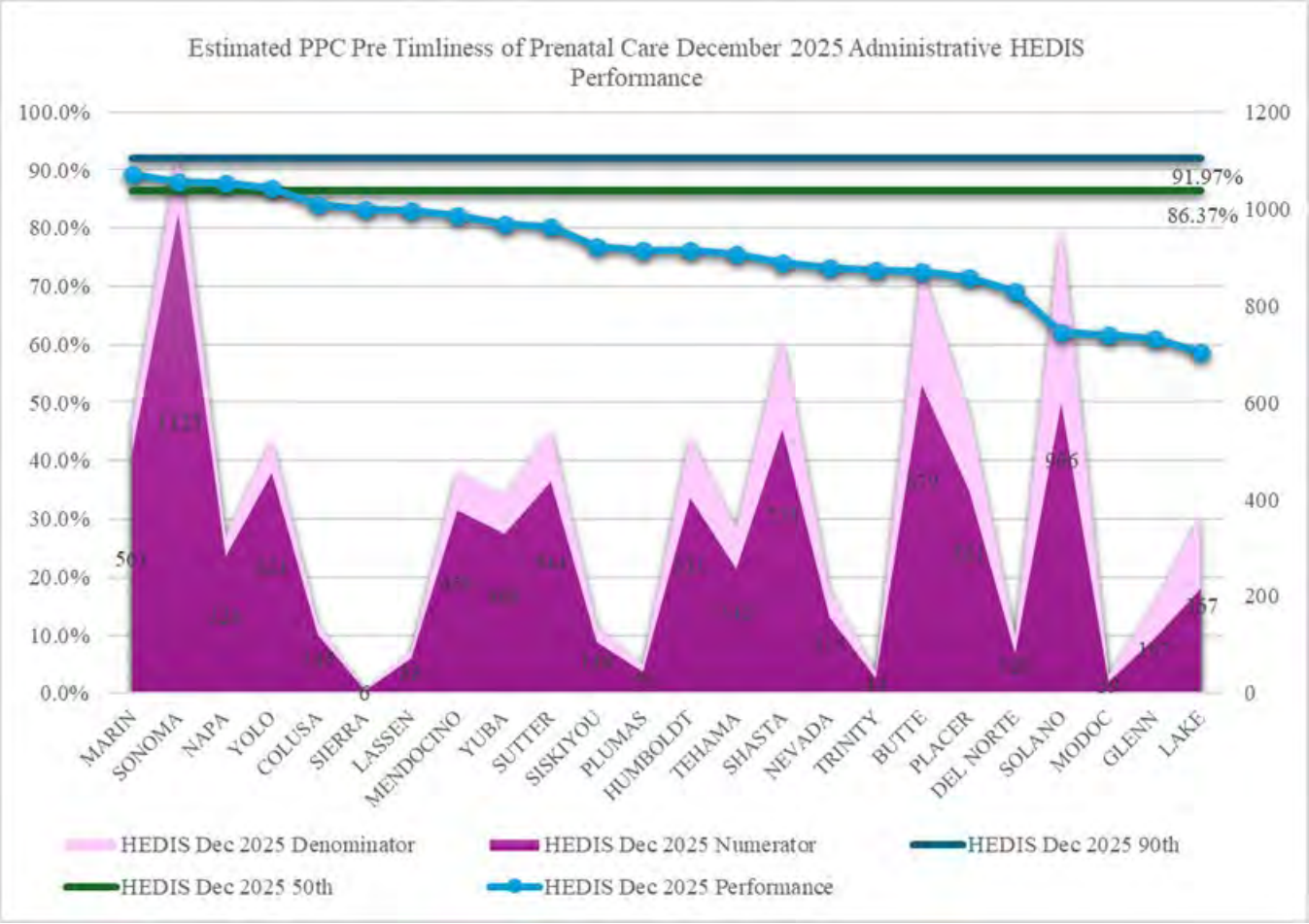
This initiative focused on improving performance for the Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre) measure by partnering with improvement advisors who had established relationships with providers in effort to strengthen awareness of measure timing requirements and identify barriers to timely first prenatal visits.

PPC-Pre is a Department of Health Care Services (DHCS) quality withhold measure that is Managed Care Accountability Set (MCAS) accountable. Additionally, it is a component of Partnership's NCQA Health Plan Accreditation, Health Plan Rating, QI3 Care Coordination audit, and Health Outcomes Accreditation. PPC-Pre reporting methodology is Hybrid/Admin and must be stratified by race/ethnicity per NCQA categorizations. The work was prioritized due to impact on members and financial risk from withholds, sanctions, and Quality achievement community investment.

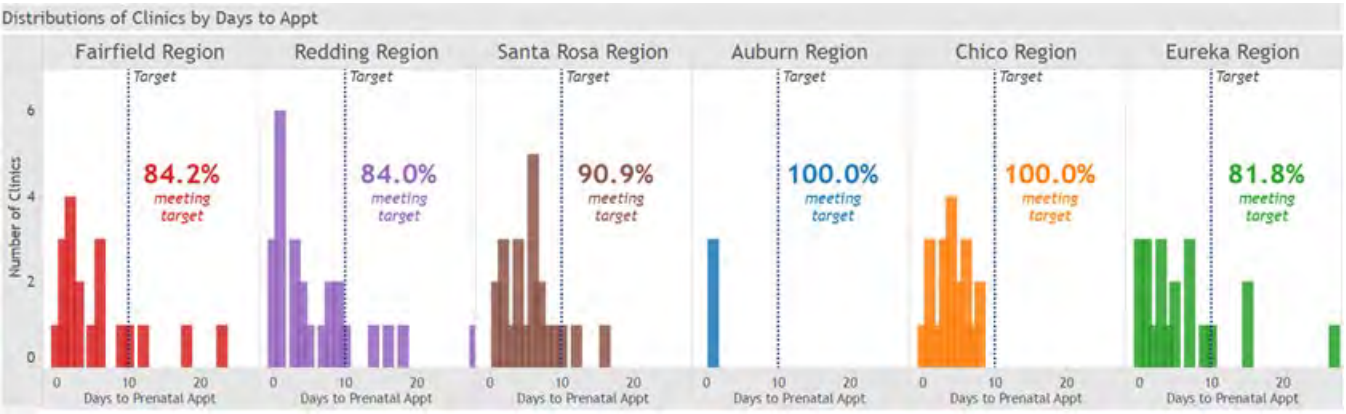
Baseline Performance and Opportunity

Priority sites were identified based on PCP QIP participation using HEDIS PPC-Pre MY2024 and MY2025 performance data, P-QIP submission data, and the 2025 Third Next Available (TNA) Prenatal Care Appointment Access survey. These data helped highlight practices with lower performance, higher denominators, and third next available prenatal appointments exceeding the 10-day access standard. These same priority providers identified were also used to target for participation in the Fostering Connections series. HEDIS PPC-Pre MY2024 and MY2025 performance data were analyzed to identify counties consistently below the 50th percentile benchmark, as well as counties within 5 percentage points of meeting the benchmark. The highest denominators by

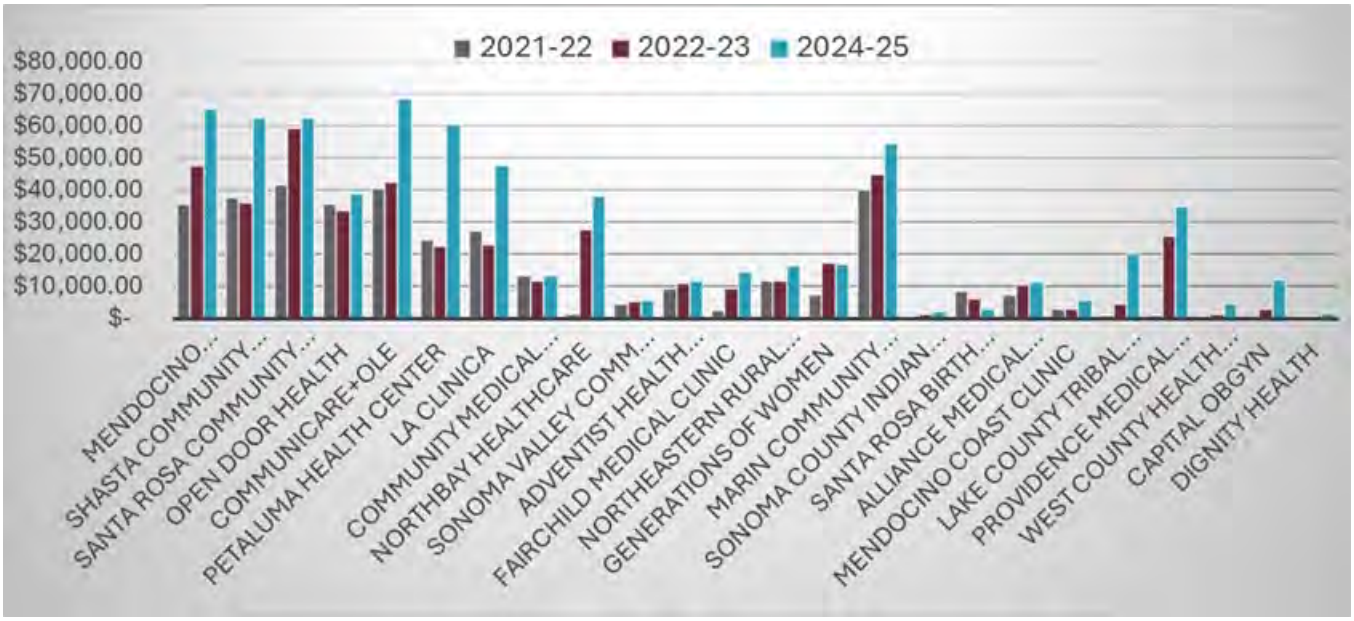
Partnership County are Sonoma, Solano, and Butte. County denominators coupled with low performance were considered when determining prioritization.



The 2025 Third Next Available Prenatal Care Appointment Access survey identified the Eureka region with the longest wait times for prenatal care appointments. At the county level, Shasta and Siskiyou had the lowest compliance, followed by Mendocino. At the provider level, 15 of 100 health centers reported a TNA prenatal appointment of 10 days or more.



P-QIP participating providers are incentivized for timey prenatal care visits through monthly attestation. P-QIP year-over-year incentive payments by parent organization demonstrates all but one provider had increases in incentive dollars earned. To date, 98 provider sites participate in the P-QIP.



Performance data, PCP QIP participation, and third next available appointment findings identified practices with lower performance, higher denominators, and delays in access to an initial prenatal visit. These findings highlighted an opportunity to strengthen awareness of PPC-Pre timing requirements, improve workflows for newly pregnant patients, and support faster connection from primary care to obstetric care.

Interventions Implemented

- Analyzed PPC-Pre MY2024 and MY2025 performance data, P-QIP submission data, and 2025 Third Next Available Prenatal Care Appointment Access survey data to identify practices performing below the MY2025 PPC-Pre 50th percentile and 10 or more days to a third next available prenatal care appointment.
- PPC-Pre data analysis was used to identify priority practices for the Fostering Connections series. Improvement Advisors were included in the series to increase measure awareness and provide quality improvement support when barriers to timely prenatal care were identified.
- PPC-Pre data analysis was used to identify priority providers participating in both PCP QIP and P-QIP for Improvement Advisor outreach. This approach was used because Improvement Advisors already support PCP QIP practices and have established relationships that could offer valuable insight into performance barriers and facilitate engagement. Improvement Advisor outreach focused on discussions around prioritizing newly pregnant patients, supporting first-trimester appointments, and reinforcing the prenatal care access standard of 10 days or less to the third next available appointment.
- Developed a training deck to orient Improvement Advisors to the PPC-Pre measure, including measure requirements, timing criteria, performance observations, third next available survey findings, and relevant P-QIP context.
- Pulled site-specific data for each health center to inform provider coaching conversations.
- Initiated outreach to the lowest-performing sites with high denominators to schedule virtual and in-person Fostering Connections education sessions. Ensured appropriate staff participation with support from the P-QIP Program Manager.

- Met with clinical compliance inspection team to gain understanding of medical record review standards for PCP and OB providers on prenatal care documentation criteria, coordination criteria, adult preventive criteria, and OB/CPSP Preventive criteria.

Outcomes, Equity, and Current Performance

- PPC-Pre HEDIS performance and access data were analyzed to identify a total of thirty-three priority practices for Improvement Advisor outreach and/or Fostering Connection education, enabling more targeted engagement with sites that had high denominators, lower performance, and longer waits for prenatal appointments.
- A training deck was developed to orient Improvement Advisors to PPC-Pre, creating readiness for more consistent provider education and coaching.
- Outreach to priority sites were initiated to schedule virtual and in-person Fostering Connections education sessions, with support from the P-QIP Program Manager to ensure the appropriate staff were included in these discussions. Out of the thirty-three identified sites, 1 session has been completed, thirteen have been scheduled, and nineteen are in progress or awaiting a response to schedule.
- Meetings with the Clinical Compliance Inspections team helped clarify documentation and coordination standards for primary care and obstetric providers, supporting more consistent understanding of qualifying prenatal encounters and related medical record expectations.

Key Learnings, Barrier Analysis, and Next Steps

Key Learnings:

- Clear, repeated messaging on PPC-Pre requirements is needed to build and sustain staff awareness.
- Site-specific performance and access data supports more focused coaching and helps prioritize outreach to practices with the greatest opportunity for improvement.
- Medi-Cal Managed Care plans require first prenatal visits within 10 business days.
- Documentation of initial prenatal visit completed within four weeks of entry to prenatal care. Optimally within the first trimester.
- First prenatal visit access is a site review standard for PCPs who provide obstetric care and missed appointments and referrals require documented outreach and follow-up. Failure to follow up on missed specialty referrals results in a zero score under coordination criteria.
- If prenatal visit periodicity does not meet current ACOG standards, OB providers must document missed visits and outreach efforts.
- Established relationships through Improvement Advisors offers a valuable entry point and provides knowledge of clinics, counties, and regions, as well as insight into local barriers. This can improve provider's engagement and aid in identifying and addressing both site specific and local performance barriers.

Barrier Analysis:

- Variation in clinic scheduling and intake workflows can delay timely access to the first prenatal visit.
- Inconsistent understanding of qualifying prenatal visit criteria and documentation requirements may limit HEDIS numerator capture.
- Staff turnover and competing priorities create the need for ongoing education.
- Improvement Advisors have limited familiarity with P-QIP, its measures, and related requirements.

- Not all P-QIP providers participate in PCP QIP, which limits alignment of outreach and improvement strategies.
- The P-QIP PPC Pre-measure relies on monthly provider attestation rather than claims data, making performance assessment more challenging. Without a denominator, it is not possible to identify how many pregnant members are not being seen, only those for whom attestations are submitted.
- Large provider organizations operating within a county or across multiple counties can significantly influence county-level performance.
- In some rural areas, access to obstetric care is limited by long travel times, limited appointment availability, and a low number of obstetric providers, creating significant barriers to timely care.

Next Steps:

- Continue using site specific provider data to prioritize follow-up with low-performing sites and apply final HEDIS results to determine whether additional providers should be prioritized for outreach and support.
- Continue Improvement Advisor outreach and coaching with priority providers to reinforce PPC-Pre timing requirements.
- Continue scheduling and delivering Fostering Connections sessions with priority sites, ensuring appropriate clinical, operational, and quality staff are included.
- Continue collaboration with Clinical Compliance and P-QIP leadership to align guidance on documentation, coordination of care, and timely first prenatal visit expectations.
- Strengthen workflows that support prompt PCP-to-OB connection and timely scheduling of the initial prenatal visit.

Tribal Perinatal Program

Measure Focus

This initiative focused on supporting Tribal entities in developing and expanding Tribal Perinatal Programs to improve access to timely prenatal and postpartum care. The Tribal Perinatal Program Tribal Birth Equity Initiative was designed to build culturally informed perinatal care capacity through training, case management, peer support, doula development, and implementation of reimbursement pathways that support sustainable services in Tribal communities. The program goal is to support Tribal communities achieve the best possible outcomes for pregnant American Indians in Northern California.

The Tribal Perinatal Program supports Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre) and Prenatal and Postpartum Care: Postpartum Care (PPC-Pst). PPC-Pre and PPC-Pst are Department of Health Care Services (DHCS) withhold measures in the Managed Care Accountability Set (MCAS) held to the minimum performance level (MPL). Additionally, PPC-Pre and PPC-Pst are annually reported measures for Partnership's National Committee for Quality Assurance (NCQA) Health Plan Accreditation, Health Plan Rating, QI3 Care Coordination audit, and Health Outcomes Accreditation. PPC-Pre and PPC-Pst reporting methodology is Hybrid/Admin and must be stratified by race/ethnicity per NCQA categorizations.

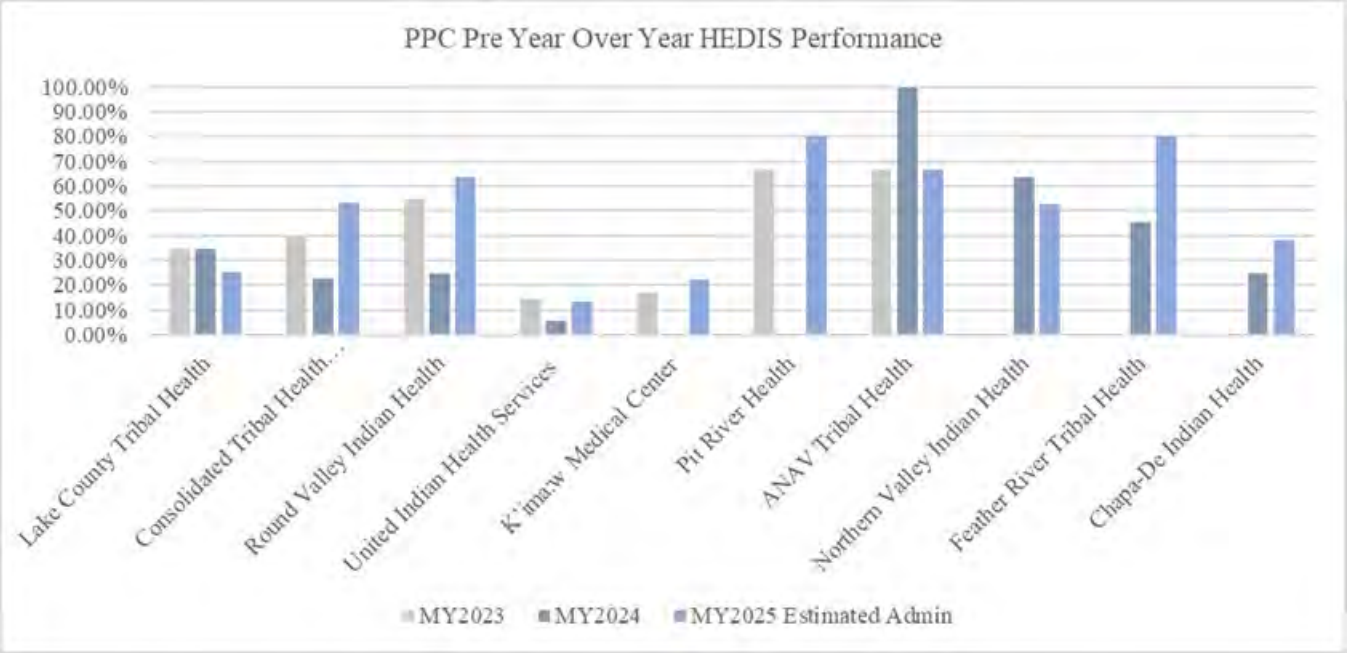
Baseline Performance and Opportunity

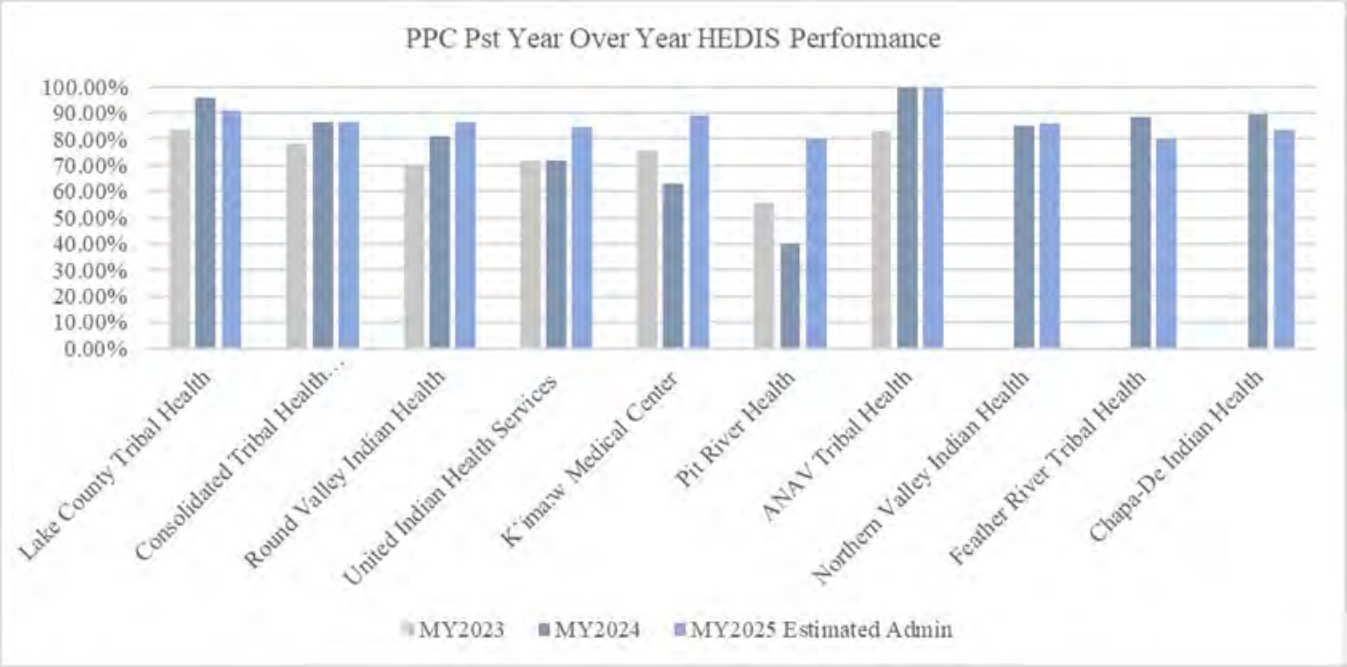
Baseline program tracking focuses on provider contracting and completion of three required deliverables tied to grant funding: identification of a case manager or doula, completion of at least 80% of the training curriculum (100 hours), and execution of an ECM Birth Equity Population of Focus agreement. Currently, the program has

10 tribal health providers contracted or in process of contracting. Progress on deliverables and associated grant payments is tracked for each participating provider.

PPC-Pre rates vary widely across the tribal health providers year over year. In MY2024 one provider reached the 90th percentile benchmark, with the remaining providers did not reach the 50th percentile benchmark. MY2025 estimated administrative data shows an increase in performance for most providers, however no providers met the 50th benchmark.

PPC-Pst consistently outperforms prenatal care across all providers. In MY2024 seven out of ten providers met the 50th benchmark, with four achieving the 90th benchmark. In MY2025 eight out of ten providers met the 50th benchmark, with three achieving the 90th benchmark.





In addition to PPC measure performance, additional program tracking is under development. Planned measures include:

- Enhanced Care Management Birth Equity data by provider from the CalAIM Tableau dashboard, such as members enrolled, members served, and claims volume.
- Partnership Health Plan Perinatal Services utilization by provider from the Maternal Health Tableau dashboard, including distinct utilizers, average services per member, distinct providers, and service volume by category.
- P-QIP participation, submission, and performance data for participating providers.

The initiative focused on strengthening Tribal perinatal care systems by identifying opportunities to expand culturally informed perinatal services across participating Tribal health organizations. Baseline program tracking and early implementation progress showed variation in contracting, training completion, staffing, and readiness to operationalize case management, doula, and Enhanced Care Management services. These findings highlighted an opportunity to strengthen prenatal and postpartum support through a California Indian birth equity framework, improve PPC-Pre and PPC-Pst performance, and build workforce capacity to better address social, behavioral, and cultural needs throughout the perinatal period.

The work also created an opportunity to align grant funding, ECM participation, and PHPS into a more sustainable model for Tribal perinatal care. This informed a structured implementation approach that prioritized culturally grounded curriculum development, reimbursement planning, and practical program support intended to strengthen care coordination, support timely prenatal and postpartum care, and reduce barriers to program launch and long-term operation.

<u>Interventions Implemented</u>

- Tribal Liaison conducted outreach and education to Tribal Health providers in Partnership's network to support awareness of the Tribal Perinatal Program.

- Analyzed Tribal provider PPC-Pre and PPC-Pst performance trends and began development of additional program tracking to support ongoing monitoring of Tribal perinatal program growth.
- Implemented a multidisciplinary training model that included Family Spirit, trauma-informed care, Adult Mental Health First Aid, Motivational Interviewing, substance use disorder content, doula-specific training, ECM and PHPS core training, case management boundary training, and overview of Partnership's perinatal resources.
- Provided education and implementation support related to ECM and PHPS with support from Regional Medical Director champion to clarify reimbursement pathways, review program applications, and provide subject matter expertise on perinatal measures and program requirements.
- Began planning culturally relevant program enhancements, including collaborative workgroup development, member engagement strategies, culturally relevant incentives, testimonial storytelling, and community-based visibility efforts to support long-term program uptake and sustainability.

Outcomes, Equity, and Current Performance

- The program is actively scaling across Northern California Tribal health organizations, with participating sites progressing through contracting, training, staffing, and implementation at different rates. Program tracking now includes Tribal provider PPC-Pre and PPC-Pst performance trends, and additional monitoring is under development to strengthen visibility into ECM, PHPS, and broader program implementation such as P-QIP participation over time.
- Implementation has emphasized workforce and program capacity-building through a structured 100+ hour training curriculum that includes Family Spirit, trauma-informed care, Motivational Interviewing, Adult Mental Health First Aid, doula training, ECM and PHPS core content, and Partnership perinatal resources. These efforts are intended to strengthen culturally grounded, multidisciplinary support for prenatal and postpartum care across Tribal communities.
- Current performance suggest stronger postpartum follow-up than timely first prenatal care across all Tribal Health providers. This reinforces the importance of continued focus on earlier pregnancy identification, timely access to initial prenatal visits, stronger prenatal workflow support, and care coordination strategies.
- Equity is foundational to the program design, which emphasizes respectful, culturally informed, person-specific care and locally relevant approaches to case management, peer support, and doula services for Native American birthing individuals and families. Program development also includes culturally relevant member engagement strategies and community-based approaches intended to strengthen trust, continuity, and uptake of perinatal services.
- Early implementation experience also highlights the value of local collaboration. Tribal perinatal work has supported stronger relationships with hospitals, public health, and community partners, while some Tribal programs have already begun expanding services such as high-risk consultation, lactation support, diabetes education, and locally tailored perinatal supports that can strengthen maternal and infant outcomes over time.

Key Learnings, Barrier Analysis, and Next Steps

Key Learnings:

- Culturally grounded training and program design are central to building Tribal perinatal care capacity.
- Trusted entry points and sustained subject matter support, including outreach from the Tribal Liaison and education from a Medical Director champion, can strengthen engagement, improve understanding of program requirements, and support movement from interest to implementation.

- Aligning training, ECM, and PHPS within a shared implementation approach can strengthen care coordination and support long-term sustainability of Tribal perinatal services.
- Baseline performance suggests Tribal providers may be better positioned to support postpartum follow-up than timely first prenatal care, highlighting a need for continued focus on earlier pregnancy identification, access to initial prenatal visits, and stronger prenatal workflow support to improve PPC-Pre performance.

Barrier Analysis:

- Some organizations view participation as the burden of adding another program, even when many of the services and workflows may already be in place.
- Staff turnover and variation in staffing can delay progress and interrupt continuity which delays implementation.
- ECM contracting and operational implementation require continued follow-up and support to ensure participating organizations can move from agreement to active service delivery.
- Training requirements are substantial and may be difficult to complete alongside other clinical and operational priorities, particularly for smaller organizations with limited staffing capacity.
- Data and performance monitoring are under development, which can make it more difficult to assess implementation progress.

Next Steps:

- Establish a Tribal Perinatal Program collaborative workgroup with participating and non-participating Tribal health clinics to share resources, identify best practices, support peer to peer learning, and gather program feedback.
- Develop culturally relevant member engagement strategies, including a Tribal pregnancy passport to support member engagement and inform care navigation, as well as milestone-based incentives such as baby rattles, baby baskets, or cultural baby books.
- Continue advancing sustainable reimbursement and funding strategies related to ECM, PHPS, and potential P-QIP participation, including development of more detailed presentation with Partnership's CMO and Medical Director champion to support shared understanding of these pathways.
- Develop a testimonial or success-story video that follows a pregnant member through the care journey from pregnancy through postpartum support.
- Explore development of an Indigenous photo shoot tailored to participating Tribal communities, modeled after Partnership-sponsored maternal photo shoots.
- Develop guidance on PHPS participation from a clinic perspective, including key components, requirements, and operational considerations from start to finish.
- Maintain regular follow-up with TPP participating organizations through bi-monthly meetings to monitor progress, review data, discuss barriers, and provide support related to coding, documentation, and movement from contracting to active service delivery.
- Develop survey tools and collect impact statements to evaluate how grant funds are being utilized, assess program implementation progress, and identify opportunities for continuous improvement.

New Dashboards in Development

The Missed Opportunities and Member Engagement dashboards were prepared for final development and deployment in the production environment. Resources needed to complete the deployment were reassigned to finish out the HealthRules Payer (HRP) deployment. After go-live of HRP, the system is expected to go through a period of stabilization, after which resources will be reassessed, reprioritized, and redeployed. This will result in continuation of work on these two dashboards in FY2026-27. Dashboards are being maintained using Amisys data but will need to go through HRP UAT once HRP launches.

Quality Improvement Coaching

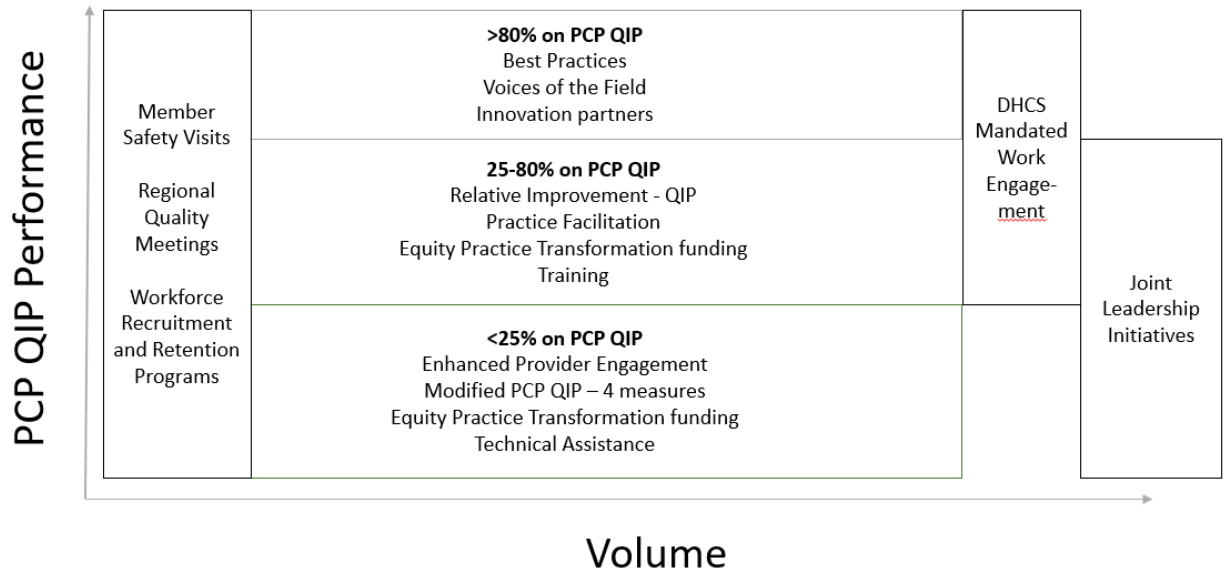
Partnership uses a practice's Primary Care Provider Quality Incentive Program (PCP QIP) scores on clinical measures as a proxy for assessing the strength of a practice's quality program. Each practice is assigned into one (1) of three (3) tiers based on their PCP QIP performance in the previous year, and each tier is associated with coaching and collaborative programs meant to maximize the capacity of the practice for success with the PCP QIP.

The diagram below visualizes the three (3) tiers of PCP practices based on past PCP QIP performance, and the coaching and collaboration programs associated with each tier.

The three (3) PCP practice tiers are:

1. Highest tier: Scoring over 80% of clinical points on previous year's PCP QIP
2. Middle tier: Scoring between 25-80% of clinical points on previous year's PCP QIP
3. Lowest tier: Scoring under 25% of clinical points on previous year's PCP QIP

PCP Practice tiers based on PCP QIP scores, and associated coaching/collaboration programs



Enhanced Provider Engagement and Modified PCP QIP

Enhanced Provider Engagement (EPE) and Modified PCP QIP are two (2) programs centered around Provider Organizations (PO) who are in the Low Performing Tier. These PO's often have significant infrastructure and workforce challenges and are more likely to be located in rural or frontier areas with inadequate health system infrastructure, and to be serving communities who have historically had less access to healthcare resources. Practices in the Low Performing tier are more likely to have higher rates of leadership and workforce turnover, and a lack of dedicated quality resources and structures. Tribal health organizations are overrepresented in this tier, partially because these health centers center their quality work around the Government Performance and Results Act (GPRA), a quality measure set that is not fully aligned with Partnership's QIP.

Partnership provides a structured program to support improvement in the performance of POs who scored less than 25% of clinical points in the previous year's PCP QIP. This program included the Modified QIP from calendar years 2023 – 2025. The Modified program restricted low-performing practices to 4 measures, which were selected by Partnership HealthPlan, and redistributed the points and incentive dollars among these 4 measures, effectively making it easier for low-performing practices to earn their full quality incentive by meeting the performance goals in a smaller measure set.

Enhanced Provider Engagement (EPE): Recognizing that practices who fall into the Low Performing Tier of the QIP often have significant core challenges with infrastructure, leadership, and funding, the EPE coaching methodology centers around the Building Blocks from UCSF's Center for Excellence in Primary Care. The EPE coaching program focuses on interventions that will impact core areas of a practice such as leadership engagement, use of data systems, empanelment, and clinical team formation.

Modified PCP QIP for Low Performing Providers (2023-2025 only): Partnership developed and implemented consequences for Primary Care Provider Organizations with persistent low performance in Partnership's PCP QIP. Provider Organizations who are assigned more than 1,000 Partnership members and who earned less than 25% of their clinical points for the previous year's PCP QIP are assigned the Modified QIP. The Modified QIP assignment includes several requirements for Provider Organizations qualifying, including:

- Reduction of QIP clinical domain measure set from 11 to 4 measures
- Required Executive meeting with PO's Board
- Required participation in Enhanced Provider Engagement coaching with PI Team
- Demonstrated improvement in QIP measures to 50% or more of clinical measure points to return to fill QIP measure set by next MY

The Modified QIP program was updated in 2026 with the goal of supporting health centers who had persistently struggled within the Modified QIP. Because the Modified QIP limited health center participation in the Quality Incentive program to only four measures, which were chosen by the Health Plan, some health centers were unable to make enough improvement within the mandated measures to graduate. The Enhanced Provider Engagement principles were adapted to meet the needs of low performing providers by:

- Allowing Low-Performing practices to have access to the full set of incentivized measures.
- Mandating a Performance Improvement Plan based on improving four (4) measures of the health center's choosing (within the QIP clinical measure set) to be submitted by the executive leadership of the health center.

- Partnership summary and recommendation for impactful quality interventions, based on submitted PIP goals, strategies, and identified resource needs.
- Mandated coaching with planning and implementation of interventions designed to impact core quality improvement capacity and measure performance
- Partnership presentation of Quality Measure Performance and the Enhanced Provider Engagement program to the health centers Board of Directors (if they have one) or top leadership.

2025 EPE and Modified QIP Goals:

- 80% participation by POs assigned EPE and Modified QIP
- Coach two high-volume practices in each region and conduct at least one intervention in a measure of focus
- Improve Quality Improvement knowledge and infrastructure at low performing health centers.

2025 EPE and Modified QIP Outcomes: Partnership assigned 14 Provider Organizations to Enhanced Provider Engagement and Modified QIP. Seven (7) of the Parent Organizations continued from last year because they did not earn at least 50% of their clinical points in the QIP which was the graduation criteria. The 2025 cohort had the following outcomes:

81% of POs assigned EPE and Modified QIP engaged with Partnership and completed at least one (1) of the program activities – GOAL ACHIEVED

- 100% of POs also participated in coaching activities around opportunities identified by their Needs Assessment
- 43% of POs had a Partnership executive or senior leader present on Partnership's quality program to their Board

POs improved their 2024 PCP QIP scores by an average of 7.29%.

- Providers participating in EPE had an average increase in points earned year-over-year of 7.29% compared to non-EPE providers improvement in Partnership's legacy counties of 2.57%
- Five (5) out of 12 POs earned fewer points than the previous year.

The PI Team continued the EPE and Modified QIP programs in 2025, although it was decided to include POs who scored less than 33% (vs. 25%) of possible clinical points in the previous year's PCP QIP. The 2025 Modified QIP cohort consists of:

- Two (2) POs graduating from the program
- Ten (10) POs continuing the program
- Three (3) POs entering the program
- Two (2) POs exited the program due to membership falling below the required thresholds
- Two (2) POs graduated from their CAP and returned to the program

The 2026 cohort consists of 23 provider organizations who either scored less than 25% of their weighted clinical points, or who were in the MQIP the prior year and did not earn enough points to graduate to the standard QIP measure set. 11 of the 23 providers are in Partnership's expansion counties. This is the first year that expansion providers are eligible for EPE because 2024 was the first year within Partnership and were given a baseline year for MQIP in 2025.

Expansion Region Coaching

Partnership expanded into ten (10) additional counties beginning January 1, 2024. Between July 1, 2025, and June 30th 2026 performance improvement efforts shifted to engagement of all providers with 500 or more assigned lives. During this time period, the newly (January 2025) formed "East Region" PI team became fully staffed with 3 Improvement Advisors focusing on nine (9) of the ten (10) expansion counties making up Partnership's Chico and Auburn a. The tenth county was integrated into an already established performance improvement region with other legacy counties.

There were about 313,000 members in the 10 Expansion Counties on January 1, 2026. Improvement Advisors successfully engaged with practices holding 248,000 members (79% of assigned members). Ongoing outreach is being conducted for all Provider Organizations within these counties with more than 500 assigned members with an emphasis on those that are larger and have more opportunity for quality improvement. Final PCP QIP data for measurement year 2025 showed that approximately 50% of members in the nine (9) eastern expansion counties were assigned to one of eight (8) providers earning at least 50% (or more) of their total PCP QIP points. Conversely, eleven percent (11%) of members were assigned to one of nine (9) provider organizations that earned less than twenty-five (25%) of their total PCP QIP points. The highest performance achieved in this region was 76.52% percent of total available points. (See the table below for full results in this region.). It is important to note that the thresholds to earn partial and full points for these provider orgs were increased to match the 75th and 90th percentile achievement that were required of the legacy county provider organizations.

Performance Category	Number of Providers*	Percent of Members assigned to a Provider in this Performance Category
Earned 50% or more PCP-QIP points	8	50
Earned between 26 and 49.9% of PCP-QIP Points	19	39
Earned 25% or below of total PCP-QIP Points	9	11

* Represents provider organizations except for two (2) Adventist Health sites

Based on established criteria of the Enhanced Provider Engagement (EPE) Program , eleven (11) provider organizations from these nine (9) counties were added to the 2026 EPE program.

The criteria for the EPE program is to have more than 1,000 members assigned as of December, 2025 and have earned less than 25% of *clinical* points possible.

Equity and Practice Transformation (EPT) Program

In January 2024, the Department of Healthcare Services (DHCS) launched the Equity and Practice Transformation (EPT) Program, as a state-wide initiative focused on advancing health equity and reducing COVID-19 driven care disparities. Partnership leveraged this funding opportunity to prioritize provider organizations with the greatest need for infrastructure and capacity-building support.

The EPT funding is divided between three (3) programs; the Initial Planning Incentives Payments (IPIP), the Provider Directed Payment Program (PDPP), and the Statewide Learning Collaborative (SLC).

Initial Planning Incentive Payments (IPIP)
Through the IPIP, Partnership awarded $10,000 each to 23 qualifying provider organizations, primarily small and medium-sized independent practices, to support their PDPP planning and application process. Ten of these provider organizations were already engaged under Partnership's Enhanced Provider Engagement (EPE) strategy in 2023, demonstrating alignment between EPT investments and existing efforts.

The remaining $1.2 million in IPIP funds were strategically invested into two initiatives aimed at strengthening provider capacity;

- The Systems Advancement for General EHR (SAGE) Grant led by the QI Project Management team, is designed to assist health care 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 Partnership Clinic Leadership Academy led by the Workforce Development team, is a program designed to develop leadership skills among healthcare professionals, such as physicians, nurses, and behavioral health providers, so they can better lead teams and improve care delivery across Partnership's network. Developed in collaboration with the Healthforce center at UCSF, the academy focuses on building management capabilities, strengthening leadership, and addressing complex healthcare challenges.

The IPIP funds were effectively used to both support immediate participation in PDPP and invest longer term infrastructure and leadership development. These investments are expected to strengthen providers' readiness for sustained practice transformation though full impact will require longer-term evaluation.

Provider Directed Payment Program (PDPP)
A total of 56 provider organizations applied to participate in the PDPP under Partnership. Of those, 27 were invited by DHCS to participate, giving Partnership the third-highest acceptance rate among managed care plans (49%, compared to a statewide average of 29%). These providers span across all Partnership's regions and include five (5) provider organizations contracted with Partnership through the 2024 10-county expansion, eight (8) tribal health centers, and seven (7) provider organizations already engaged through Partnership's EPE program.

Based on the updated funding criteria, there is a possible draw-down of $13M for Partnership's contracted provider organizations upon meeting the practice transformation activities over the program's three-year (3) timeline (January 1, 2024 – December 31, 2026). As of June 2026, Partnership has awarded a total of approximately $5M to 27 participating practices through the four (4) deliverable cycles.

All 27 practices successfully submitted the initial Year 1 Population Health Management Capabilities Assessment Tool (PhmCAT) in 2024. The PhmCAT is a practice self-assessment tool designed to help sites reflect on their current performance across key quality domains, identify strengths and gaps, and prioritize improvement efforts.

Statewide Learning Collaborative (SLC)

The Statewide Learning Collaborative (SLC) is designed to support the PDPP awardees in implementing transformation goals, sharing and spread of best practices, practice coaching activities, and achieving the quality and equity goals outlined in their PDPP applications. Participation in the SLC is mandatory for all PDPP participants.

The Population Health Learning Center (PHLC) is facilitating the Technical Assistance strategy within the SLC for practices. They launched three (3) forms of Technical Assistance:

- PopHealth + eLearning curriculum – An eLearning platform with short (10-15) minute training videos and resources available to all practices.
- Peer Learning Cohorts – Practices are grouped into two cohorts (health centers, tribal health and public hospitals in one and private practices in the other) based on region, and size to encourage peer-to-peer learning and application of the curriculum.
- Coaching Pool – This optional offering provides tailored coaching to support implementation of the EPT curriculum. Unlike the common curriculum and the peer learning components, the Coaching Pool is optional and is not funded by DHCS. Practices may purchase a coaching package using their own funds, directed payment dollars, or financial support from their sponsored managed care plan.

In lieu of PHLC's coaching pool, Partnership has a team of coaches dedicated to EPT awardees and may draw on outside experts for specific transformation topics as needed. The success of participating practices is dependent on the collaboration between Managed Care Plans (including Partnership's QI Performance Improvement team, who act as their dedicated coaches and the organization and management from the Program Management team), the guidance and open communication from PHLC and DHCS, and how engaged a practice is with the Technical Assistance activities and the rate of completing EPT milestone deliverables. Through our coaching efforts, we have seen firsthand how aligned support from all parties can drive meaningful practice transformation. Partnership anticipates more data and trends will emerge as the program matures.

Performance Trends and Outcomes

Completion rates and participation in subsequent cycles, have declined. In July 2025, after the second deliverable cycle, three (3) practices voluntarily withdrew from the program and one (1) was removed for failing to submit the required deliverables.

In early 2026, one (1) additional practice voluntarily opted out of the program, and three (3) more practices are currently at risk of removal for not completing the required deliverable submissions by the due date.

Although participation declined during the reporting period, Partnership's remaining participating practices continued to perform at or above statewide benchmarks across key program deliverables.

Statewide Performance (198 participating practices)

- 75% (148) met criteria for 2025 Model of Care deliverables
- 81% (160) met criteria for Data Implementation Plan deliverables.

Partnership HealthPlan Performance

- 77% met criteria for 2025 Model of Care deliverables, exceeding the statewide rate of 75%
- 86% met criteria for Data Implementation Plan deliverables, exceeding the statewide rate of 81%.

- As of June 2026, 86% (19) met criteria for at least one (1) May 2026 deliverable related to social and behavioral health, value-based payment, or completion of the third and final Population Health Management Capabilities Assessment Tool (PhmCAT) reassessment.

Program Assessment

While overall participation has declined, performance among engaged Partnership practices remains strong and exceeds statewide benchmarks in several key areas. Partnership practices outperformed statewide results for both Model of Care deliverables and Data Implementation Plan deliverables, demonstrating continued progress in practice transformation activities. These findings suggest that providers who remain engaged in the program are successfully implementing program requirements and advancing foundation population health management capabilities. However, continued attrition and inconsistent participation remain challenges that may affect overall program reach, impact, and funding realization.

Challenges and Program Response

Statewide data for the most recent reporting period is still pending; however, preliminary trends indicate that declining participation is not unique to Partnership.

- Limited staffing capacity
- Organizational transitions
- Shifting operational priorities.

In response, Partnership's QI Program Management and Performance Improvement teams met with these practices through targeted outreach and coaching. These conversations revealed that many practices were already actively implementing transformation activities but struggled with translating and aligning their work into required deliverable submissions.
Partnerships coaching support focused on helping providers bridge this gap and promote continued engagement.

Targeted coaching and technical assistance helped address a key gap between implementation and reporting, supporting continued engagement for participating practices. This intervention represents an effective strategy to mitigate attrition risk, though ongoing support will be critical to sustain participation over the life of the program.

Overall Program Assessment and Next Steps

The Equity and Practice Transformation (EPT) Program has demonstrated strong early progress in advancing provider capacity, engagement, and performance across and outside of Partnership's network. Partnership achieved a higher-than-average acceptance rate into the program (49% vs. 29% statewide), indicating effective provider selection and readiness. Among remaining participating practices, performance on key deliverables has remained strong, suggesting meaningful progress in implementing population health management and value-based care capabilities.

However, declining participation and practice withdrawals represent a significant risk to overall program impact and full funding realization. Overall, the program is performing well among actively engaged providers and demonstrates clear alignment with health equity and practice transformation goals. Sustained success will depend on maintaining engagement, helping practices find opportunities to reduce administrative burden, and continuing to strengthen provider capacity over the remainder of the program period.

The Population Health Learning Center (PHLC) and DHCs have yet to provide additional guidance on program close-out activities beyond attending technical assistance events provided by the SLC and submitting deliverables

by the last cycle in November 2026. In the interim, to build on current progress and identified challenges so far, Partnership will continue to explore the following strategies:

1. Enhance Technical Assistance and Reporting Support

- Simplify and standardize guidance for deliverable requirements
- Provide hands-on support and tools to reduce administrative burden
- Continuing alignment on reporting expectations with real-world practice workflows

2. Maximize Funding Drawdown and Program Impact

- Prioritize support for practices with high likelihood of meeting deliverable thresholds
- Ensure practices remain on track to fully leverage available EPT resources

3. Incorporate Ongoing Evaluation and Learning (including SLC insights)

- Integrate insights from the Statewide Learning Collaborative (SLC) to inform local strategies
- Track longitudinal improvements using tools such as PhmCAT
- Document best practices and lessons learned to inform future transformation initiatives

4. Plan for Sustainability Beyond The Equity and Practice Transformation Program

- Begin identifying pathways to sustain successful transformation activities post-funding
- Align EPT efforts with broader organizational and state priorities
- Support practices in embedding changes into routine operations

Provider Coaching

Practice coaching is offered to all contracted providers within the Partnership Network. For Health Centers who score above the threshold for EPE or MQIP, practice coaches offer optional coaching opportunities and encourage regular meetings at a cadence that meets the needs of the practice. Coaches monitor QIP rates and offer advice on improvement for underperforming measures and provide regular updates to practices regarding important dates, program updates, educational opportunities, and updated clinical guidelines.

Practice Coaching uses the Institute for Healthcare Improvement's (IHI) Model for Improvement framework to build capacity for provider organizations to implement impactful interventions via Plan-Do-Study-Act (PDSA) cycles and other tools and promote a culture of quality throughout the provider organizations. Improvement Advisors serve as Practice Facilitation Coaches, and their role includes the following duties:

- Provide guidance on QI Project Team make-up and management
- Work with practice's leadership team on QI infrastructure development
- Provide consultative support and tools for project management of QI projects
- Train and support application of the Model for Improvement methodology. Enable workgroup members to implement changes by providing tools, guiding them through rapid-cycle tests of change, and assisting when obstacles are identified
- Provide best practice change ideas and build capacity for brainstorming
- Build capacity for collection and use of measurement data, assess the effectiveness of changes made
- Support change management aspects of QI projects

Joint Leadership Initiative

The Joint Leadership Initiative (JLI) was implemented in 2019 as an effort to increase executive level engagement with large, contracted provider organizations that have significant room for improvement on quality metrics.

In FY 2025-2026 the following provider organizations participated in the JLI: Adventist Health, Ampla Health, Mendocino Community Health Center, Shasta Community Health Centers, Solano County Family Health Services, Oroville Hospital, WellSpace Health, and Western Sierra Medical Center. Collectively, these organizations are responsible for the care of approximately 180,000 Partnership members, which is about 23% of the health plan's membership as of December 2025. The JLI aims to provide mutual benefits for these organizations and Partnership, including:

- Significant improvement of quality scores for Partnership
- Maximization of QIP dollars, giving significant additional resources to the organizations
- Improved performance, leading to significant improvement in quality outcomes for members/patients

Overall, the JLI meetings have been well received and have helped improve the relationships with the provider entities. Feedback from participants has also cited that the meetings have allowed focused time to discuss quality issues and provided a platform to discuss provider concerns. When evaluating 2025 QIP performance of JLI providers, all but two participating JLI practice improved their QIP score from 2024 to 2025. Improvement ranged from moderate (about 3%) to significant (over 15%). One site saw a negligible decline of less than 1%. The single site that showed a significant decline in QIP earnings participated in their first year in Modified QIP, which reduced their measure set to 4 measures which were not met, resulting in no QIP Points or earnings.

Provider Organization	YoY Difference
Adventist Health	-0.10%
Ampla	2.66%
Mendocino Community Health	2.20%
Oroville Hospital	15.80%
Shasta Community Health Centers	2.66%
Solano County Family Health Services	-33.84%
WellSpace Health	6.22%
Western Sierra Medical Center	19.10%

Expansion of Regional Quality Meetings

For FY 2025-26, the QI Team continued to expand regional quality meetings to the Chico and Auburn Regions. Following the expansion of regional quality meetings in the Redding and Eureka regions, quality observed increased collaboration within the Redding and Eureka Region provider network which mirrored practices in the Fairfield and Santa Rosa Regions. These meetings serve as an opportunity to address regional quality improvement topics with local stakeholders. Existing regional meetings include:

Solano Quality Improvement Program Initiative (SQIP-I): This monthly meeting is co-sponsored by Partnership and Aliados Health, the Federally Qualified Health Center (FQHC) consortium that is active in Solano County.

The SQIP-I Workgroup engages four (4) of the largest PCPs in Solano County as a collaborative forum for collective learning and for partnership on quality measures that are best addressed on a systems level. In 2025-2026, the SQIP-I Workgroup's projects included:

- Continuation of improvement work related to Well Child care improvements. This work included creating shared educational materials for caregivers of pediatric patients, showing the frequency and importance of Well Baby visits. The group also designed a shared resource for incentivizing caregivers to bring children to all of these visits in order to receive an incentive in return (gift card or raffle tickets).
- Sharing of best practices around Lead Screening for Children (LSC) measure.
- Presentation on Cologuard bulk ordering program to increase Colorectal Cancer Screening (COL) rates.

Napa/Solano/Yolo Regional Meeting: This quarterly meeting engages all PCPs in the Fairfield Region. In 2025-2026, the Meeting's topics included:

- Colorectal Cancer Screening
- Chlamydia Universal Screening
- Cervical Cancer Screening
- Electronic Data Transfer
- Well Child Visit Improvement

Santa Rosa Regional Quality Meetings began in September 2025, following a reorganization of this Regional territory, which now excludes Lake and Mendocino Counties and only includes Marin and Sonoma Counties. The Santa Rosa region holds two Quarterly meetings – one for all health centers in the region and another for Small Health Centers to discuss strategies specific to their size of operation. Topics covered in the 3 meetings that have been held in FY 2025-2026 include:

- Childhood Immunization/Vaccine Hesitancy
- Chlamydia screening – implementing Universal Screening Protocols
- Colorectal Cancer Screening – Utilizing Cologuard (Bulk ordering and other tips and tricks.

Lake, Mendocino Quality Meeting:

Northwest Region Quality Meeting: These meetings are now held quarterly and have been expanded to include PCPs across Eureka, Del Norte, Lake, and Mendocino Counties. Topics focus on quality improvement, including HEDIS and QIP county rate reviews, sharing measure best practices, guest presentations on storyboards and improvement initiatives, and open discussion for PCPs to explore successes and barriers. The meetings also create valuable opportunities for peer networking and collaboration among attendees.

Chico and Auburn Regional Quarterly Quality Meetings:
The Chico/Auburn Performance Improvement team hosted 4 Regional Quality meetings in both the Auburn and Chico regions for a total of 8 meetings. At these meetings the Regional Medical Director and the Regional Director are given an opportunity to give updates and present appropriate material to the group. It is the goal of these meetings to allow for collaboration between parent organizations and especially the sharing of best practices. In 2025-2-26, that sharing was largely led by the Partnership team. Increased peer to peer sharing will continue to be pursued in 2026 2027.

Redding and Eureka Regional Meetings:

- Several voices of the field presentations including blood pressure recheck and cervical cancer self-screening pilots in Shasta and Humboldt counties.
- Review of regional and county QIP and HEDIS rates to determine areas of improvement and discussion of strategies.
- Updates to state Managed Care Accountability Set and QIP measure sets

QI Technical Assistance in Partnership with Northern Region Consortia

Partnership, HANC, and NCCN continue to collaborate to maintain a QI Measurement Systems Toolkit, initially developed and launched in 2017. The QI Measurement Systems Toolkit provides background information on the measures defined under HEDIS®, Uniform Data Set (UDS), Site Reviews, and the PCP QIP. This toolkit also includes measure by measure data sets reflective of consortia member performance across the varying measurement sets. And, recommended best practices from national change packages and regional interventions are also included by measure. A key component of the toolkit is a measure crosswalk that indicates which measures fall under each measure set, as well as what criteria constitutes denominator and numerator compliance, and any exclusions that exist for the measure. The scope of the crosswalk is primarily determined by the PCP QIP measure set versus attempting to offer a fully inclusive view of all the new measures Partnership has taken on via MCAS and NCQA accreditation. The crosswalk acknowledges when a comparable HEDIS® measure exists but does not detail the measure specs, given sensitivity around licensing agreements with NCQA. These tools allow organizations to potentially target measures for performance improvement that affect multiple measure sets. The Northern consortia also continue to cite this toolkit as a key onboarding tool for health center staff either new to QI or taking on new responsibilities under the PCP QIP.

HANC and NCCN offer great avenues for communicating with the largest PCP organizations serving Partnership members in the Redding, Eureka, and Auburn Regions. In the past year, Partnership has leveraged the consortia QI and CMO Peer Networks, which each meet monthly, to share key changes in measure sets, HEDIS®/QIP measure education, HEDIS®/QIP performance results, and emerging best practices from ongoing regional performance improvement projects. It is also a forum by which barriers to achieving improved HEDIS® performance can be openly discussed, informing Partnership's HEDIS® Score Improvement tactical strategies and dialog with DHCS. Historically, HANC and NCCN member organizations perform higher than non-members.

Other QI Provider Resource Updates and Changes

The Performance Improvement (PI) Team publishes a set of Measure Best Practices for each PCP QIP measure on an annual basis. 2026 Measure Best Practices feature Partnership programs and tools, and include best practices around data and coding, member care, and health equity best practices for each PCP QIP measure.

Frequently Asked Questions (FAQs) documents were developed by the QIP Team to support newly enhanced dashboards in the Partnership Quality Dashboard (PQD) called Preventive Care Reports. Each dashboard includes supplemental data for three (3) measures included in the PCP QIP core clinical measure set: Immunization for Adolescents, Childhood Immunization Status – Combo 10, and Well Care Visits in support of the Well Child First 15 Months measure, and well visits between 15-30 months. The Preventive Care Report FAQs document provides descriptive highlights of each measure dashboard including guidance on how to use the data in support of measure

score improvement. The QIP Team also distributes an educational quarterly newsletter that outlines important dates and activities in the QIP program and measure-specific recommendations.

Quality Improvement Training

Improving Measure Outcomes

In conjunction with Partnership medical directors, the Performance Improvement Team offered six (6) virtual Improving Measure Outcomes (IMO) sessions to primary care provider organizations between February - April 2026. The webinars aimed to provide clinical background and best practices related to 2026 Primary Care and Perinatal Provider Quality Incentive Program (PCP and Perinatal QIP) measures. Each session was approved for Continuing Medical Education (CME)/Continuing Education (CE) credits through the American Academy of Family Physicians and the California Board of Registered Nursing for 1.0 contact hours per session.

The focus of the webinars and attendance rates are included below:

- 02/11/2026 - Preventive Care Ages 0 - 30 Months
  - 72 attendees, representing 41 unique organizations, 13 requests for CME/CEs
    (Webinar covered Well-Child Visits in the First 30 Months of Life, Childhood Immunizations Status, Blood Lead Screening, and Topical Fluoride in Children measures)
- 02/25/2026 - Pediatric Preventive for Children and Adolescents Ages 3 - 17 Years
  - 52 attendees, representing 35 unique organizations, 12 requests for CME/CEs
    (Webinar covered Child and Adolescent Well-Care Visits, Immunizations for Adolescents, Blood Lead Screening, and Topical Fluoride in Children measures)
- 03/11/2026 - Preventive Cancer Screenings: Improving Outcomes through Early Detection
  - 63 attendees, representing 45 unique organizations, 8 requests for CME/CEs
    (Webinar covered Breast Cancer Screening, Cervical Cancer Screening, and Colorectal Cancer Screening measures)
- 03/25/2026 – Managing Chronic Disease: Strategies for Blood Pressure and Diabetes Control
  - 62 attendees, representing 31 unique organizations, 11 requests for CME/CEs
    (Webinar covered Controlling High Blood Pressure, Blood Pressure Control for Patients with Diabetes, Comprehensive Diabetes Management – HbA1c Good Control, Diabetes Retinal Exam, Kidney Health Evaluation for Patients with Diabetes measures)
- 04/08/2026 - Sexual and Reproductive Health
  - 59 attendees, representing 32 unique organizations, 7 requests for CME/CEs
    (Webinar covered chlamydia screening measure)
- 04/22/2026 - Improving Perinatal Outcomes
  - 69 attendees, representing 34 unique organizations, 12 requests for CME/CEs
    (Webinar covered timely prenatal care, postpartum care, depression screening, and prenatal immunization status measures)

- All six (6) IMO trainings featured one to two leaders from a high-performing provider organization as a "Voices from the Field" presenter, allowing these providers to share their best and promising practices with their peers throughout the provider network.

The target audience for IMO trainings were quality improvement staff at primary care and perinatal care physician offices within the Partnership geographic footprint. Strategies to increase training attendance included the following:

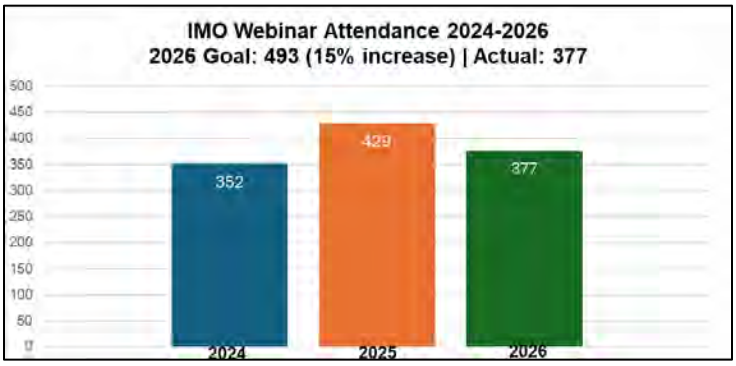
- Conducted an analysis to identify high-priority sites with historically low prior-year attendance and Quality Incentive scores >50% in Measure Years 2023 and 2024. This resulted in a focused intervention utilizing direct coaching notifications and site-specific outreach. To build upon this framework for provider site engagement, this initiative was scaled across the team. By equipping the entire team, not just session facilitators, with regularly updated registration tracking, the coaches proactively identified unregistered provider sites and reinforced attendance through follow-up meetings/conversations.
- Targeted marketing strategies implemented included e-blasts, which included an expanded contact list from Patient Safety and Advanced Life Support Obstetrics workshops, website event listings, QR-enabled flyers, newsletter placements, Provider Relations outreach, leadership distribution, and coordination with Quality teams.

Of attendees who completed the post-session evaluations for all six webinars, 100% selected *Strongly Agree* or *Agree* when asked if the webinar was relevant and useful.

When surveyed on how attendees planned to implement the strategies from the session, the following is a sampling of insights shared:

- *I plan to update our current workflows to be more proactive and work toward gap prevention instead of how we have been operating, at a more gap filling. Some best practices will be adopted completely, like data pulls each month…..there are places my clinic can grow here.*
- *Collaborative team communication and using the who team to get the measure met.*
- *I love how clinics share what practices they use in their real-life clinics to meet measures.*
- *Using standardized scripts for providers and MAs to have these conversations and begin universal screening.*

Although the goal of increasing 2026 IMO attendance by 15% was not met, substantial effort was made to increase participation through expanded outreach and targeted engagement strategies.



Feedback from sites indicated that barriers to attendance included limited new content, given the absence of measure changes from the prior year, as well as competing Partnership trainings and meetings that required sites to prioritize among multiple commitments. Analysis of 2026 attendance shows figures trending in alignment with 2024 baseline data. While 2025 saw a significant surge in participation, this could be attributed to having a more

comprehensive contact list for the expansion counties, which was not compiled in early 2024. The 2026 data suggest a return to prior engagement levels, further impacted by the content redundancy and scheduling barriers identified in recent site feedback. To improve future engagement, webinar content that offers fresh measures or new value will be prioritized. Training calendars will be streamlined to try and avoid internal competition.

ABCs of Quality Improvement

In FY 2025-2026, Partnership offered three (3) in-person ABCs of Quality Improvement (QI) training series for its provider network. The purpose of the ABCs of QI training is to introduce quality improvement concepts to clinical and non-clinical provider staff to improve performance in the PCP QIP.

The all-day trainings covered a range of topics, including:

- What is Quality Improvement?
- Introduction to the Model for Improvement
- How to create an aim statement
- How to use data for improvement
- Why and how to establish outcome and process measures
- Tips for developing change ideas that lead to improvement
- Testing changes with the Plan-Do-Study-Act (PDSA) cycle

Attendance and overall training satisfaction were as follows:

- 02/05/2026 – Fairfield: 63 attendees, representing 22 unique provider organizations with 95% of respondents reporting being extremely satisfied/satisfied with this course.
- 03/19/2026 – Redding: 46 attendees, representing 22 unique provider organizations with 100% of respondents reporting being extremely satisfied/satisfied with this course.
- 05/14/2026 – Auburn: 24 attendees, representing 16 unique provider organizations with 100% of respondents reporting being extremely satisfied/satisfied with this course.

Participants in the trainings included clinicians, front-line staff, quality improvement staff, administrators, and public health professionals. Continuing Medical Education (CME)/Continuing Education (CE) credits through the American Academy of Family Physicians and the California Board of Registered Nursing were offered for each training.

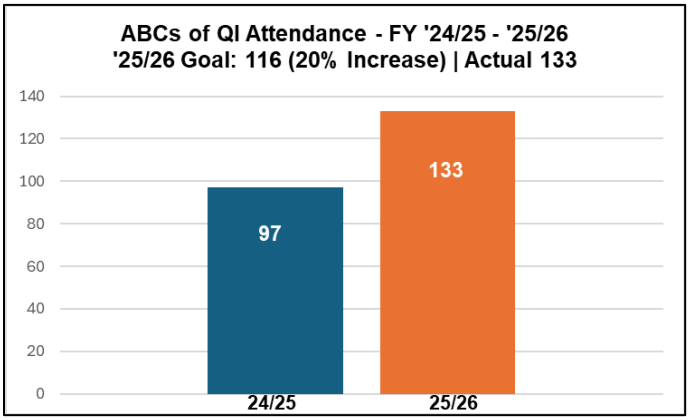
All post session evaluations asked:

- If the information presented directly related to participant's current role. Respondents who choose *Strongly Agree* or *Agree* ranged from 93% to 100% across all three trainings.

- If strategies from this training would be implemented in the participant's daily work. Respondents who choose *Strongly Agree* or *Agree* ranged from 97% to 100% across all three trainings.

- If participants would recommend this course to a colleague. Respondents who choose *Strongly Agree* or *Agree* equated to 100% across all three trainings.

The goal of increasing in-person attendance at the ABCs of QI was exceeded. While the initial target was a 20% increase, improvement of 37% was achieved.



Microlearnings

Microlearnings, designed as short tutorials, were introduced last fiscal period. Building on this momentum, two additional microlearnings were developed. Care Team Huddles focus on key huddle elements that improve team communication, enhance workflows, and result in better patient outcomes. The Pre-Visit Planning microlearning, currently in production, focuses on proactive chart review and early outreach to reduce care gaps, support quality of care, and enhance the patient experience.

Both offerings will be promoted to the provider network through eblasts, newsletters, regional meetings and via the Improvement Academy web page.

Value Based Pay-for-Performance Programs

Partnership's Quality Incentive Programs (QIP) provided financial incentives, data reporting and technical assistance to providers for improving in key domains of quality: clinical care, patient experience, access and operations, and resource use. The total pay-out for the MY2023-2024 QIP was approximately $74,767,133.42 across the five (5) QIP programs managed within the Quality Improvement (QI) Department. The total payout for MY2024-2025 is reflective of payouts distributed for Fiscal and Calendar year programs. The following is a breakdown of the QIP measurement year ranges included in the total payout of $74,767,133.42:

- Hospital QIP: full measurement year (FY2024-2025)
- Perinatal QIP: full measurement year (FY2024-2025)
- PCP QIP: full measurement year (CY2024)
- ECM QIP: Two partial measurement years (Q3 - Q4 2024 and Q1 - Q2 2025)
- Palliative Care QIP: Two bi-annual payments (Q3 - Q4 2024 and Q1 - Q2 2025)

Primary Care Provider Quality Incentive Program

The Primary Care Provider (PCP) Quality Incentive Program (QIP) Core Measurement Set evaluated six (6) domains of quality: Preventative Screening, Chronic Disease Management, Pediatric Access, Hospital Utilization, Primary Care Utilization, and Patient Experience. . The Unit of Service measures provided additional dollars for providing specific services such as Tobacco Use Screening, Advance Care Planning, etc. All PCPs with Medi-Cal assigned members are automatically enrolled in the program if their organization has an existing signed contract amendment related to the QIP, prior to the beginning of measurement year. Any new parent organization joining by March 31 of the current measurement year may be permitted on an exception basis, subject to review and approval by Partnership's Executive team, to participate in the PCP QIP.

Program Goals

The PCP program goals and activities outlined in the FY 2025-2026 QI Work Plan were completed and are highlighted below.

- Development of measures for the 2026 PCP QIP by December 31, 2025.
- Partnership adhered to DHCS guidance regarding this program by including a performance threshold for measures that rewarded providers for conducting activities they may already be compensated for through capitation payments.
- Supported providers enrolled in the program by hosting webinars, distributing quarterly newsletters & surveys, provider notifications/reminders, and responding to provider inquiries via phone and email in a timely manner.
- Continued provider engagement and program activities to support quality (HEDIS®) measure score improvement, including monitoring changes to relative improvement methodology, payment methodology, and continuous enrollment requirement.
- Supported provider network and respective sites/clinics in their efforts to use data to improve reporting and performance improvement activities through FY 2024-25.
- Implement process improvement which includes documenting and updating current and new program protocols based on lessons learned.

The PCP QIP program performs annual evaluations. The 2025 Measurement Year evaluation was completed during the FY 2025-2026 and is highlighted below.

MY2025 PCP QIP Program Evaluation Summary

The PCP QIP offers pay-for-performance (P4P) financial incentives. The intent of P4P is to improve access and quality of care across all domains. The PCP QIP, designed in collaboration with Partnership providers, offers substantial financial incentives, data resources, and technical assistance to primary care providers who provide services to our l members so that significant improvements can be made in the following areas: 1) Preventative Screening, 2) Chronic Disease Management, 3) Pediatric Access , 4) Primary Care Utilization, 5) Hospital Utilization and 6) Patient Experience. This evaluation is an analysis of the January 1, 2025 – December 31, 2025, Measurement Year.

Program Performance

PCP QIP performance observed incremental year-over-year recovery from 2024 to 2025 in the following clinical measures:

- Breast Cancer Screenings
- Cervical Cancer Screening
- Chlamydia Screening
- Colorectal Cancer Screening
- Lead Screening in Children Controlling High Blood Pressure
- Diabetes - HbA1c Good Control (<= 9.0%)
- Diabetes – Retinal Eye Exams, Well-Care Visit (First 15 months)
- Well-Care Visit (First 15-30 months)
- Child & Adolescent Well Care Visits
- Immunization for Adolescents
- Childhood Immunization Status, Combo 10

PCP QIP eReports System

The eReports system is an online tool provided to PCP participants in the PCP QIP. It serves as a means for providers to track their performance under the clinical care domain of the Core Measurement set at both an organizational level and individual site level. Under the 2025-2026 QI Work Plan, the eReports system was successfully enhanced to support the 2026 PCP QIP clinical measure set and released to providers on-time, March 2nd 2026.

The information from eReports presents providers with member-level data corresponding to eligibility and compliance status under each measure. eReports data sources are: claims, lab data, pharmacy data, California immunization registry (CAIR) data, and the eReports user supplemental upload data. eReports supplemental upload functionality gives the provider the opportunity to upload medical record data to substantiate member compliance where administrative data is unavailable.

In the second quarter of 2025, the PCP QIP Team conducted its annual eReports Upload Audit for measurement year 2024. The QIP Team selected to audit the Child and Adolescent Well Care Visits (WCV) measure. A random sampling was performed, and we identified 35 Parent Organizations (PO) who uploaded WCV data into eReports. Sampling results were used to compile the audit list and request supporting medical records. As a result of the audit, 16 PO were provided education based on our results. This approach allowed us to take more time with our audit analysis and identify opportunities for improving the quality of our audit through education. Our 2025 analysis will be completed by the end of June 2026.

Hospital Quality Incentive Program

The Hospital Quality Incentive Program (HQIP) is a pay-for-performance incentive program that began in 2012 for selected hospitals in the Partnership network. The purpose of the HQIP is twofold: 1) To help improve the health outcomes of Partnership members served by its contracted hospitals and 2) to help participating hospitals assess the quality of care provided to their patients by serving as a guide to their existing quality improvement efforts. To do this, the program offers substantial financial incentives for hospitals that meet specific performance targets, connects HQIP hospitals with regular training opportunities and resources, and hosts an annual Hospital

Quality Symposium (HQS). The HQS supports HQIP participants' work in quality by bringing stakeholders together from each hospital entity across two Partnership regions for thoughtful discussion on high-priority, hospital related topics.

Program Goals

The HQIP program goals and activities outlined in the FY 2025-2026 QI Work Plan were completed and are highlighted below. Partnership completed development of the 2026 6-Month Bridge and CY 2027 measurement set during this period. Partnership also provided ongoing technical assistance to providers throughout the year and conducted an evaluation of the program for the 2024-2025 measurement year which is summarized below. Sierra Nevada Memorial Hospital began participation in the HQIP in July of 2025, which brought the total number of participating hospitals to 34.

During the 2025-2026 measurement year, Partnership conducted ongoing measure performance monitoring on participating hospitals while providing as needed technical support and updating them on performance status through operations meetings and mid-year performance reports.

Completed Goals

Goal #1: By June 30, 2026, develop the 2026-2027 measurement year Hospital Quality Incentive Program (H-QIP) Measurement Set to support Hospital Performance Improvement.

The measurement sets include focus areas in the following domains: readmissions, advanced care planning, clinical quality: maternity care, patient safety and operations & efficiency, and patient experience. Measurement set development is informed by insights from the annual evaluation, regulatory needs, and trends in care.

Six-month Bridge Measurement Set Development

Due to a new federal regulation introduced at the end of 2025, the HQIP needed to develop both a 6-month and a calendar year measurement set between July 1, 2025, and June 30, 2026. To accomplish measure set development, the Program Manager held monthly Tech Workgroups which included Medical Directors, Regional Directors, Department Managers, Improvement Advisors and other Partnership stakeholders. The six-month measure set covering July 1, 2026 – December 31, 2026, is an abbreviated transition period measure set both in time-period and number of measures.

The members of the technical workgroup determined which measures needed to remain the same and which measures needed to be removed. The following three measures were the only measures removed from the abbreviated set due to the measures not fitting with a 6-month timeframe: QI Capacity, Cal Hospital Compare, and Health Equity. The group determined that the following three measures would continue in their current phase of implementation requirements during the 6-month period: Expanding Delivery Privileges, Doula Support and Vaccines for Children Enrollment. These measures are included in the 2027 measure set. The 6-month measurement set was presented to our internal IQI committee in April and approved by the Physicians Advisory Committee in May.

The 2026 Six-month Measure Set includes the following:

1. Risk Adjusted Readmissions
2. 7-day Clinical Visit Follow-up
3. Palliative Care Capacity
4. Rate of Elective Delivery Before 39 Weeks

5. Exclusive Breast Mild Feeding Rate
6. Nulliparous, Term, Singleton, Vertex Cesarean Rate
7. Vaginal Birth After Cesarean
8. Increased Screening Mammography Capacity
9. Doula Support
10. Expanded Delivery Privileges
11. Vaccines for Children Program Enrollment
12. Patient Safety Organization Participation
13. Substance Use Disorder – Medication Assisted Treatment
14. Hospital Quality Incentive Platform

2027 Measurement Set Development

The 2027 measurement set development was completed in the same manner as the six-month bridge set. The proposed set was brought to IQI Committee in June 2026 and will be brought to PAC for approval in August. HQIP Advisory Group meetings were held in January and June to review proposed changes to the six-month measure set. These meetings allow hospital representatives to give comments, feedback and suggestions about the measure sets. The June 2nd Advisory Group meeting included a review of the changes to the 6-month measure set, introduced ideas for the 2027 set and gave representatives space to provide feedback about measures.

The 2027 measurement set removes two measures; Vaccines for Children Enrollment and Increasing Screening Mammogram Capacity and it introduces two measures; Hepatitis B Vaccination, and Advanced Life Saving in Obstetrics & Basic Life Saving in Obstetrics (ALSO & BLSO) Certified Training. Additionally, the Substance Use Disorder measure is updated to align with the HEDIS FUA 7- day follow-up measure.

The 2027 calendar year measurement set includes the following:

1. Risk Adjusted Readmissions	10. Hepatitis B Vaccination
2. 7-day Clinical Visit Follow-up	11. ALSO & BLSO Certified Training
3. Palliative Care Capacity	12. Patient Safety Organization Participation
4. Rate of Elective Delivery Before 39 Weeks	13. Substance Use Disorder 7-Day Follow-up After ED Visit (FUA)
1. Exclusive Breast Mild Feeding Rate	14. QI Capacity
2. Nulliparous, Term, Singleton, Vertex Cesarean Rate	15. Hospital Quality Incentive Platform
3. Vaginal Birth After Cesarean	16. Cal Hospital Compare – Patient Experience
4. Increased Screening Mammography Capacity	17. Health Equity
5. Doula Support	

Goal #2: By June 30, 2026, develop Partnership's Hospital Quality Symposium for the 2026-2027 H-QIP measurement year

This goal was terminated due to needing to transition the HQIP from a fiscal year program to a calendar year program. The decision to not host the Hospital Quality Symposium (HQS) was due to the timing of needing to create the 6-month bridge set to transition to a calendar year program in 2027. The HQS will return in the 2027 calendar year.

Goal #3: By January 31, 2026, complete evaluation of the 2024-25 HQIP and deliver summary to the Partnership Quality Committee meetings (IQI, QUAC, PAC).

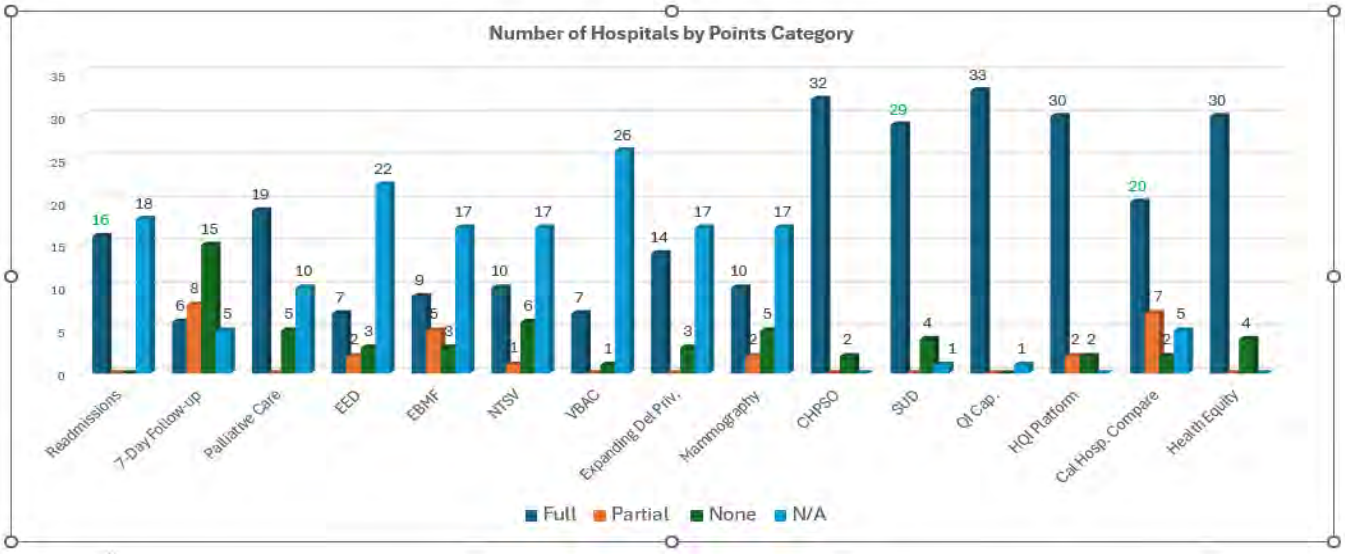
Annually, the HQIP compiles a year-end evaluation utilizing performance relative to targets and performance points distributed by measure. The goal was completed in January 2026. This year's summary and presentation highlighted the addition of 6 new hospitals to the HQIP, as well as the continued increase in hospitals meeting the Risk Adjusted Readmissions measure.

Chart: Risk Adjusted Readmissions Improvement

The FY 2024-25 HQIP annual evaluation highlighted that participating hospitals continue to do well with their Risk Adjusted Readmissions rate as evidenced by the same number of hospitals meeting the full points target rate of 1.2 in 2024-25 as did in 2023-24; showing a stable rate of improvement. Since the measure was not applicable to two hospitals, this represents 81% of hospitals meeting the full points target and an additional 6% meeting the partial points target.

One of the highlights from the 2024-25 measurement year was the number of hospitals that are now working toward expanding delivery privileges to family physicians and certified nurse midwives. One of the highlights from the 2024-25 measurement year was the number of hospitals that are now working toward expanding delivery privileges to family physicians and certified nurse midwives. As this chart shows 82% of the participating birthing hospitals in the HQIP have policy and procedures in place to extend delivery privileges to these provider types. While some hospitals already had both provider types delivering babies, many did not. These numbers represent roughly a 30% increase in the number of hospitals that allow both provider types to perform deliveries. This measure moved into Phase 2 in during the 2025-26 measurement year, which required hospitals to provide privilege lists for the providers delivering at the hospital and/or show evidence of actively recruiting them to their hospitals.

Table: 2024-25 Performance Relative to Targets with Points Distribution by Measure



The annual evaluation also reviewed the table above, which summarizes performance by measure and points distribution. For Risk Adjusted Readmissions, 18 hospitals were marked N/A because small hospitals were not scored on that measure during the measurement year. To maintain emphasis for small hospitals, HQIP assigned

20 points to the 7-day Follow-up measure. That measure was a major focus in 2024-25 and was refined throughout the year; however, only 14 of the 29 hospitals for which it applied earned points.

The evaluation also identified data capture issues for several hospitals that use outside providers for mammography services. As a result, the measure was marked N/A for large hospitals, as reflected in the chart above. Among hospitals with available data, 71% increased mammography screenings by 5% to 10% over baseline, and three very small hospitals hosted mobile mammography events with Partnership support.

The evaluation also highlighted the importance of hospitals' health equity efforts during the measurement year. As shown in the chart above, 30 of 34 hospitals met the measure requirement, an increase of nine hospitals from the previous year. Many hospitals focused on improving care coordination for members experiencing food insecurity, homelessness, poverty, and substance use disorders. The Providence and Adventist systems also developed programs to reduce disparities in these populations through partnerships with community organizations.

Perinatal Quality Incentive Program

The Perinatal Quality Incentive Program (QIP) is a pay-for-performance program offering financial incentives to participating Partnership Health Perinatal Services Program (PHPS), formerly Comprehensive Perinatal Service Program (CPSP) providers and select non-PHPS providers administering quality and timely prenatal and postpartum care to Partnership members.

Program Goals

The Perinatal Quality Incentive Program (PQIP) has three goals and associated activities in the 2025-2026 QI Department Work Plan designed to improve the quality of perinatal services provided to its prenatal and postpartum members. These goals revolve around the development of the PQIP measurement sets for the 2026 6-month Bridge period and the 2027 calendar year measurement set, continuing to support provider on-boarding and ECDS implementation to satisfy programmatic gateway measure (ECDS), and annual program evaluation. All three goals were met during the measurement period as noted below.

Completed Goals

Goal #1: By June 30, 2026, continue to develop Perinatal QIP Measurement set to support HEDIS® Score Improvement through May 30, 2026, and leverage support from Partnership's Population Health team and the Growing Together Program to improve scores for the Timely Prenatal Care measures.

Throughout the measurement period, particularly between January and May, work was completed on the development of the 2026 Six-month Bridge Measurement set and the CY 2027 Measurement Set. Perinatal QIP Measurement Set. The Program Manager held monthly Tech Workgroups with direct input form Medical Directors, Regional Directors, Department Managers, Improvement Advisors and other Partnership stakeholders to develop the measurement sets. The 6-month measurement set was presented to our internal IQI committee in March and approved by the Physicians Advisory Committee in April. The 2027 Measurement Set was brought to IQI Committee in May and approved by PAC in June. The six-month set is an abbreviated version of the full year set with minimal clinical measure changes. No new measures were added. The main change is to use DataLink as Option 1 for submission of timely prenatal visits with depression screening. The main changes to the 2027 measure set revolve around only using DataLink as the data source for measures 3 and 4, and the Timely

Comprehensive Assessment monitoring measure is moved to a fully incentivized measure with an incentive of $100 per qualifying member with all the qualifying assessments being provided during the pregnancy and postpartum.

The PQIP measures tend to maintain a comprehensive yet simple measure set with the intent to improve HEDIS® performance among providers offering prenatal and postpartum services often occurring outside of a PCP visit. The PQIP is also looking to the future in the area of comprehensive assessment. The timely comprehensive assessment measure will continue to be monitored in the six-month set and will move to an incentivized measure during CY 2027.

- Electronic Clinical Data System (ECDS) DataLink Implementation
- Timely Tdap and Influenza Vaccine
- Timely Prenatal Care
- Timely Postpartum Care
- Timely Comprehensive Assessments

Goal #2: By June 30, 2026, continue to support provider on-boarding and ECDS implementation to satisfy programmatic gateway measure (ECDS).

Partnership is utilizing connectivity with DataLink to help support ECDS implementation. 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. Contracting and connecting with DataLink became a gateway measure for the 2025-26 measurement year with the goal of all

Throughout the measurement period, the Perinatal QIP Program Manager supported providers by facilitating communication among DataLink, Partnership, and provider sites, while weekly meetings with DataLink were used to monitor implementation, data extraction status, and overall project progress. As of December 2025, 24 of 34 providers had signed data-sharing agreements with DataLink, and 13 of those providers had begun active data pulls, with the majority of the remaining contracted providers scheduled to complete implementation by the end of the year. Partnership also conducted outreach to remind providers of the contracting and connectivity requirements. Although some providers experienced delays due to third-party scheduling, DataLink continued working to streamline the implementation process. By May 2026, 19 providers had successfully completed data extraction to Partnership. Providers not connected during the 2025-26 measurement year are expected to do so by December 31, 2026.

Goal #3: By June 30, 2026, complete PQIP program evaluation for FY 24-25.

Annual Program Evaluation Summary

The FY 2024-25 Program Evaluation was completed in November 2025. A preliminary version was shared with the internal PQIP Technical Workgroup in November, and the full evaluation was presented to IQI, QU/AC, and PAC in January and February 2026. The evaluation includes a year-over-year comparison of measures across the 2023-24 and 2024-25 measurement years.

The first chart below illustrates several factors that contributed to rate increases across 88 facilities. Although much of the growth reflects the addition of providers to the PQIP, improvements were also driven by targeted outreach and technical assistance to help providers submit claims and data attestations accurately and consistently.

Does the Perinatal QIP continue to *improve* care?

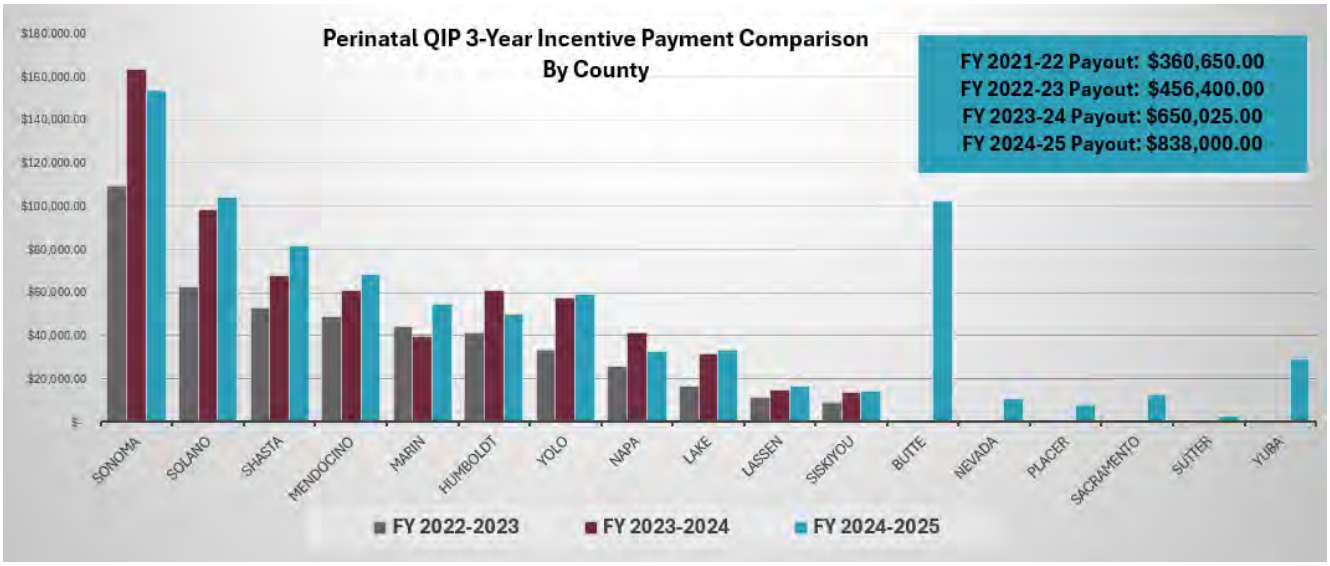
Fiscal Year	Approved Timely Prenatal Attestations COUNT < 14 Weeks	Approved Timely Prenatal Attestations COUNT ≥ 14 Weeks	Timely Postpartum Care 1st & 2nd Visits COUNT	Tdap	Influenza
2024-25	↑3,473	↑1,569	↑7,260	↑4,280	↑1,624
2023-24	↑2,080	979	↑4,721	↑3,082	↑1,164
2022-23	1,820	N/A	4,417	2,879	1,139

67% increase in < 14 weeks attestations
60% increase in ≥ 14 weeks attestations
53.8% more Postpartum Visits
38% Increase in Tdap
39.5% Increase in Influenza vaccination

Contributing factors:

- ✓ Increased provider engagement
- ✓ Follow-up and training with providers
- ✓ Partnership/provider workgroups focusing on improving overall perinatal performance
- ✓ Addition of Expansion County Providers
- ✓ Refined procedure codes list

The following chart presents a three-year comparison of payment distribution across 17 Partnership counties. Although providers in the Eastern Region were new to the PQIP in 2024-25, their results are included to show their substantial contribution to overall payment and performance for FY 2024-25. Across 88 participating organizations, the Perinatal QIP supported quality care for more than 5,600 pregnant members. Payment and performance increased in all counties except Sonoma, Napa, and Humboldt. Clinical measure volume also increased, reflecting broader access to services, particularly in the Eastern Region expansion counties. Nine Eastern Region providers accounted for 20% of the $838,000 distributed across 88 clinics, with especially notable impact in Butte County. Overall, the widespread increases in payment across providers indicate that performance gains were driven not only by new provider participation, but also by improvement across existing participants.



MY2025-26 Program Focus

Throughout MY 2025-26, the PQIP promoted high-quality prenatal and postpartum care through Fostering Connections meetings with program participants. During these meetings, Partnership reviewed its perinatal services programs, reinforced best practices in perinatal care, and targeted outreach to providers with lower performance on program measures. The PQIP also required providers to complete a PHPS survey/application describing how perinatal care is delivered at their facilities or through outsourced service providers. After reviewing the application, Partnership reached out to providers with details on how to improve service delivery and with tips on billing for services being rendered at the perinatal sites.

In addition, the program introduced a monitoring measure for timely comprehensive assessments to evaluate the volume of assessments provided to members. These assessments include nutrition, health, and psychosocial screenings in each trimester and at least once postpartum. Based on the results, PQIP determined that an incentivized measure will be developed for the 2027 calendar year measurement set.

Palliative Care Quality Incentive Program

In 2017, Partnership began a pay-for-performance program for Palliative Care Quality Improvement Program (PC QIP) providers. The Palliative Care QIP offers sizeable financial incentives to support and improve the quality of palliative care provided to Partnership members. In collaboration with Palliative Care providers, Partnership has developed a simple, meaningful measurement set to measure quality of care using two (3) measures: Avoiding hospitalization and emergency room visits, Completion of POLST (Physician Orders for Life-Sustaining Treatment), and Completion of Palliative Care Survey .

The PC QIP program goals and activities outlined in the FY 2025-2026 QI Work Plan were completed. Partnership conducted ongoing performance evaluation of the participants, continued to use the most meaningful and feasible measures available, offered technical assistance to providers throughout the year, tracked all submissions, validated them, and gave participants updates on their performance

The Palliative Care QIP runs on a calendar year, from January 1 – December 31. Providers are paid based on their performance during two (2) six-month measurement periods. In 2025, the program had 10 participants, and a total payout of $2,746,920. Major program activities during 2025 included: participant engagement and education; webinars, technical assistance, and program communications; work with providers to coordinate data validation; work with analytics to coordinate data collection and validation for avoiding hospitalization and ED visits measure; and distribution of reports to providers.

Program strengths include an opportunity for Partnership to decrease utilization and improve quality of care provided to members, strong provider engagement, and connecting providers with useful quality monitoring resources.

Partly due to the aligned incentives of the Palliative Care QIP, the overall financial savings of this program has continued, and Partnership's palliative care data have demonstrated the average performance better than other, non-Partnership palliative care programs.

Enhanced Care Management (ECM) Quality Incentive Program

The Enhanced Care Management Quality Incentive Program (ECM QIP) debuted on January 1, 2022. ECM is a statewide benefit which is part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative organized by the Department of Health Care Services (DHCS). This pay-for-reporting program utilizes Incentive Payment Program (IPP) funds to incentivize providers to present Partnership with quality data tied to the timeliness of required ECM program reporting.

Program measures are developed based on DHCS directives and requirements, as well as through collaboration with internal and external stakeholders. As an example, Partnership is held accountable by HEDIS for members receiving proper depression and blood pressure screenings and follow-up. ECM data is captured through provider submitted reports and internal TAR data.

The ECM QIP runs on a calendar year, from January 1 – December 31 and is divided into quarterly reporting periods. Earned incentive payments are distributed quarterly. ECM contracted providers are automatically enrolled in the program on condition that a contract amendment related to the QIP is signed prior to the beginning of measurement period. The program's 2025 measurement set included the following measures:

- Timely Reporting (Gateway Measure)
- ECM Care Plans and Release of Information (ROI) Forms uploaded into PointClickCare (PCC)
- PHQ-9 Depression Screening
- Blood Pressure Screening
- Timely Review of ED/Admissions Notifications in PointClickCare

Program Goals and Activities

Program goals and activities outlined in the FY 2025-2026 QI Work Plan were completed as follows:

- Goal 1: Develop a measurement set for the calendar year (CY) 2026 Enhanced Care Management Quality Incentive Program (ECM QIP) that supports quality improvement and aligns with DHCS's requirements.
  Activities: 2026 measure development was completed in September and resulted in no new measures for the 2026 measurement set.

- Goal 2: Complete MY 2025 ECM QIP Evaluation
  Activities: The evaluation was completed and will be presented in Partnership committee meetings in July 2026.

- Goal 3: Improve provider engagement by offering one-on-one assistance through meetings and trainings, and annual Advisory Group.
  Activities: Provider outreach was successful, and group onboarding twice a month and refresher trainings monthly was added to outreach efforts. Outreach to low performing providers with an offer to schedule one-on-one trainings went well.

Program Evaluation Summary

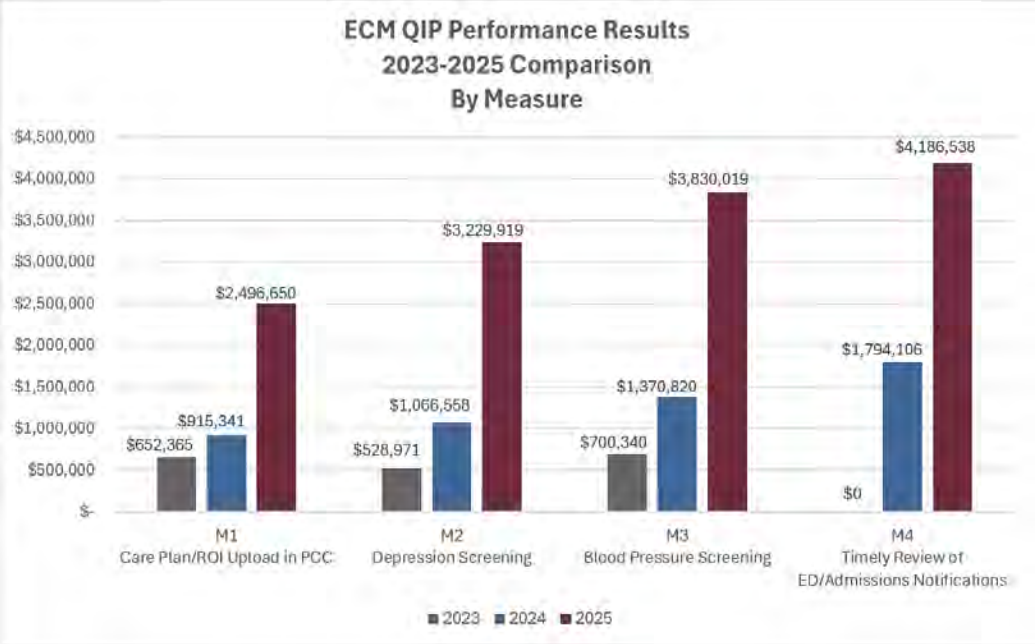
This summary reviews ECM QIP performance over a three-year period of MY 2023 through MY 2025. MY 2025 performance resulted in 234 participating provider sites with 190 provider sites earning $13.7 million (2025

YTD). This represents an increase of $8.6 million compared to $5.1 million (2024 YTD) earned by 125 provider sites in the 2024 measurement year. Below is a breakdown of results of all three measurement years.

Calendar Year	Provider Site Participants	Provider Sites Paid Incentive Dollars	Total Earned Incentive Dollars Dollars (YTD)	Total Members Served
2023	75	43	$ 1,881,676.00	4875
2024	á 155	á 125	á $ 5,146,825.00	á 15908
2025	á 234	á 190	á $ 13,743,125.00	á 24006

These results confirm marked increases in ECM enrolled members, provider participants, and earned incentive dollars.

The table below compares earned incentive dollars by measure.



<u>Contributing Factors</u>

Several factors contributed to the increases over the three-year period.

- ✓ Increased provider engagement
- ✓ Improved onboarding and refresher training processes
- ✓ Expansion of Partnership counties
- ✓ Additional measures were added to 2024 measurement set in 4th quarter
- ✓ Significant increase in providers and members in the program

Conclusion

After analysis and review of the results, this evaluation reveals the ECM QIP continues to improve the quality outcomes for our members and is a beneficial program for providers.

Long-Term Care Quality Assurance Performance Improvement (QAPI) Monitoring

In 2016, Partnership began a value-based performance program targeting long-term care facilities. The Long-Term Care (LTC) QIP was designed to offer sizeable financial incentives to support and improve the quality of long-term care provided to Partnership members. On December 31, 2023, the LTC QIP was sunset due to the implementation of the State's Workforce & Quality Incentive Program (WQIP).

Assembly Bill 186 (Chapter 46, Statutes of 2022), Nursing Facility Financing Reform, amended the Medi-Cal Long-Term Reimbursement Act to reform the financing methodology applicable to subacute care facilities and intermediate care facilities. The finance methodology authorized the implementation of three (3) major programs, one (1) of which was the Workforce & Quality Incentive Program (WQIP). As a part of the implementation of the State's WQIP, guidance released under *APL 24-009: Skilled Nursing Facilities –LTC Benefit Standardization & Transition of Members to Managed Care* created a requirement for managed care plans (MCPs) to be responsible for maintaining a comprehensive Quality Assurance Performance Improvement (QAPI) program for LTC services provided. MCPs must also have a system in place to collect quality assurance and improvement findings from CDPH. MCPs are also required to annually submit QAPI program reports with outcomes and trending data as specified by DHCS.

There are five (5) mandatory elements that an MCPs QAPI program must incorporate. Partnership has developed a framework to demonstrate fulfillment of the LTC QAPI plan requirements as outlined in APL 24-009and is monitoring QAPIs for each of the five (5) DHCS require QAPI elements:

Element 1: Design and Scope
Element 2: Governance and Leadership
Element 3: Feedback, Data Systems and Monitoring
Element 4: Performance Improvement Projects (PIPs)
Element 5: Systematic Analysis and Systemic Action

Working with the Partnership Long Term Support Services (LTSS) Liaison, we continuously work to obtain evidence of QAPI programs currently in effect at each contracted LTC facility. To support this effort, the Partnership Quality Improvement team works with the LTSS Liaison and newly formed Skilled Nursing Facility (SNF) Quality Workgroup to design and maintain a documented Managed Care Plan (MCP) LTC QAPI Program. The Quality Improvement team supports the LTSS Liaison in completing any requested secondary reviews of QAPI attestations determined to be insufficient or incomplete regarding the required Five (5) Key Elements identified by CMS and required for MCP monitoring by DHCS. QAPI deficiencies are tracked internally by the LTSS Liaison and key findings are used as education opportunities during LTC provider luncheons and on-site training with the goal of improving the quality of LTC facilities' QAPI programs.

The Partnership LTSS Liaison also serves as a primary contact for facilities with questions or concerns in post-acute and extended care settings by assisting with TAR processing, claims, grievances, appeals, contracting and

many other issues. The addition of the LTSS team and the LTSS Liaison have added increased support to facilities to help them meet designated goals within their QAPI plans.

However, following state budget shortfalls, the WQIP has been discontinued as of December 31, 2025. Partnership's executive team sought board approval to reinstate a dedicated QIP to ensure providers don't face a financial cliff when these state funds disappear. The QIP team rebranded the program as the Extended Care Center QIP, or EXT QIP. The EXT QIP includes several gateway measures such as CMS five-star rating, California Immunization Registry enrollment, and QAPI plan submissions and attestations. Also included are clinical measures like weight loss and pressure ulcers, functional status measures like falls and catheter insertion, as well as operational measures like staffing rating and health inspection rating.

D-SNP Quality Incentive Program

The Dual Eligible Special Needs (D-SNP) Quality Incentive Program (QIP) is a pay-for-performance program set to launch in parallel with Partnership Advantage. The D-SNP program offers financial incentives to support and improve the quality of our Partnership Advantage members. The program focuses on rewarding high performing providers, 3 STARs and above, that meet our proposed measure set and our Medicare STAR performance metrics. The D-SNP program will roll-out in eight (8) Partnership counties initially and as we continue to refine the D-SNP QIP more counties will be added.

Partnership Advantage, and the D-SNP QIP were slated to launch January 1, 2026, however the launch was postponed to 2027 and then again to 2028. The initial D-SNP QIP was designed to closely mirror the PCP QIP measure set with the intention of promoting provider familiarity and with the addition of measures reflecting D-SNP enrollee needs. The quality metric alignment measures were Breast Cancer Screening, Colorectal Cancer Screening, Eye Exam for Patient with Diabetes, Diabetes Care - Blood Sugar Controlled, Controlling Blood Pressure, Statin therapy for Patients with Cardiovascular Disease, and Annual Wellness Visits. D-SNP QIP measures were weighted using CMS metrics and provide flexibility in measure weighting; permitting Partnership to adjust throughout the year to target performance gains where needed.

The review of our current QIP systems show there is more advanced technology available in today’s vendor market, offering a higher level of support and responsiveness than what we currently offer in our Medi-Cal QIPs. A new technology system will provide our clinicians with better structure for incentives by offering user-friendly support and a more responsive QIP overall. The D-SNP QIP program will be contracting with a system vendor to perform and maintain payment and performance tracking for the D-SNP QIP.

Our selected system vendor is able to provide payment calculations and offer direct payment to our providers, if needed. The D-SNP program will run on a calendar year, from January 1- December 31st and our contracted D-SNP providers are able to utilize our contracted vendor system starting day one (1) of go-live.

D-SNP launch was originally postponed to January 1, 2027 given readiness concerns due to the HRP core claims system launch. During 2026 it was observed that D-SNP enrollment across the state was significantly lower than original projections. This lead to a change in approach for the D-SNP QIP program. Instead of focusing on an entire measure set, Partnership has elected to focus on the Annual Wellness Visit (AWV) goal. However D-SNP launch has again been delayed to January 1, 2028. The proposed AWV measure will still need Executive team approval before it can be incorporated into the 2028 D-SNP Quality Improvement Program (QIP) measures.

Additionally, the contract with chosen D-SNP vendor has been discontinued as part of a strategic decision by leadership to transition to a more streamlined, internally managed approach for the first year of the DSNP QIP. Given the updated timeline and lower projected membership, external vendor support is not necessary at this time. However, the organization remains open to re-engaging D-SNP vendor in the future if additional support is needed.

Year 1 Program Focus

Partnership's expansion into Medicare provides the D-SNP QIP team an opportunity to connect with newly contracted Medicare providers and engage them in the D-SNP QIP. In collaboration with our Quality colleagues and Medical Directors, the D-SNP QIP will offer traditional QIP programmatic offerings such as Kick Off webinars, newsletters, provider check-ins and any other support needed in the introductory year of this program.

Member Safety and Quality Compliance Activities

QI TRILOGY

Member Safety and Quality Compliance Activities

Quality Assurance and Member Safety activities include investigation of Potential Quality Issues (PQIs), Site Reviews (including facility site and medical record reviews), Physical Accessibility Review Surveys (PARS) (which assess the level of physical accessibility of provider sites including specialist and ancillary providers that serve a high volume of seniors and persons with disabilities), and monitoring Initial Health Appointment (IHA) rates.

Potential Quality Issues

A PQI is defined as a possible adverse variation from expected clinician performance, clinical care, or outcome of care which requires further investigation to determine whether an actual quality of care concern or opportunity for improvement exists. The PQI investigation and Peer Review process provide a systematic method for the identification, reporting, and processing of a PQI to determine opportunities for improvement in the provision of care and services to Partnership members and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity. Actions include sending letters with recommendations, issuing Corrective Action Plans (CAP), Focused Reviews, and referral to the Credentials Committee or other oversight entities.

Partnership identifies PQIs through the systematic review of a variety of data sources, including but not limited to: 1) Grievances and Appeals; 2) UM (utilization review); 3) Claims and encounter data; 4) Care Coordination; 5) Medical Record Review; 6) Referrals from other health plan staff, providers and members of the community; 7) HEDIS® medical record abstraction process; and 7) Facility and Medical Record Site Reviews.

The top three (3) referral sources were Grievance and Appeals, Utilization Management and referrals from Partnership Medical Directors. The rest of the PQI cases were referred by other sources such as the Care Coordination Pharmacy departments, and external providers. The top three (3) Referral Types were Assessment/Treatment/Diagnosis, Communication/Conduct, and Access/Availability. The top three (3) Provider Types were Primary Care Provider (PCP), Hospital/ER, and Specialist.

Table: A

Region-wide Report (includes expansion region, as of 2024)	2024		Grand Total	2025		Grand Total
PQI Referral Rate, Count and Membership	Q1/Q2	Q3/Q4		Q1/Q2	Q3/Q4	
PQI Count	97	150	247	138	153	291
Members Months	5,932,733	5,684,834	11,470,123	5,436,516	5,403,853	10,837,815
Rate per 1,000 Members	0.20	0.32	0.26	0.30	0.34	0.32

Table: B

Potential Quality Issues
Referral Dates: 2025

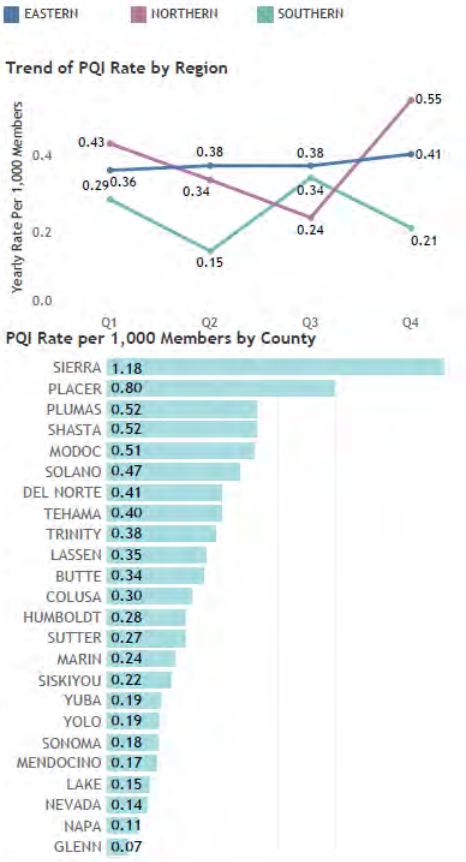
PQI Rate, Count and Membership

	EASTERN	NORTHERN	SOUTHERN	Grand Total
Member Months	3,440,010	2,402,871	4,994,934	10,837,815
PQI Count	109	78	104	291
Yearly Rate Per 1,000 Members	0.38	0.39	0.25	0.32

Count, Membership and Rate per 1,000 Members by County

	Member Months	PQI Count	Yearly Rate Per 1,000 Members
SIERRA	10,145	1	1.18
PLACER	737,804	49	0.80
PLUMAS	68,733	3	0.52
SHASTA	782,305	34	0.52
MODOC	46,723	2	0.51
SOLANO	1,229,660	48	0.47
DEL NORTE	147,812	5	0.41
TEHAMA	357,582	12	0.40
TRINITY	62,687	2	0.38
LASSEN	103,204	3	0.35
BUTTE	1,022,003	29	0.34
COLUSA	122,016	3	0.30
HUMBOLDT	688,730	16	0.28
SUTTER	528,126	12	0.27
MARIN	558,631	11	0.24
SISKIYOU	213,828	4	0.22
YUBA	444,922	7	0.19
YOLO	646,555	10	0.19
SONOMA	1,337,806	20	0.18
MENDOCINO	486,899	7	0.17
LAKE	405,832	5	0.15
NEVADA	342,602	4	0.14
NAPA	329,551	3	0.11
GLENN	163,659	1	0.07

Yearly Rate per 1,000 is defined as: [(Number of PQIs)/(Membermonths)]*12,000
Created by: Paul Leung (pleung@partnershiphp.org)



As illustrated in the preceding tables A & B, in 2025, 291cases were referred for PQI investigation compared to 113 in 2021, 156 in 2022, 227 in 2023, 247 in 2024. As expected, PQIs case referrals continued to increase as a result of the expansion to 10 additional counties in January 2024. There was an 8% increase in PQI case referrals in 2024 compared to 2023 and 17% increase from 2024 to 2025. Cases from the expansion region accounted for 49 (20%) of the 247 cases referred in 2024 and 91 (31%) of cases in 2025. A total of 291 cases were processed and closed to completion compared to 126 in 2021, 156 in 2022, 235 in 2023, and 207 in 2024 There were 84 more cases closed than in 2024, reflecting a 40% increase. There was also a noticeable increase in referrals from non-grievance internal departments, which had historically contributed relatively few referrals in prior years. Closed cases included three (3) Provider Preventable Conditions (PPC). Providers must report potential PPCs directly via online reporting to the DHCS Audits & Investigation Unit (A&I) after discovery of the event and confirmation that the patient is a Medi-Cal beneficiary.

In accordance with Partnership policy, cases score as P2 or P3 or S2 or S3 (refer to the grid below: *Assignment of Practitioner Performance and Systems Scores), by the CMO/physician designee during the internal weekly PQI rounds*, are reviewed by Partnership's Peer Review Committee (PRC) to determine what actions on the part of the health plan are indicated. A total of 14 cases were reviewed by the PRC in 2025. Assignment of practitioner

performance and system scores are based on the reviewed medical records, responses from the facility or provider, other information submitted by the provider, independent Subject Matter Expert reviews, and additional supporting documentation as needed to thoroughly review the case. Upon determination that a PQI case requires an opinion review by a specialty physician, the case can be sent to an external subject matter expert (SME) medical reviewer. In 2025, there were 15 cases sent to an SME reviewer. These reviews by a specialist, assisted with the decision making on PQI scores and subsequent recommendations/actions.

A PQI may involve both a practitioner performance issue and system issue. In addition, some cases involve multiple providers who are scored individually. Physician oversight of the PQI/Peer Review process includes weekly PQI rounds attended by an internal team consisting of the Medical Director for Quality, Regional Medical Directors, Associate Medical Directors, the Behavioral Health Clinical Director, a Clinical Pharmacist, the Manager of Member Safety Quality Investigations, the RN Quality Investigators, some RN Clinical Compliance Inspectors, and the Project Coordinator. In addition to the internal PQI team, the PRC committee is comprised of external primary care physicians and specialists who are currently practicing in hospitals, clinics, and medical groups within the Partnership provider network. Cases with significant concerns are communicated to the Credential Committee at the recommendation of the PRC. Physician and nurse participation in PRC and PQI rounds, inclusive of Partnership medical directors and network providers from diverse specialties was sufficient to meet the requirements for reviewing and making determinations regarding PQIs. In January 2024, a Nurse Practitioner from a network provider facility joined the PRC and subsequently, the PRC policy was updated to include Non-Physician Medical Practitioners as voting members.

One of our main goals for the 2025-2026 growth and improvement strategy was the upgrade of SugarCRM PQI application which is a case management tool that the Member Safety Quality Investigations team uses for the purposes of documenting PQI case investigations and storing relevant documents such as medical records, letters, and provider responses. The application, version 8, was initially built in 2019 and the opportunity arose to update the applications with new features which would decrease inefficiency in the workflow. The update to version 14 began in early 2025, went live in August 2025, and ongoing enhancements continue. In an effort to standardize our processes, we implemented new processes, enhanced existing processes and updated our policies and procedures to be aligned with business operations, regulatory requirements, technological advancement and internal practices. In addition, a training guide for new RN Investigators was created to ensure consistency of workflows and expectations. By focusing on these key aspects, we increased our efficiency, reduced costs, and improved quality.

Assignment of Practitioner Performance and Systems Scores

Practitioner Performance Severity Scores		
P Score	**Definition**	**Action/Follow-up**
P0	Care is appropriate.	No action required.
P1	Minor opportunity for improvement. Potential for or actual, minor adverse outcome to member.	The reviewer will send a letter and/or secure email to the provider. Response may or may not be required.
P2	Moderate opportunity for improvement and/or care deemed inappropriate.	Send a certified letter and/or secure email to provider of concern, requiring a response.

Practitioner Performance Severity Scores		
P Score	**Definition**	**Action/Follow-up**
	Potential for minor or moderate adverse outcome to member.	May impose a CAP and/or other interventions.
P3	Significant opportunity for improvement and/or care deemed inappropriate. Potential for significant adverse outcome to member.	ASAP communication by certified letter, secure email and/or direct phone call to the provider of concern requiring a response. Requires a CAP and/or other interventions. May be referred to the Credentials Committee with recommendations from the PRC.
PUTD	Use whenever the PQI cannot be scored through the usual process.	Referral to the Peer Review Organization (PRO) of the Facility of Concern (FOC) or the Provider of Concern (POC). If none identified, it may be through direct contact with the management of the FOC or with oversight of the POC. Refer to the appropriate licensing entity, if indicated.

System Issue Severity Scores		
S Score	**Definition**	**Action/Follow-up**
S0	No system issue.	No action required.
S1	Minor opportunity for improvement. Potential for or actual, minor adverse outcome to member.	The reviewer will send a letter and/or secure email to the provider. Response may or may not be required.
S2	Moderate opportunity for improvement and/or care deemed inappropriate. Potential for or actual minor or moderate adverse outcome to member,	Send a certified letter and/or secure email to the provider of concern, requiring a response. May impose a CAP and/or other interventions.
S3	Significant opportunity for improvement and/or care deemed inappropriate. Potential for or actual significant adverse outcome to member.	ASAP communication by a certified letter, secure email and/or direct phone call to FOC/POC, requiring a response. Requires a CAP and/or other interventions. May be referred to the Credentials Committee with recommendations from the PRC.
SUTD	Use whenever the PQI cannot be scored through the usual process.	Referral to the PRO of the FOC or the System of Concern (SOC). If none identified, it may require direct contact with the management of the FOC or with oversight of the SOC. Refer to the appropriate licensing entity, if indicated.

Site Reviews

Partnership conducts Site Reviews to ensure that primary care providers have the capacity to maintain member safety standards and practices. Each PCP site is required to pass an Initial Facility Site Review prior to joining Partnership's network. Site Reviews are conducted, at least every three (3) years. DHCS requires that a DHCS Certified Site Reviewer (Registered Nurse) conduct these reviews. Since April 2024, Partnership has maintained two (2) Master Trainers on the Inspections Team along with seven (8) Certified Site Reviewers (CSR). Partnership follows standards and guidelines outlined in APL 22-017.

DHCS issued updated Facility Site Review (FSR) and Medical Record Review (MRR) Tools that went live on July 1, 2022. DHCS later released updated FSR/MRR tools (2024 Version) with additional requirements that were implemented on January 1, 2024 . Any additional DHCS updates are disseminated to site review nurses and primary care providers as they are published.

Currently, Partnership continues to educate sites on the 2024 FSR/MRR Tools to assist sites in understanding the new requirements. Best practices are shared with sites to help drive improvement. Education is provided onsite during the exit interview process of site reviews and is additionally offered as separate educational sessions to all sites. Each site receives an educational packet during the exit interview that consists of information such as: Initial Health Appointment (IHA), Adverse Childhood Experiences (ACES)/Developmental Screening, Blood Lead Testing, Interpretive Services, CalAIM Enhanced Case Management (ECM), Doula Services, Telemed Program, Medical Equipment Distribution, Transportation Benefits, and Potential Quality Issues (PQI).

Certified Site Reviewers address areas identified from the review tool that do not meet the DHCS guidelines at the time of discovery during the Site Review. Partnership nurses also use this time to provide educational feedback to provider staff (i.e., handouts on TB risk assessments, reviewing IHA/Blood Lead Screening [BLS] and any other identified problem areas faced by the provider). For some areas, as required by the Site Review APL, corrective action plans (CAPs) are issued to the provider. If the site is issued a Critical Element corrective action plan (CE CAP), the site is scheduled to have a virtual CE verification with a nurse to validate all CE's were corrected appropriately. An interim assessment is also conducted at the halfway point between periodic reviews. The interim assessment addresses all Critical Elements and any additional CAP criteria from the site's last review (if applicable). Sites are supported throughout the entire CAP process to ensure site success.

Facility Site Reviews

Reviews completed from 7/1/2025-5/20/2026

Overall, the Facility Site Review domain scores remained very high in 2026. There are some areas in need of improvement. Through the Facility Site Review process, Partnership identified and communicated to providers where specific improvement is needed, with the following areas commonly cited:

- Emergency Medications and Dosage Chart
- Eye Charts (height adjustable chart)
- Emergency Phone Number are posted and updated annually

- Site Personnel receiving annual training for Infection Control/Universal Precautions, Blood Borne Pathogens, and Biohazardous Waste Handling
- Site Personnel receiving training in Cultural Linguistics and Disability Rights
- All Telephone and Recording services periodically checked and updated
- Language Interpreters being trained in Medical Interpretation
- Policy and Procedures for dispensing Sample Drugs

FSR Performance	2023-2024	2024-2025	2025-2026
Access & Safety	96%	96%	97%
Personnel	94%	93%	95%
Office Management	98%	98%	99%
Clinical Services	98%	99%	99%
Preventive Services	99%	97%	97%
Infection Control	98%	98%	98%

Medical Record Reviews

Reviews completed from 7/1/2025-5/20/2026

Format and documentation domain scores for the Medical Record Review (MRR) remained fairly high – within the 90th percentile range. The number of Adult and Pediatric Preventative measures were greatly increased with the release of the 2022 and 2024 MRR Tools. Partnership has been working with sites to understand the new guidelines and where specific improvement is needed.

Areas for improvement:

- Missed Appointments have documented outreach
- Member Risk Assessment/Subsequent Risk Assessment (IHA)
- Certified Screening Tools
- Advance Healthcare Directive
- All Preventative Healthcare Measures
- Medical Interpreter is Identified

MRR Performance	2023-2024	2024-2025	2025-2026
Format	98%	98%	98%
Documentation	93%	94%	95%
Coordination of Care	96%	98%	98%
Pediatric Preventive	81%	80%	81%
Adult Preventive	76%	72%	75%
OB Preventive	90%	89%	87%

Provider Billing Guide

The Inspections Team joined with the Claims Team to create a new provider billing guide to assist sites in correctly coding for preventative services. The guide covers Adult and Pediatric preventative services. The billing guide lists the preventative services from the Medical Record Review (MRR) Site Review tool and includes demographics along with the corresponding billing codes. By supporting providers to use the proper billing codes, providers can better demonstrate completion of preventative services required by quality measures and the DHCS Site Review Tools. PCP sites are provided with laminated copies of this guide at the Site Review exit interview. (Providers have given us positive feedback and have asked for additional copies of the billing guides to assist their site in better billing practices). Partnership continues to utilize this tool and updates the document quarterly or as needed.

Provider Educational Trainings

Site review measures correspond to priority quality measures defined under the DHCS Managed Care Accountability Set (MCAS) as well as those required for reporting and scoring under NCQA Health Plan Accreditation. Providers are encouraged to engage in educational sessions to drive improvement throughout the communities they serve. Partnership offers educational sessions as needed to our provider network through various forums.

Providers are offered one-to-one educational training sessions with a Certified Site Review Nurse (CSR RN) at every Site Review. Education is provided as requested. Educational offerings are provided through multiple forums such as provider newsletters, the Partnership website and regional meetings. Trainings are tailored to each specific site to assist sites with overcoming barriers and to provide best practices.

As of May 2024, Partnership has been offering (Comprehensive Health Interventions for Lifelong Development (CHILD) trainings to primary care provider (PCP) offices. Training topics include hearing and vision screening, anthropometric measurements, BMI calculation, fluoride varnish application, and immunizations, all in alignment with the DHCS CHDP Transition Plan. PowerPoint training materials were developed using CHDP references provided by the California Department of Health Care Services (DHCS) and in collaboration with CHDP offices across the counties served by Partnership. We currently offer training via Webex with an education specialist or through videos that are available on our website (content is reviewed and updated annually collaboratively amongst Managed Care Plans).

Dental Liaison

The plan has established a Dental Liaison role who serves providers as Partnership's designated Dental contact. As Dental Liaison, this position is responsible for collaborating with providers, internal departments, and other stakeholders to identify process improvements and other improvement activities for enhancing the quality of dental and oral health care our members received. This position maintains current knowledge of related benefit changes from the Department of Health Care Services and standards of care to help improve member health status and quality outcomes while establishing a positive provider experience and rapport.

Improving Blood Lead Screening

Consistent with APL 20-016, Partnership's Facility Site Review (FSR) and Performance Improvement Teams have regularly educated providers on Blood Lead Screening (BLS) and anticipatory guidance for all children ages 6 months to 6 years. Partnership was able to collaborate with some Partnership network county Public Health offices in order to better support our communities in increasing awareness and testing for Blood Lead. This is an ongoing relationship.

The Inspections Team (Site Review Team) collaborates with Provider Relations (PR) and joins their Operational meetings between Partnership and clinics. These customized meetings with providers and practice staff allow for direct interaction with Partnership staff from multiple departments. They provide a forum for Partnership to present updates on specific topics, review identified gaps in care and to field questions directly from providers about various topics of concern. The Inspections Team is currently presenting on BLS, developmental screening, fluoride varnish and the Initial Health Appointment (IHA) (content to be amended based on statewide initiatives).

Blood Lead Screening flyers are given as part of an educational packet at every Site Review. Education is provided 1:1 while on-site during the Site Review exit interview process. Formal education is also offered through various avenues such as provider newsletters, member facing newsletters, webinars, Regional Directors Forums, Partnership's website, etc. Providers receive quarterly lists of members eligible for BLS testing with the expectation they will contact and schedule members to receive the required services they are due for. BLS testing is monitored through the medical record review (MRR) process.

Member Engagement:
Members also receive notifications and reminders through various sources such as member newsletters, Partnership's member website, mailings, community events, etc. Partnership has multiple member programs such as "Growing Together" prenatal and postpartum programs, "Healthy Toddlers and Healthy Kids- Growing Together." These programs help create awareness on multiple topics including blood lead screening.

Physical Accessibility Review Survey

(PARS), aka Part C Review

The purpose of the Physical Accessibility Review Survey (PARS) is to assess provider sites' physical accessibility for Partnership's seniors and persons with disabilities (SPDs) using a set of standards approved by DHCS. Results from the reviews are made available to Partnership's members through its website and provider directories. The findings of these reviews are informational only. Providers are designated as having either "Basic Access" or "Limited Access."

- Basic Access: Indicates that the facility met all 29 critical elements that identify a site's capability of accommodating SPDs
- Limited Access: Indicates that the facility does not meet one (1) or more critical element related to the six (6) indicators listed below:
  - Parking
  - Interior Building
  - Exterior Building
  - Restroom
  - Exam Room

- Medical Equipment
- Medical Equipment Access: PCP sites only. Demonstrates if a site has a height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patient)

PARS Results for PCP and Specialist Offices July 1, 2025-May 22, 2026

Count of PARS Level:	OB	PCP	Spc	Grand Total
Basic	13	64	21	98
Limited	5	77	48	130
Grand Total	18	141	69	228

Initial Health Appointment

The DHCS contract mandates that each new member receive an Initial Health Appointment (IHA) within 120 days of enrollment in the health plan. The IHA includes a comprehensive history of the member's physical and mental health, identification of risks, an assessment of needed preventive screenings or services and health education, and development of any necessary diagnosis or treatment plan.

Effective January 1, 2024, one additional requirement was added to the Initial Health Appointment. Now, along with the completion of a history and physical within 120 days of enrollment, providers are required to complete a Member Risk Assessment as part of the IHA.

The initial Member Risk Assessment identifies health and social needs of members including cultural, linguistic, and health education needs; health disparities and inequities; lack of coverage/access to care; and social drivers of health (SDOH).An assessment of at least one of the following risk assessment domains meets the standard:

- *Social Determinants of Health (SDOH):* The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of SDOH include housing instability, food insecurity, transportation needs, utility needs, interpersonal safety, etc. Documented assessments of SDOH in the progress notes or use of an SDOH screening tool meet the standard (ex: Social Needs Screening Tool).
- *Adverse Childhood Experiences (ACEs)* (birth to 64 years old): Potentially traumatic experiences, such as neglect, experiencing or witnessing violence, having a family member attempt or die by suicide, household with substance use problems, mental health problems and other experiences that occur in childhood that can affect individuals for years and impact their life opportunities. Examples of validated screening tools that meet the standards include:
  - The Pediatric ACEs and Related Life-Events Screener (PEARLS), used to screen children and adolescents ages 0-19 for ACEs
  - The ACE Questionnaire for Adults, used to screen adults 18 years and older for ACEs
- *Cognitive Health Assessment*

A Subsequent Risk Assessment shall be completed annually, or more frequently, if any significant changes in health status are identified. This consists of at least one (1) of the risk assessment domains listed above.

Performance and Oversight Activities
Partnership focused on strengthening provider education, outreach and monitoring.

- Continued provider education through newsletters, regional meetings, site reviews and exit interviews
- Monitored IHA compliance via the medical record review process and site reviews, providing targeted feedback and support
- Enhanced outreach strategies by encouraging providers to regularly access lists of newly enrolled members via the provider portal and to proactively schedule IHA appointments
  Provided members with IHA reminder through new member packets, letter, and the Wellcare Guide.

Internal and external QI committees review the results of completed Site Reviews, including the review of IHA compliance, at least annually. This allows an opportunity to provide constructive feedback regarding the existing processes.

Partnership is currently working on strengthening our internal data analysis by reviewing coding and reporting procedures. This has proven to be a large task and continues to be a topic of discussion.

Recognizing the challenges in achieving high rate of success in this measure, Partnership continues efforts to influence performance on a provider-by-provider basis through the site review process.

Improvement Activities

Efforts Made During Site Reviews:

a. Sites receive a monthly reminder to outreach to their new members and are educated to document their outreach attempts to new members. Partnership provides spreadsheets for the sites to document their efforts, as many sites do not wish to open a new chart before the member is actually located and establishes care. These spreadsheets are reviewed and discussed during the Site Reviews.

Miscellaneous Continuous Efforts:

a. A multi departmental collaborative meeting is held biannually to discuss IHA efforts and opportunities. Participating departments include: Quality, Claims, Provider Relations, Utilization Management, Care Coordination, Member Services, Population Health, and Regional Directors, as available.
b. Newsletter articles: Information continues to be shared through our Provider and Member Newsletters. These articles are available on the Partnership website.
c. IHA Provider education is available on the Partnership website including a webinar for Providers.
d. Newly credentialed providers are educated on the IHA requirement, and a new member packet is sent to members informing them of the importance of an IHA.
e. Member Services mails an initial letter encouraging members to schedule a PCP appointment and will remind members to schedule an IHA if the member calls Partnership.
f. Partnership currently contracts with a vendor to call all newly assigned members to complete Partnership mandated assessments along with recommending an IHA visit (tracked by Care Coordination).

Partnership implemented a script change to add the statement "Reminder -Please contact your Primary Care Provider to schedule your important Initial Health Appointment within 90 days of becoming a Partnership member."

g. Partnership has a "Healthy Growing Together" program and mailers/outreach goes out to babies from birth to 18 months with outbound calls and incentives. This activity particularly focuses on members newly enrolled with the plan, so it provides the opportunity to promote IHAs.
h. IHA is discussed at Operational Meetings with sites along with BLS (see BLS section for further details)

Delegation Oversight

Partnership's oversight of QI activities delegated to DHCS subcontractors/NCQA Delegates is reviewed and approved at least annually by the Delegation Oversight, IQI, and Q/UAC Committees. Designated leaders within the Member Safety team serve as primary reviewers of Carelon's QI program and distinct quality functions it carries out on behalf of Partnership. A delegation agreement, including a detailed list of delegated activities and reporting requirements, is mutually agreed upon by Partnership and the entity. Currently Partnership contracts with Carelon Behavioral Health (formerly known as Beacon Health Options) to administer non-specialty mental health consistent with NCQA standards.

Latent TB Infection – 12 Dose Treatment

The Pharmacy Department tracks, monitors, and evaluates member adherence to Latent Tuberculosis Infection (LTBI) treatment regimen by analyzing pharmacy claims data. The goal is to enable the clinical pharmacist to timely and proactively identify members who are at risk of becoming non-adherent to their LTBI regimen and cooperate with the pharmacy and prescriber to refill the medication and ensure patient complete their regimen. Prescribers are notified at Day 16 and Day 20 of members late on their refills and out of medication. The objective is to inform the prescribers so they can reach out to members to refill their medications before the adherence gap exceeds the CDC allowed gap which would require the member to restart the regimen.

For current evaluation period, 330 notification letters were sent to providers (21 members had > 1 letters sent).

Timeliness:

- 298 of the 330 letters (90.3%) were faxed by Day 16
- 1 of the 330 letters (0.3%) were faxed by Day 20
- 31 of the 330 letters (9.4%) were faxed beyond Day 20

Percent completing a refill of their LTBI medication after provider notification.

- 106 refills resulted from 330 letters (32.1%) faxed for 308 members; 102 of 308 members refilled after prescriber letter(s)
    - 287 members had 1 letter faxed to their prescriber; 98 of 287 members (34.1%) refilled after prescriber letter
    - 21 members had 2 letters faxed to their prescriber; 4 of 21 members (19%) refilled after each prescriber letter
- 62 of 308 members (20.1%) completed their LTBI regimen after faxed prescriber notification

Number of total LTBI treatments initiated, completed, and in-progress for evaluation period (first LTBI prescription on July 1, 2025 or later)

- 280 members currently are in-progress
- 608 members completed their prescribed regimen
- 204 members did not complete their prescribed regimen

The current process for monitoring and improving completion rates for LTBI treatment is effective in identifying members who are late on their refills, notifying prescribers regarding their patient's late refill, and increasing LTBI medication refills. The 20.1 % completion rates observed for regimens associated with a prescriber notification may directly or partially be attributable to this intervention.

The Day 16 and Day 20 notifications provide an opportunity for the prescriber to engage the member on continuing their LTBI regimen rather than identifying non-completion only after treatment lapses requiring a full restart. Additionally, comprehensive monitoring across all LTBI regimens has enabled the identification of more treatment gaps, leading to additional opportunities to educate prescribers and pharmacies on the nuances of different LTBI regimens and common prescribing and dispensing errors. Lastly, we are working with county public health departments by sharing information on identified LTBI treatment gaps and collaborating with public health on improving LTBI treatment completion rates. Currently, we are sending our LTBI pharmacy claim information to public health officers of 7 counties.

As needed, the health plan pharmacy technician or clinical pharmacist will also contact the dispensing pharmacy to assist with coordinating Isoniazid and Rifapentine refills when non-adherence is detected or inform and educate the pharmacy when inappropriate dispensing is identified. Partnership continues to advocate to Medi-Cal Rx and the California Department of Public Health (CDPH) for consideration of an interface between the Medi-Cal Rx prescription data with CalREDIE, the health information and management system used by County Public Health departments and CDPH. If CDPH and Medi-Cal Rx can effectuate this interface, it will allow public health agencies to actively monitor, track, and trend LTBI detection and treatment.

Quality in Member Experience

QI TRILOGY

Care for Members with Complex Needs and Community Partnerships

Partnership HealthPlan of California is committed to supporting members with complex health and social needs through coordinated care, strong community partnerships, and focused quality improvement initiatives. During FY 25/26, these efforts centered on advancing equitable, high-quality care and improving member experience across our regions. This section highlights our work to enhance care for members with complex needs, including maternal and child health, complex case management, and transitions of care, to ensure services are safe, coordinated, and effective. It also describes our collaboration with counties and community organizations to expand provider capacity and strengthen local resources to improve access to care. In addition, it reflects our efforts under the CAHPS® / Member Experience Program, which evaluates member feedback to identify opportunities for improvement in access, service delivery, and overall satisfaction. Together, these initiatives demonstrate Partnership's ongoing commitment to addressing health disparities, improving outcomes, and enhancing the experience of care for the communities we serve.

Care for Members with Complex Needs

With the goal of improving HEDIS® rates for PPC-Pre, PPC-Post, W15, and to comply with California AB2193 (Maternal Mental Health Screening, 2018), Partnership's Population Health Department decided to review and revise the Growing Together Program by conducting an assessment that asks questions on a variety of topics, including social determinants of health and mental health. Efforts of this revision also consisted of continued focus on HEDIS® measures to support and reinforce maternal participation in prenatal and postpartum appointments, obtaining well-child exams for children within the first 15 months of life, and encourage members to take advantage of mental health services during and after pregnancy. Population health coaches assist members progress with a healthy pregnancy and wellness guides help families to consistently go to all well baby visits. The teams work to improve early identification of pregnant women and improve well child visit and immunization rates. Over FY 2025-2026, the percentage of participation across programs is as follows: Prenatal 65.4% and Healthy Babies 71.2% . When the team identifies a pregnant, postpartum, or baby that might need additional services, the team will submit a referral into Care Coordination for case management.

Complex Case Management

Partnership's Care Coordination (CC) Department has continued to monitor for any updates in Complex Case Management (CCM) activities to meet DHCS and NCQA requirements and strive for continuous compliance and improvement. The CC Department has been using the online NCQA Auditing Tool to keep track of CCM Cases. CCM Cases are continuously audited to ensure compliance with NCQA standards and to identify opportunities for additional training and tools to support the staff—primarily Nurse Case Managers and Social Workers—who conduct CCM assessments. We are collaborating closely to finalize our plan for the CCM Assessment and workflow in preparation for Jiva's go-live implementation. The Care Coordination (CC) Department underwent a mock audit in October 2025, during which the NCQA consultant provided recommendations for updates to our policies and procedures. The CC Department has addressed these recommendations to ensure compliance, and the required updates have been completed. The CC Department recently had a mock audit for our CCM case files with our NCQA Consultant in April 2026, CC has met compliance and we have integrated the necessary recommendations in our current practices. Ongoing efforts are being made to ensure staff training, resources, and any additional necessary activities are successfully completed to maintain continuous compliance with our CCM

program. We are proactively ensuring that our CCM policy remains current and undergoes a thorough review to maintain compliance and alignment with program requirements. In response to new NCQA regulations, we have revised our CCM process to include sending a notification letter to the provider upon a member's enrollment in the CCM program. This communication includes a summary of case management activities and the member's care plan for reference, as well as an invitation to collaborate when appropriate. Updated information is subsequently shared to reflect the member's progress and again upon completion of the CCM program. Policies and procedures were also updated to reflect compliance and supporting evidence for an additional new NCQA regulation. The CC Department is expanding with the addition of new Nurse Case Managers and Social Workers. To support their integration, CCM new hire trainings are conducted as needed, offering comprehensive guidance on program requirements to ensure staff proficiency and regulatory compliance. Ongoing support and education are being provided to staff as needed. The department remains committed to maintaining survey readiness across the CCM program and services and continues to actively promote the CCM program to members.

Community Resource Web Pages

Partnership has recognized that community resources provide significant support to its member population and their health and well-being. In December 2018, Partnership's Population Health Team created web-based community resource pages that show the various resources available in each county by resource type. New resources are added to the existing pages as they are identified. The community resources pages are organized by county and use pictographs and titles to be mindful of readability and education-level, ensuring easy access for all literacy levels. Over the past year, the Population Health Team has partnered with Communications to add new resource pages for the 10 expansion counties and ensure they have all twenty-five categories available and populated. Additionally, in September 2024, the Population Health team launched a new category for all twenty-four counties – Tribal Health and Wellness. This resource category showcases resources that are specific to tribal communities or members of American Indian/Alaska Native (AI/AN) descent. The creation of this category is an acknowledgement of the unique health challenges faced by AI/AN communities and is also a step towards equitable healthcare but providing culturally relevant and easily accessible local resources. The Population Health Team validates all resources in each page no less than annually, and shares county resource page web links with providers, members, and community-based organizations to promote the programs and services offered within a member's community.

Services and Patient Experience

Transitional Care Services (TCS) focuses on members who are transitioning across settings or benefit structures who are vulnerable to challenges occurring in transitions. Partnership's Care Coordination (CC) team provides TCS to ensure implementation of the discharging facility's transition plan and connects members to medical care and community resources that support member needs following a transition of care. TCS replaced Transitions of Care (TOC) program in April of 2025, which has broader criteria than TOC as defined in the PHM Policy Guide. TOC only included acute care hospital length of stays longer than four days, out-of-county hospitals with any length of stay, more than one admission in 10 days, and excluded members in Long Term Care or in a Long Term Care Psychiatric facility. The current TCS criteria for the members identified include the following:
Adult members (age > 20) **and**:

- Discharging home from an inpatient admission with any length of stay, **and**
- meet the criteria for high-risk transitioning members

Pediatric members (under age 21) **and**:

- Discharging home from an inpatient stay with an admission date > 60 days from his/her date of birth and having any length of stay.

At the close of TCS, a Partnership designee contacts the members by phone to complete a member-experience survey. Response options are Agree (3 points) Neutral (2 points) Disagree (1) or No Response. In addition to weighted responses, members have an opportunity to provide comments. Since the TOC program was still performed during the first quarter of 2025, its data is also included.

Adult Member Experience

There were 255 adult members who were assigned to the TOC or TCS survey intervention after completion of the program, and 224 provided responses to the Adult TOC or TCS Satisfaction Surveys between January 1 and December 31, 2025; a survey completion rate of 88%. The goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response. Average scores for each of the questions were as follows:

Survey Question	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my health issues.	2.98	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager).	2.99	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.94	Yes
After working with the case management team, I feel my ability to manage my healthcare needs is better.	2.92	Yes
My health has improved since working with my case management team.	2.77	Yes
I was able to safely transition between Providers with the help of my Care Team	2.87	Yes
The relationship that I have with the PCP and/or Specialist offices has improved since working with my case management team.	2.82	Yes
I was provided the available equipment, medication and/or services that were needed.	2.94	Yes

The average score for each satisfaction measure exceeded the goal of at least 75% of members surveyed, agreeing with each statement of the Adult TOC or TCS Satisfaction Survey. The average score ranged from the lowest at 2.77 to the highest at 2.99, which exceeds the goal average of 2.5. The results of the Adult TOC and TCS surveys and the positive comments left reveal a high satisfaction rate among the members surveyed. Our adult members report good outcomes with this program, and we will continue providing this benefit.

Pediatric Experience Member

There were 38 pediatric members who were assigned to the TOC or TCS survey intervention after completion of the program, and 30 of them provided responses to the Pediatric TOC or TCS Satisfaction Surveys between January 1 and December 31, 2025; a response rate of 79%. The goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response. The average responses were as follows:

Survey Question	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my child's health issues.	3.00	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager).	3.00	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.90	Yes
After working with the case management team, I feel my ability to manage my child's healthcare needs is better	2.93	Yes
My child's health has improved since working with our case management team	2.83	Yes
I was able to safely transition my child between Providers with the help of my Care Team.	2.83	Yes
The relationship that my child and I have with the PCP and/or Specialist offices has improved since working with our case management team.	2.90	Yes
My child and I were provided with the available equipment, medication and/or services that were needed.	2.80	Yes

The average score for each satisfaction measure exceeded the goal of at least 75% of members surveyed agreeing with each statement of the Pediatric TOC or TCS Satisfaction Survey. The average score ranged from the lowest at 2.80 to the highest at 3.00, which exceeds the goal average of 2.5. The results of the Pediatric TOC or TCS surveys and the many positive comments left reveal a high satisfaction rate among the members surveyed. Families report good outcomes with this program for our Pediatric members, and we will continue providing this benefit.

Complex Case Management (CCM)

Complex Case Management is a support for members who have multiple chronic conditions, social support needs and/or have difficulty navigating the healthcare system without the intensive support of a care coordinator and an individualized care plan. Care Coordination licensed staff engage the member or caregiver to perform a comprehensive assessment, clarify member/caregiver's goals and desired level of involvement, and develop an individualized care plan to overcome barriers to care and to support the member/caregiver in reaching his/her assessed needs and prioritized goals. Individual goals are time-bound; however, a member may remain in complex case management for an extended period of time to ensure they receive appropriate care.

Member satisfaction with the complex case management program is ascertained via telephonic survey by a Partnership designee either annually (for multi-year interventions) or upon case closure, if the case is active for less than one year. Response options are Agree (3 points), Neutral (2 points), Disagree (1), or No Response. In addition to weighted responses, members have an opportunity to provide comments.

Adult Experience Measure

The number of Adult CCM Satisfaction Surveys completed was low because many of the adult members enrolled in the CCM program with open cases were closed after becoming unable to reach or had insufficient time within the program per NCQA standards to qualify for a satisfaction survey in 2025.

There were 6 adult members assigned to the Adult CCM Survey intervention after completion of the program and 5 members provided responses between January 1 and December 31, 2025, a response rate of 83%. The goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response. The average responses were as follows:

Survey Question	Average Response	Goal Met
The CM program helped me manage my health issues.	3.00	Yes
I am happy with the number of calls I received from our case management team	3.00	Yes
I am confident in the abilities of the team members who contacted me	3.00	Yes
My team referred me to medical and community resources that were valuable and helped me.	3.00	Yes
I feel my ability to manage my healthcare needs is better after working with CM	2.60	Yes
I have a better understanding of my health conditions and/or diagnosis after working with CM	2.80	Yes
I have a better understanding of my medications after working with CM.	2.60	Yes
My health has improved since working with our case management team.	2.60	Yes
The relationship that I have with the PCP and/or Specialist offices has improved since working with our case management team.	3.00	Yes
I feel like my providers and I work together better to help me since working with our case management team.	2.80	Yes
I have had more success reaching our health goals since working with our case management team.	2.80	Yes

With five respondents, the average score for each satisfaction measure met the goal of at least 75% of members surveyed agreeing with each statement of the Adult CCM Satisfaction Survey. The average score ranged from the lowest at 2.60 and 3.00, which is above the goal average of 2.5. The number of members eligible to complete the survey is low; nevertheless, with the average scores meeting the goal along with the positive responses, Partnership will continue providing this benefit.

Pediatric Experience Measure

In addition to the above program criteria, Partnership's Clinical CC staff outreach to all newly identified CCS members and members currently eligible for CCS who develop an additional CCS condition to complete a comprehensive assessment, determine acuity, and to offer enrollment into CCM if meets criteria. The final activity upon completion of the program for these CCS members along with other enrolled Pediatric CCM cases is the satisfaction survey. For each satisfaction measure, the goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response.

There were five pediatric members assigned to the Pediatric CCM Survey intervention after completion of the program and all five members completed a Pediatric CCM Satisfaction-Survey between January 1 and December 31, 2025, a response rate of 100%. The goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response. The average responses were as follows:

Survey Question	Average Response	Goal Met
The CM program helped me manage my child's health issues.	3.00	Yes
I am happy with the number of calls I received from our case management team	3.00	Yes
I am confident in the abilities of the team members who contacted me	3.00	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.80	Yes
I feel my ability to manage my child's healthcare needs is better after working with CM	2.60	Yes
I have a better understanding of my child's health conditions and/or diagnosis after working with CM	2.80	Yes
I have a better understanding of my child's medications after working with CM.	2.60	Yes
My child's health has improved since working with our case management team.	2.60	Yes
The relationship that my child and I have with the PCP and/or Specialist offices has improved since working with our case management team.	2.60	No
I feel like my providers and I work together better to help my child since working with our case management team.	2.80	Yes
My child and I have had more success reaching our health goals since working with our case management team.	2.60	Yes

With five respondents, the average score for each satisfaction measure exceeded the goal of at least 75% of members surveyed agreeing with each statement of the Pediatric CCM Satisfaction Survey. The average score ranged from 2.60 to 3.00, which is above the goal of 2.5. The number of members eligible to complete the survey is low; nevertheless, with the average scores meeting the goal along with the positive responses, Partnership will continue providing this benefit.

Access to Care

Annually, Partnership collects data from a variety of sources to evaluate all aspects of information related to Network Adequacy to ensure Partnership provides members with adequate network access for needed healthcare

services. The provider types covered include primary care clinicians, medical specialists, and hospitals. Partnership follows both the DHCS and NCQA requirements. A detailed analysis of access to care data is included in the Assessment of Access and Availability (NET 3) Grand Analysis Report (see Appendix A). The following provides a preliminary high-level summary of the data available to date.

Analysis was conducted in collaboration between the Quality Improvement, Network Services, and Health Analytics Teams. Based on opportunities identified, interventions are defined, and measurable goals are set, to improve network adequacy.

The following access to care findings reflect information included for the calendar year 2025 in the 2026 Network Management Grand Analysis Report.

Methodology and Notable Findings

Member Grievances

There were 6,149 Grievances, Second Level Grievances, and Appeals closed in 2024 compared to 6,486 in 2025. This reflects a 5.5% increase in cases. These cases are broken into two (2) groups – Grievances accounted for 5,638 and Appeals and Second Level Grievances accounted for 848.

Partnership met the minimum threshold for Access related Grievances in 2025 with the total number holding steady as compared to 2024. Over 43.4% of the reported concerns pertained to transportation services. Common complaints include missed rides, delayed driver arrivals, and scheduling inconsistencies.

Partnership did not meet the minimum threshold for Appeals in 2025 with a 30% increase from 2024. The total number of cases filed per 1,000 members increased from 0.49 to 0.70. Grievance and Appeals experienced a steady increase in appeals each quarter in 2025. This is primarily attributed to an increase in Community Supports-related appeals, specifically the Medically Tailored Meals benefit. Partnership released a new Community Supports policy in August 2025 outlining the eligibility criteria for each of the benefits available, including Medically Tailored Meals. This led to members being suddenly denied after having received 2-3 rounds of the service previously.

Out of Network (OON) Requests (January 2025 – December 2025):

Requests: Partnership met the goal of less than 20 per 1,000 members for requests. Out of the 3,135 OON Requests submitted (2.6 per 1,000 members) in 2025, 1,424 (45%) were approved and 1,711 (55%) of requests were denied. The counties with the highest number of requests included Placer County with 11.2%, Butte County with 10.8%, and Sonoma County with 10%. Some requests were due to excessive appointment wait times or excessive driving distance, and approvals were allocated in those instances. Where services were available in network, those requests were denied.

Utilization: There was 2,219 OON Claims submitted (2 per 1,000 members) meeting the 10 or less per 1,000 members performance goal for utilization. Of the 2,219 OON Claims submitted, 1,425 (66%) were approved and 794 (38%) were denied. This appears to demonstrate that authorization review processes are effectively identifying and redirecting out-of-network requests to qualified in-network providers and practitioners. Of the 794 approved requests Plan wide, 512 (64%) were used. The three specialties with the highest OON requests included: Dermatology with 54% of requests used, General Surgery with 38% of requests used, and Plastic/Reconstructive

Surgery with 38% of requests used. Analysis of data on paid claims did not reveal additional insights related to the practitioner network.

Practitioner Availability (Ratio and Geographic Availability)

- *Measured through the 2024 Network Adequacy Report Availability of Practitioners (NET 1, Element B, C).* The Plan met the standard for all Primary Care Practitioners in 2025. The primary care overall ratio exceeded the performance goal despite a 5.7% decrease from 2024. A breakdown of the data at the county level shows Lassen County as not meeting the time or distance standard for primary care for both children and adults. Out of 7,879 Partnership members in Lassen County, 779 do not meet the time or distance standard despite the Family Practice to member ratio in Lassen County being 1:1,313.
- A deeper dive into the three categories of Primary Care shows that despite a ≥95% coverage by Family Practice Physicians, there are five counties that lack Pediatricians and Internal Medicine providers, and one that lacks Pediatricians. This is indicative of a rural county, where the population is widely dispersed, and the providers are in, or near, towns and cities.
- The Workforce Development Program provides incentives for Primary Care practitioners to join our network. Partnership is actively recruiting for all categories of Primary Care, specifically in our rural areas that traditionally have a lower number of providers.
- The six (6) high volume specialties utilized by members remained unchanged from 2024 to 2025. The six (6) specialties include Obstetrics/Gynecology, Cardiology, General Surgery, Orthopedic, Ophthalmology, and Dermatology. Plan-wide, the provider ratio standards for all high-volume specialist providers were met. When the data is broken down to the county level, four rural counties did not meet the 60 miles, or 90 minutes standard for access to specialists. Modoc, Siskiyou, Lassen and Del Norte missed the mark for Ophthalmology and Hematology/Oncology. Partnership contracts with all available high-volume and high-impact specialists that practice within our rural counties. Modoc, Siskiyou, Lassen, and Del Norte are sparsely populated and have an insufficient population to sustain a practice for many specialties. Currently, there are no qualified specialists who are enrolled in Medi-Cal practicing in these geographic areas with whom to contract. Partnership will assist members in making appointments and arrange transportation for members to see a specialist that is outside of the time or distance standards.

Practitioner Accessibility (Appointment Time Standard)

Measured through the 2024 Third Next Available Appointment Provider Survey

- As a plan, three (3) of the four categories of primary care appointments fell below the established median 10-day appointment goal in 2025. Non-urgent adult and pediatric primary care appointments fell short with a 6.7 decrease from 2024, while newborn appointment access fell 9.6%
- As a plan, two (2) high-volume specialties fell below the established median 15-day appointment goal in 2025 . Dermatology fell short of the goal in the Fairfield, Redding and Santa Rosa Regions. Cardiology fell below the standard in the Fairfield and Santa Rosa Regions.

Member Experience

The 2023-2023 4Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Composite Scores taken from the ME7 CAHPS® Results Report revealed the Adult Composite score for getting needed care and getting care quickly both had a slight decrease as compared to 2023. Both failed to meet the benchmark. The Adult Composite score for getting needed care increased by 0.5% to 74.5% and getting care quickly increased from 68.1% to 74.0%. Both failed to meet the benchmark. The Child composite score for Getting Needed Care

increased from 77.1% to 77.9% and Getting Care Quickly increased from 78.9% to 80.0%. However, both measures failed to meet the benchmark.

Our expanded service area revealed important insights about how healthcare needs and experiences vary across Northern California communities. CAHPS® survey results highlighted differences in how adult and child populations experience care across regions, with Tehama County demonstrating the most significant variations. These regional differences deepen our understanding of how service delivery and member satisfaction interact across diverse geographic areas.

These service delivery challenges reflect broader healthcare system constraints, as California continues to experience workforce shortages across clinical and non-clinical positions. This staffing environment, combined with Partnership's significant growth, likely will continue ongoing pressure on appointment availability and service delivery.

Looking ahead, additional external factors may significantly influence member experience. The implementation of H.R.1, the One Big Beautiful Bill Act (HR1) changes are expected to impact Medi-Cal eligibility and coverage transitions, in particular Adults 19 years of age or older. These mandates, coupled with ongoing redetermination processes, could affect how adult members perceive and access healthcare services. As communities navigate these changes, member satisfaction scores may reflect both system-wide adjustments and individual challenges in maintaining continuous care.

Member Services Access

The Member Services Department monitors and analyzes the performance of both the internal Call Center and contracted delegates. Currently, Carenet is the delegate under Member Services' purview and its performance is evaluated against Partnership's established service and quality standards.

- Service Level: 80% or greater of calls answered within 30 seconds
- Average Speed of Answer: 30 second or less
- Abandonment Rate: 10% or less

To monitor delegate performance, Partnership requires Carenet to submit a monthly performance report in which Partnership tracks and trends results against the established performance criteria on a quarterly basis. Delegate performance is reported out through our Delegation Oversight Review Subcommittee (DORS). Additionally, the quarterly Carenet/Partnership Joint Operations Meeting provides an open forum for both entities to collaborate and discuss areas of opportunities. Since August 2025, delegate performance has been variable, with performance challenges identified across all SLA metrics: Average Wait Time, Abandonment Rate, and Service Level. To support performance stabilization and ensure closer oversight, Partnership increased monitoring effective February 2026, which included the implementation of monthly performance meetings in addition to ongoing quarterly Joint Operations meetings. Member Services leadership continues to partner with Carenet to finalize their Root Cause Analysis (RCA), which will evaluate factors contributing to performance variability and identify targeted corrective actions. Following discussions held during these monthly performance meetings, Carenet conducted a Full-Time Equivalent (FTE) analysis to assess staffing levels. The analysis determined that additional staffing was required to consistently meet established SLAs, and recruitment efforts are underway. Based on these staffing adjustments, Carenet is projecting improved performance aligned with SLA standards, with expected improvement to be reflected in the May 2026 reporting. Performance trends, progress, and

remediation activities will also remain a standing agenda item at Partnership's Delegation Oversight Review Subcommittee (DORS) meetings to support ongoing alignment with SLA expectations.

Opportunities for Improvement

Partnership operates in a broad service area encompassing urban, suburban, and rural settings. Improving member access to care is consistently the number one opportunity for improvement and top priority for leadership. Partnership's provider network is challenged by a national shortage of providers, competition from other entities, and an aging provider community.

Activities to Improve Access

Opportunity: Appointment access to non-urgent primary care fell short of the goal for the second year in a row with a 6.7% decrease from 2023 to 2024 and an additional decrease of 6.4% in 2025.

Planned Action: Partnership extended and refined the Provider Recruitment Program (PRP) to incentivize providers to join and remain in the Partnership network. The PRP offers sign-on bonuses to providers who are new to the Partnership network, including providers practicing outside of Partnership's 24-county service area as well as graduates completing training programs within the service area.

- The current PRP cycle is active from July 2025 through June 2026. Incentive payments are structured over longer commitment periods to promote retention: 60 months for physicians, nurse practitioners, and physician assistants; 24 months for behavioral health clinicians; and 12 months for certified SUD counselors.
- Effectiveness of Action: During calendar year (CY) 2025, Partnership approved 185 PRP awards, an increase from 163 awards approved in CY 2024. Family Medicine remained the most frequently awarded specialty, accounting for approximately 51 percent of awards compared to 57 percent in CY 2024.
- Between January and December 2025, 185 new primary care clinicians were recruited to the network. Three of these providers were recruited to Sierra and Trinity Counties, two of Partnership's most rural counties, where 75 percent or more of the geographic area is classified as rural under U.S. Census Bureau definitions. Early recruitment and retention indicators are favorable, though long-term outcomes will continue to be assessed over the full incentive payment periods.

Planned Action: Partnership continued targeted recruitment efforts for specialty providers, with a particular focus on obstetrics and perinatal care, including obstetricians, women's health nurse practitioners, and certified nurse midwives.

- Effectiveness of Action: In CY 2025, nine obstetrics providers, including five advanced practice clinicians and four physicians, received PRP awards to support labor, delivery, and perinatal services across the network

Planned Action: Partnership launched a Provider Retention Initiative (PRI) pilot in January 2024 and extended it through 2025. The PRI recognizes long serving safety net providers, including primary care clinicians, obstetrics and perinatal providers, and psychiatrists, and incentivizes additional years of service. The program is intended to preserve institutional knowledge, clinical leadership, and mentorship while stabilizing care delivery during generational workforce transitions.

- Effectiveness of Action: Since program inception, 75 providers have received PRI awards. Fifty-nine awards were approved in CY 2024 and 14 in CY 2025. Seventy-three percent of the providers awarded were in

Family Medicine. The year over year decline in awards was expected, as eligibility is tied to reaching a 15 year practice milestone.

CAHPS® Program | Member Experience

Overview

At Partnership HealthPlan of California (Partnership), our commitment to members goes beyond policy or compliance; it is rooted in purpose. As of December 2024, we proudly served over 905,570 members across a 24-county service area. This evaluation highlights year-over-year trends and our ongoing commitment to listen, learn, and lead efforts that improve our members' healthcare experience. As a member-centered organization, we recognize that member experience is fundamental to our success in delivering high-quality care. To ensure we are meeting this commitment, we systematically measure and evaluate member experience through the following approaches.

What We Measured and Why it Matters

Through coordinated efforts across departments, we capture member feedback through two primary channels:

- Annual member experience surveys (Calendar Years: 2023-2024)
- Grievance and appeals reporting (Calendar Years: 2023-2024)

We maintain a comprehensive view of performance by evaluating both historical trends and current NCQA Member Experience data. This analysis informs our continuous improvement efforts and reinforces our commitment to delivering high-quality care. Detailed trending analyses and supporting documentation are available in Appendix C: Member Experience (ME 7) Report.

Together, these data sources provide a comprehensive view of member experience, including survey insights as well as grievances and appeals, helping us better understand and respond to what matters most to the people we serve.

Accreditation Compliance

NCQA requires accredited health plans to conduct an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. The Agency of Healthcare Research and Quality (AHRQ) designed and governs this survey.

CAHPS Survey Objectives

The CAHPS survey captures member-reported experiences with their healthcare, through three key focus areas:

1. Measuring how effectively plans meet member expectations and goals
2. Determining which service areas most impact overall member satisfaction
3. Identifying opportunities for quality improvement in care delivery

The structured evaluation process below highlights the disciplined approach that Partnership applies to quality improvement efforts to continuously enhance service quality and member care experience.

I. Introduction

This evaluation provides retrospective performance analysis that links previous fiscal year reporting period (FY 2024-25) outcomes to FY 2025-26 Organizational Goal activities. This comprehensive review enables us to assess historical performance while informing strategic quality improvement initiatives.

This analysis evaluates plan-covered members' experience and quality metrics for Measure Year 2024, Reporting Year 2025, and FY 2025-2026.

Note: In this evaluation, "Partnership" and "Plan" refer to Partnership HealthPlan of California.

II. Scope of Evaluation

The FY 2025-26 QI Evaluation draws on a comprehensive, evidence-based methodology to assess member experience and inform targeted strategies. This multi-dimensional evaluation integrates both qualitative and quantitative insights to guide meaningful improvements in service delivery and member outcomes.

Key Components:

1. Member Experience Data	2. Grievances and Appeals Data
• CAHPS survey results • Service quality metrics • Member satisfaction indicators	• 2025 Annual Report • Ongoing complaint monitoring • Trend analysis

The evaluation process follows an evidence-based methodology incorporating:

3. Quantitative Analysis	4. Qualitative Analysis
• Year-over-year CAHPS survey results • Statistical trending of key metrics • Benchmark comparisons against national standards • Internal performance indicators	• Member narrative feedback • Contextual assessment of survey responses • Process evaluation findings • Implementation effectiveness review

This integrated analytical approach enables Partnership to:

- Identify statistically significant trends
- Pinpoint high-impact improvement opportunities
- Develop data-driven action plans
- Track progress against strategic objectives
- Demonstrate alignment with organizational mission

Ultimately, these insights drive informed, decision making to enhance member experience and health outcomes, and reinforces Partnership's commitment to delivering high-quality, equitable, and responsive managed care delivery.

III. CAHPS Program Framework and Methodology

The CAHPS program operates on a comprehensive member-centric Continuous Quality Improvement (CQI) framework that drives evaluation and enhancement of member experience. This framework encompasses:

Core Components	CQI Diagram

• Member experience assessment	
• Performance analytics	
• Outcome measurement	
• Data collection and validation	
• Targeted improvement initiatives	

CAHPS Regulated Survey Methodology

The plan contracts with an NCQA-certified vendor annually to administer the CAHPS Regulated survey from February to May. It employs a multi-protocol engagement strategy in English and Spanish to enhance outreach and inclusivity by utilizing mail, phone, and digital options. The protocol begins with a mailed questionnaire, followed by a reminder letter and a second questionnaire in the second month. Phone outreach includes a reminder call before the second mailing and up to three follow-up calls in the third month for non-responders. Members can also complete the survey online through a secure portal or by scanning a QR code.

CAHPS

The survey sample frame size includes qualifying Adult and Child member populations. Each member must have continuous Partnership primary coverage for the prior year, six (6) months (July 1 – Dec 31), and have been treated by a contracted provider within our network. Annual survey results provide a retrospective data set on key NCQA ratings and composite measures (Tables I and II).

Grievances and Appeals

The Grievance & Appeals (G&A) Department is responsible for investigating, monitoring, and reporting member dissatisfaction regarding their experience with Partnership's Medi-Cal plan. Routine G&A reports shared internally and externally provide real-time insight into service dissatisfaction across five (5) NCQA-defined categories, including: Access, Attitude/Service, Billing/Financial, Quality of Care, and Quality of Provider's Office. The reporting triggers a threshold alert when case numbers per 1,000 members increase by more than 10% compared to the previous period.

Evaluation Summary

Grievances

In 2024, Partnership’s 10-county expansion increased membership to 905,570 members, a 33.5% increase from 678,546 members in 2023. During the same period, total grievances increased from 3,572 to 5,477, with the overall rate rising from 5.26 to 6.05 per 1,000 members, exceeding the 2024 threshold of 5.79 (Tables VI and VII).

Grievances increased modestly on a rate basis (5.79 to 6.05 per 1,000 members), while appeals and second-level grievances decreased, with second-level grievances declining from 1.02 to 0.74 per 1,000 members (Tables VI and VII).

At the category level, Access and Attitude/Service remained the highest-volume drivers, with 2,567 and 2,569 grievances, respectively. Access-related grievances increased from 2.25 to 2.83 per 1,000 members, exceeding the 2024 threshold of 2.47. Attitude/Service grievances increased from 2.58 to 2.84 per 1,000 members, meeting the threshold of 2.84.

Billing/Financial and Quality of Care grievances remained below threshold, with slight improvements in rates compared to 2023. Quality of Provider Office grievances increased from 2 to 5 cases, with the rate rising from 0.00 to 0.01 per 1,000 members, exceeding the threshold of 0.00 (Table VI).

Table: VI

Grievances Only Reporting Period: Annual 2023 vs. Annual 2024								
	Previous Period: 2023			Current Period: 2024				
NCQA Category	Grievances	Avg PHC Mship	Grievances p/1,000	Grievances	Avg PHC Mship	Grievances p/1,000	Threshold	Threshold Met?
Access	1,526	678,546	2.25	2,567	905,570	2.83	2.47	No
Attitude/Service	1,752		2.58	2,569		2.84	2.84	Yes
Billing/Financial	106		0.16	140		0.15	0.17	Yes
Quality of Care	186		0.27	196		0.22	0.30	Yes
Quality of Provider Office	2		0.00	5		0.01	0.00	No
TOTAL	3,572		5.26	5,477		6.05	5.79	No

Appeals & Second Level Grievances

Appeals and Second Level Grievances decreased from 689 to 672 cases year over year, with the overall rate declining from 1.02 to 0.74 per 1,000 members, remaining below the 2024 threshold of 1.12 (Table VI).

All five categories (Access, Attitude/Service, Billing/Financial, Quality of Care, and Quality of Provider Office) remained within threshold. At the category level, Access accounted for the highest volume, increasing from 350 to 442 cases; however, the rate decreased from 0.52 to 0.49 per 1,000 members, remaining below the threshold of 0.57. Attitude/Service and Billing/Financial both decreased in volume and rate, while remaining within threshold.

Quality of Care decreased from 9 to 1 case, with the rate declining from 0.01 to 0.00 per 1,000 members, and Quality of Provider Office remained at zero cases in both periods. All categories continued to perform within established thresholds (Table VI).

Table: VII

Appeals & Second Level Grievances Reporting Period: Annual 2023 vs. Annual 2024								
	Previous Period: 2023			Current Period: 2024				
NCQA Category	Appeals & SLG	Avg PHC Mship	Appeals & SLGs p/1,000	Appeals & SLG	Avg PHC Mship	Appeals & SLGs p/1,000	Threshold	Threshold Met?
Access	350	678,546	0.52	442	905,570	0.49	0.57	Yes
Attitude/Service	33		0.05	18		0.02	0.05	Yes
Billing/Financial	297		0.44	211		0.23	0.48	Yes
Quality of Care	9		0.01	1		0.00	0.01	Yes
Quality of Provider Office	0		0.00	0		0.00	0.00	Yes
TOTAL	689		1.02	672		0.74	1.12	Yes

CAHPS® Measure Year 2023 | Reporting Year 2024 Plan Performance

A summary of the MY 2023 CAHPS® survey performance for Adult and Child, identified barriers, FY 2024-2025 intervention and improvement focus are outlined below

Adult

Analysis of MY 2024 Adult CAHPS measures indicates that seven (7) of nine (9) measures performed below the plan's 33rd percentile benchmark target. Year-over-year results show declines in five (5) measures, reflecting continued performance challenges across multiple domains (Table I).

Performance varies across measures. The lowest-performing domains include Getting Needed Care (5th percentile), How Well Doctors Communicate (8th percentile), Care Coordination (9th percentile), and Getting Care Quickly (11th percentile), all of which remain well below the benchmark. Customer Service (12th percentile) and Rating of Health Plan (19th percentile) also performed below target, though Rating of Health Plan showed improvement compared to the prior year.

Moderate performance was observed in Rating of Personal Doctor (30th percentile), which declined year over year, and Rating of Health Care (35th percentile), which met the benchmark and improved from MY 2023. Rating of Specialist Seen Most Often (96th percentile) remained a strong performer and exceeded the benchmark.

Overall, while selected measures demonstrated improvement, seven (7) of nine (9) domains continue to perform below the 33rd percentile benchmark, with the lowest rankings concentrated in access and care experience measures.

Table: I HEDIS Quality Compass (QC) Benchmarks

Measure Domain	Plan Performance		
	MY 2024 HEDIS QC Ranking	Plan Benchmark Target ≥33rd Percentile Ranking	MY 2024 Ranking Compared to MY 2023
Rating of Health Plan (% 8, 9, 10)	19th	Not Met	Improvement
Rating of Health Care (% 8, 9, 10)	35th	Met	Improvement
Rating of Personal Doctor (% 8, 9, 10)	30th	Not Met	Decline
Rating of Specialist Seen Most Often (% 8, 9, 10)	96th	Met	Improvement
Getting Needed Care (% Always or Usually)	5th	Not Met	Decline
Getting Care Quickly (% Always or Usually)	11th	Not Met	Improvement
Care Coordination (% Always or Usually)	9th	Not Met	Decline
How Well Doctors Communicate (% Always or Usually)	8th	Not Met	Decline
Customer Service (% Always or Usually)	12th	Not Met	Decline

Child

Analysis of MY 2024 Child CAHPS measures indicates that four (4) of nine (9) measures performed below the plan's 33rd percentile benchmark target. Year-over-year results show declines in five (5) measures, reflecting mixed performance across domains (Table II).

Performance varies across measures. The lowest-performing domains include Getting Needed Care (13th percentile), Getting Care Quickly (13th percentile), Rating of Health Care (21st percentile), and Rating of Specialist Seen Most Often (31st percentile), all of which remain below the benchmark.

Moderate to strong performance was observed in several domains. How Well Doctors Communicate (36th percentile) and Care Coordination (52nd percentile) met the benchmark, with Care Coordination showing improvement from MY 2023. Rating of Health Plan (44th percentile) and Rating of Personal Doctor (73rd percentile) also met the benchmark but declined year over year. Customer Service (74th percentile) remained a strong performer despite a year-over-year decline.

Overall, while a majority of measures met the 33rd percentile benchmark, four (4) of nine (9) domains continue to perform below target, with lower rankings primarily observed in access-related and select experience measures.

Table: II HEDIS Quality Compass (QC) Benchmarks

Measure Domain	Plan Performance		
	MY 2024 HEDIS QC Ranking	Plan Benchmark Target ≥33rd Percentile Ranking	MY 2024 Ranking Compared to MY 2023
Rating of Health Plan (% 8, 9, 10)	44th	Met	Decline
Rating of Health Care (% 8, 9, 10)	21st	Not Met	Improvement
Rating of Personal Doctor (% 8, 9, 10)	73rd	Met	Decline
Rating of Specialist Seen Most Often (% 8, 9, 10)	31st	Not Met	Improvement
Getting Needed Care (% Always or Usually)	13th	Not Met	Decline
Getting Care Quickly (% Always or Usually)	13th	Not Met	Improvement
Care Coordination (% Always or Usually)	52nd	Met	Improvement
How Well Doctors Communicate (% Always or Usually)	36th	Met	Decline
Customer Service (% Always or Usually)	74th	Met	Decline

Identification of Opportunities and Priority

❖ Denotes NCQA Rating and Composite Scoring Measures

The QI CAHPS framework supports a coordinated, multi-disciplinary approach to improving member experience through targeted initiatives and the integration of health equity. As part of a recent strategic realignment, Access initiatives were separated from Member Experience and transitioned to the HR Workforce Development team, which now leads the FY 2024–2025 Access strategic and tactical plans in alignment with Organizational Goal #2: Network Optimization. Concurrently, the QI Department remains focused on advancing Member Experience through the Strike-Team Pilot, an initiative designed to identify, prioritize, and address service delivery barriers in real time.

Building on these structural changes and FY 2024–2025 progress, Member Experience teams will continue advancing improvement efforts in FY 2025–2026. Key focus areas include enhancing member education, strengthening dental coverage initiatives, and integrating a health equity perspective into service delivery. These initiatives, as outlined in Appendix C, are designed to address ongoing challenges while ensuring alignment with the needs of Partnership's diverse member population.

Member Experience – Priority

Building on the organizational changes outlined earlier, this analysis evaluates Partnership's member experience measures within the context of its expanded service area and increased membership. MY 2024 results reflect the transition from a 14-county to a 24-county service area and capture feedback from a broader member population.

Member Experience Measures (Not Included in NCQA Scoring)

These supplementary measures assess three (3) key drivers of member satisfaction: How Well Doctors Communicate (doctor communication), Care Coordination, and Customer Service. Together, these measures provide insight into core aspects of service delivery and member experience.

What Changed Last Year (MY2023-MY2024)

Notable Improvements:

- Care Coordination showed positive gains in both populations (Adult: **+2.5** points, Child: **+4.3** points).
- Doctor Communication maintained strong performance above 90% for both populations.
- Customer Service sustained high member satisfaction levels, particularly in Child population (90.5%).

Adult Population Performance:

- Doctor Communication: 92.6% to 90.6% (↓ **-2.0** points)
- Care Coordination: 78.8% to 81.3% (↑ **+2.5** points)
- Customer Service: 96.4% to 86.5% (↓ **-9.9** points)

Child Population Performance:

- Doctor Communication: 93.0% to 93.3% (↑ **+0.3** points)
- Care Coordination: 80.4% to 84.7% (↑ **+4.3** points)
- Customer Service: 91.2% to 90.5% (↓ **-0.7** points)

Rating Measures

These rating measures reflect members' overall satisfaction with their healthcare experience, focusing on ratings of 9 or 10 on a 10-point scale. High scores indicate strong satisfaction with healthcare delivery systems.

What Changed Last Year (MY2023-MY2024)

Notable Improvements:

- Both populations showed improved Health Plan ratings (Adult: **+1.3** points, Child: **+4.8** points).
- Health Care ratings increased significantly (Adult: **+9.1** points, Child: **+7.5** points).
- Child population demonstrated improvements across all rating measures.

Adult Population Performance:

- Health Plan: 54.5% to 55.8%

Child Population Performance:

- Health Plan: 68.1% to 72.9%

(↑ **+1.3** points)
- Health Care: 46.3% to 55.4% (↑ **+9.1** points)
- Personal Doctor: 70.0% to 65.7% (↓ **-4.3** points)
- Specialist: 69.5% to 70.3% (↑ **+0.8** points)

(↑ **+4.8** points)
- Health Care: 58.9% to 66.4% (↑ **+7.5** points)
- Personal Doctor: 75.5% to 78.6% (↑ **+3.1** points)
- Specialist: 63.8% to 73.8% (↑ **+10.0** points)

Access To Care Measures - Priority
These measures evaluate members' ability to receive timely care and necessary services, providing crucial indicators of healthcare accessibility.

❖ **Getting Needed Care (GNC)**

This measure assesses members' ability to obtain necessary treatments and specialist appointments.

What Changed Last Year (MY2023-MY2024)

Notable Improvements:

- Both populations showed improved composite scores (Adult: **+0.5** points, Child: **+0.8** points).
- Care/Tests/Treatment access improved for both populations.
- Child population maintained stable specialist appointment access.

Adult Population Performance:

- GNC Composite Score: 74.0% to 74.5% (↑ **+0.5** points)
  - *Care/Tests/Treatment: 76.1% to 78.6% (↑ **+2.5** points)*
  - *Specialist Appointments: 71.9% to 70.5% (↓ **-1.4** points)*

Child Population Performance:

- GNC Composite Score: 77.1% to 77.9% (↑ **+0.8** points)
  - *Care/Tests/Treatment: 81.3% to 82.7% (↑ **+1.4** points)*
  - *Specialist Appointments: 72.8% to 73.1% (↑ **+0.3** points)*

❖ **Getting Care Quickly (GCQ)**

This measure evaluates timely access to urgent and routine care.

What Changed Last Year (MY2023-MY2024)

Notable Improvements:

- Both populations showed improved composite scores.
- Adult urgent care access showed significant improvement (**+9.1** points).
- Both populations maintained strong urgent care performance above 78%.

Adult Population Performance:

- GCQ Composite Score: 68.1% to 74.0% (↑ **+5.9** points)
  - *Urgent Care: 69.8% to 78.9%*

Child Population Performance:

- GCQ Composite Score: 78.9% to 80.0% (↑ **+1.1** points)
  - *Urgent Care: 83.7% to 84.2%*

(↑ +9.1 points)

- *Routine Care: 66.3% to 69.2% (↑ +2.9 points)*

(↑ +0.5 points)

- *Routine Care: 74.2% to 75.9% (↑ +1.7 points)*

FY 2024-2025 Summary of Organizational Goal #4 Activities and Interventions

The detailed activities for the FY 2024-2025 Organizational Goal #4 Access and Member Experience demonstrated cross-department action focused on interventions refer to Appendix C: *(Member Experience (ME7) Report, reference Appendix B: page 38, Table III)*. The highlighted examples below showcase completed goals/actions targeting Access and, furthermore, document continuous improvement.

FY 2025-2026 Organizational Goal # 5 | Improvement Focus and Goal Summary

Member Experience

Building on FY 2024–2025 progress, Member Experience teams will continue advancing improvement efforts in FY 2025–2026 through targeted initiatives designed to address identified member barriers and support key organizational priorities.

- The summary table below outlines improvement focus areas based on MY 2024–2025 quantitative, qualitative, and causal analysis, and highlights organizational priorities related to member barriers identified in Table III. A complete evaluation of the below fiscal goal focus areas will be available in the FY 2025-26 Member Experience (ME7) Grand Analysis Report (September 2026).

Table: III

INTERVENTION & IMPROVEMENT STATUS	IMPROVEMENT FOCUS	GOAL MILESTONE #	INTERDEPARTMENTAL COLLABORATION		DEFINITIONS
			YES / NO	# OF DEPTS.	
Continue	*Access	--	--	4	• **Adjust:** a lean approach or pivot. A continued focus and intent. • **Continue:** a continuation of intervention or improvement activity and focus. • **Maintain:** score or intervention met. • **Monitor:** intervention or improvement assessment period. • **New:** a new action or intervention.
Continue	Member Experience	All	Yes		
New	Health Equity	5			
Continue	Customer Service	All			
Continue	Attitude/Service	1			
Continue	Health Care Rating	All	Yes		
Continue	Health Plan Rating	All			

FY 25-26 Organizational Goal 2*: Network Optimization

- **Milestone 1: MX Strike Team | Transportation Services:** The Transportation Department will continue its FY 2024-2025 pilot program, which connects member Grievance and Appeal cases with driver performance to enhance service quality and member satisfaction while developing data-driven improvement targets.

- **Milestone 2: MX Strike Team | Quality Improvement (QI):** The QI Consumer Assessment of Healthcare Providers and Systems (CAHPS) team will lead the MX Strike Team pilot by leveraging real-time internal influence drivers to identify and address sources of member dissatisfaction (e.g., line staff engagement, causal factors), to enhance service delivery and effectiveness.
- **Milestone 3: Enhancement & Member Education | Member Services (MS):** The MS Department will lead activities to initiate one new initiative to improve member experience (MX) through operational and/or service delivery enhancements.
- **Milestone 4: Enhancement & Member Education | QI CAHPS Team:**

  The QI CAHPS team will advance dental coverage initiatives to improve MX through enhanced education, access, and service delivery.
- **Milestone 5: Integration of Health Equity into MX Initiatives** The Population Health Management (PHM) Department, in partnership with the Health Equity (HE) team, will lead collaborative workgroup activities aimed at advancing equitable member engagement and integrating diverse perspectives into the design and delivery of member experience (MX) initiatives. These efforts will reflect our diverse member population's cultural, linguistic, and social needs.

Looking Ahead

External policy and operational changes are expected to shape member experience in the coming years. The implementation of the “One Big Beautiful Bill Act” (HR1) introduces significant Medi-Cal changes beginning in late 2026, with the most substantial impacts projected between October 2026 and January 2027.

During this period, eligibility modifications, including immigrant eligibility restrictions, along with new operational requirements such as work reporting, six-month renewals, and enhanced verification, are expected to increase administrative workload and procedural disenrollments. These changes may affect up to 1.8 million members over the implementation period. Later provisions, including cost-sharing requirements beginning in October 2028, introduce additional program changes but are not expected to drive early enrollment disruption.

In combination with ongoing redetermination activity, these factors may influence member access, communication, and continuity of care. Against this backdrop, Partnership’s FY 2026–27 Member Experience strategy focuses on strengthening core programs, advancing targeted improvements, identifying key barriers, enhancing telehealth, and building broader organizational understanding of member experience priorities.

FY 2026-27 Organizational Goal #4 - Member Experience | Goal and Milestone Summary
Building on FY 2025–26 progress, Member Experience efforts in FY 2026–27 will focus on strengthening program effectiveness and advancing targeted improvement initiatives that address identified member needs and barriers.

Milestones

- **Milestone 1: Enhance Member Experience (CAHPS) Program**
  Strengthen CAHPS program infrastructure, performance monitoring, and integration into improvement activities.
- **Milestone 2: Initiate Targeted Improvement Activities**
  Implement a minimum of three targeted initiatives aimed at improving member experience outcomes based on performance data and member feedback.

- **Milestone 3: Identify Member Experience Gaps and Barriers**
  Conduct analysis to identify key gaps, barriers, and opportunities that impact access, communication, and care continuity.
- **Milestone 4: Enhance Telehealth Strategy**
  Advance Partnership's telehealth strategy to improve access, usability, and alignment with member needs.
- **Milestone 5: Build Organizational Understanding of Member Experience**
  Increase awareness and deepen organizational understanding of the factors that influence member experience and satisfaction.

Conclusion
In FY 2026–27, Partnership will continue responding to evolving policy, operational, and service delivery conditions while advancing key Member Experience priorities. Efforts will center on strengthening CAHPS infrastructure, implementing targeted improvements, addressing member-centered barriers, enhancing telehealth, and expanding organizational understanding of experience drivers.

Through this work, Partnership remains committed to equity, responsiveness, and continuous improvement. Member feedback and performance insights will guide efforts to strengthen services, support access to care, and advance the mission to help members of our communities be healthy.

Please see Appendix C: Member Experience (ME 7 C-D) Report for a complete review of the FY 2024-2025 analysis, and interventions implemented and proposed FY 2025-2026 programmatic interventions.

Web Based Member Information Assessment

Purpose & Overview

The Quality and Accuracy of Information Report tracks the quality results of the information provided to Partnership members received during the following:

- Telephonic inquiry call(s) to the Member Services Department
- General inquiry(s) sent electronically (email) to the Member Services Department
- Partnership's website (self-service, Member Portal) online tools at https://member.partnershiphp.org/.

Member Services reviews the quality and accuracy of information monthly. On an annual basis, we document our findings through the production of this Quality and Accuracy of Information Report. The analysis of results and publishing of this report was a Member Services led initiative. The report was authored by the Member Services Manager of Quality & Training in collaboration with the Associate Director of Member Services. All Partnership contributors and their corresponding roles for this report are listed below:

Title / Department	Role
Sr. Director, Member Services & Grievance	Analysis Contributor
Associate Director, Member Services	Analysis Contributor
Manager of Quality & Training, Member Services	Author
Supervisor of Member Services	Data Contributor
Supervisor of Quality and Training	Data Contributor

Director, Grievance & Appeals	Analysis Contributor
Compliance Manager, Grievance & Appeals	Data Contributor

Methodology

Telephonic Response

Data Source: *Annual Telephone Quality and Accuracy Evaluation*

Member Service Representatives (MSR) are annually tested on the quality and accuracy of telephone support as it relates to "Referrals and Authorizations," "Eligibility and Benefits," and "Member Financial Responsibilities."

The Member Services management team assesses the quality and accuracy of telephonic support provided by an MSR through the administration of the "*Eligibility and Financial Responsibility Knowledge Check"* test. Testing is administered through Partnership's online Learning Management System (LMS) training tool. This tool tracks and trends both individual and overall results. Member Services supervisors review individual MSR testing results and provide a departmental summary for review by the Member Services management team. Through this review, the management team identifies deficiencies and determines appropriate next steps.

In terms of performance standards, a minimum score of 90% is required for individual MSRs and a minimum score of 95% for the collective department for both the "Quality" and "Accuracy" domain. If the management team identifies any departmental trend(s) within the deficiencies, they may place the individual(s) and/or the department on a Corrective Action Plan (CAP). Additionally, the management team provides their analysis to the Member Services Manager of Quality & Training to develop tailored training material that may include, but not limited to:

- Updated desktop procedures/materials
- Instructive and informative email correspondence
- Focused departmental training

In addition, results are summarized annually (both quality and accuracy) and documented in the Analysis section of the Quality and Accuracy of Information Report.

Quality & Accuracy Member Complaints

Data Source: *Member Phone Call/Email*

Member complaints received against Partnership staff are documented by Member Services supervisors. Other member facing department supervisors also have the ability to file complaints against Partnership staff. This includes complaints filed due to staff providing misinformation or not enough information related to a member's financial responsibility, referrals, and/or authorizations. If a supervisor identifies a training opportunity, they provide tailored support and conduct additional training for the staff member.

Partnership's Grievance & Appeals (G&A) Department provides Member Services with an annual report that includes details on all Partnership staff-related complaints. If trend(s) are identified for Member Services staff, the Member Services Manager of Quality & Training may develop tailored training materials that includes, but are not limited to:

- Updated desktop procedures/materials
- Instructive and informative email correspondence

- Focused departmental training

In addition to the annual reporting and analysis, there is an established feedback loop to address any instance of misinformation closer to real time. If the G&A Department identifies that misinformation was provided, the staff member's supervisor is notified and provides feedback, coaching, and monitoring.

Website Self-Service Quality

Data Source: *PartnershipHP.org*

Ten (10) of Partnership's newest staff audit the functionality and ease of use of Partnership's website. This audit is conducted on an annual basis through the use of a web-based survey tool. Partnership utilizes new employees as their lack of experience in navigating the Member Portal provides a true gauge of what a member would experience as it relates to the ease of use and the quality of information provided.

Our survey consists of 10 questions and performance is measured on a five-point rating scale, where one (1) indicates a poor experience and five (5) signifies an excellent experience with Member Portal's functionality. To ensure consistent evaluation, a performance threshold of 3.0 has been established for each question/activity. Similar to what was mentioned within the Telephonic Reponses section, each survey question is categorized into two domains, "Quality" and "Accuracy." Results are evaluated to ensure a thorough assessment process. Staff members assess the quality or accuracy of the web functionality as outlined in Table 2.

Table 2

Web Functionality Category	Survey Question	Domain Area
Changing Primary Care Practitioner	Was it easy to do?	Quality
	Was the staff member able to change a PCP?	Accuracy
	Was it completed in one attempt?	Accuracy
Determine How/When to obtain Referrals/Authorization	Was it easy to find?	Quality
	Was the staff member able to determine how and when to obtain referrals and authorizations for specific services?	Quality
	Was it completed in one attempt?	Accuracy
	Was the information provided useful?	Quality
Determine Benefits and Financial Responsibility of a Service	Was it easy to find?	Quality
	Was the staff member able to find the language that stated that members have no financial responsibility?	Quality
	Was it completed in one attempt?	Accuracy

Findings are summarized and reviewed annually. If the average score for a specific question or activity falls below 3.0, the Member Services management team will engage Partnership's Web Development team to recommend and evaluate potential enhancements for improvement.

Email

Data Source: Emails submitted via https://member.partnershiphp.org

A designated Member Services auditor selects either 10% of all email inquiries or ten (10) inquiries (whichever is fewer) per month to audit. The auditor determines the quality, accuracy, and timeliness of the email response to the member's inquiry through the following categories:

Email Etiquette

- Identified themselves to the member
- Response protects Member(s) Personal Health Information (PHI)
- Response projects professionalism and politeness
- Correct spelling, grammar, and punctuation

Resolution

- Appropriately identified member reason for email inquiry
- Offered the most appropriate and accurate solution to meet the members' needs
- Communicated at a level that the member would understand

Timeframes and Documentation

- Delivered appropriate acknowledgment or resolution response within one business day of receipt of the Member's request.
- Resolutions are completed by the end of the following business day
- Member's record is documented according to policy

Audit findings are recorded in the Member Services Department audit log, which tracks and trends individual and overall results. Individual audit results are reviewed with the staff member's supervisor and overall departmental results are reviewed by the Member Services management team. Through this review, the department aims to address any deficiencies identified as well as determine appropriate next steps. If the auditor identifies any trends within the deficiencies (meaning an aggregate score that falls below the performance threshold of 95%), they will provide their analysis to the Member Services Supervisor of Quality & Training to develop tailored training which may include, but not limited to:

- Updated desktop procedures/materials
- Instructive and informative email correspondence
- Focused departmental training

Results & Analysis

Telephonic

Member Services Call Center staff completed the Annual Eligibility and Financial Responsibility training and test. The "Quality" domain scored 91.0%, which was a 5.4% decrease from 2025 (96.4%) and a 4.4% decrease from 2024 (95.4%). The "Accuracy" domain scored 99.7%, which was a slight improvement over 2025 (99.6%) and 2024 (99.3%). When looking at the results, the department scored 96.6% overall, which reflects a 1.8% decrease from 2025 (98.4%) and a 1.3% decrease from 2024 (97.9%). Partnership exceeded the established goal of 90% for both "Quality" and "Accuracy."
To illustrate these trends, we have organized our findings at both the domain level (Table 3) and question level (Table 4). Both tables also include a comparison of results, year over year.

Table 3

Quality & Accuracy Telephonic Results Domain Level			
Domain Area	**2024**	**2025**	**2026**
Quality	95.4%	96.4%	91.0%
Accuracy	99.3%	99.6%	99.7%

Table 4

Quality & Accuracy Telephonic Results Question Level				
Question	**Domain Area**	**2024**	**2025**	**2026**
1	**Accuracy**	100.0%	99.0%	97.0%
2	**Accuracy**	97.0%	99.0%	100.0%
3	**Accuracy**	100.0%	99.0%	100.0%
4	**Quality**	100.0%	100.0%	100.0%
5	**Accuracy**	100.0%	100.0%	100.0%
6	**Accuracy**	100.0%	100.0%	100.0%
7	**Accuracy**	100.0%	99.0%	100.0%
8	**Accuracy**	100.0%	100.0%	100.0%
9	**Accuracy**	97.0%	100.0%	100.0%
10	**Accuracy**	100.0%	100.0%	100.0%
11	**Quality**	100.0%	100.0%	100.0%
12	**Quality**	77.0%	83.0%	61.0%
13	**Quality**	100.0%	99.0%	94.0%
14	**Quality**	100.0%	100.0%	100.0%
	Total:	**97.9%**	**98.4%**	**96.6%**

Although the department met the established threshold for the "Accuracy" domain, we identified an ongoing opportunity within the "Quality" domain and have taken action. The Manager of Quality & Training continues to work with departmental supervisors to provide one-on-one refresher training focused on helping staff identify relevant and useful information members may need when seeking care from a specialty provider. In addition, staff

feedback related to Question 12 was incorporated into training materials to improve alignment with established procedures. While prior training efforts led to initial improvement, the 2026 results show a continued need for reinforcement, particularly for Question 12. This area will remain a key focus in the coming year. Below is an overview of our findings, comparing current performance with prior periods and is organized by domain and overall performance.

Quality Domain (Five Questions)

- Questions 4, 11, and 14 achieved 100%
- Question 12 results decreased significantly compared to prior years:
    - 2026: 61%, 2025: 83%, 2024: 77%
    - A 22% decrease from 2025 and 16% decrease from 2024
- Question 13 experienced a decline compared to previous years
    - 2026: 94%, 2025: 99%, 2024: 100%

Accuracy Domain (Nine Questions)

- Questions 2, 3, 5, 6, 7, 8, 9, and 10 achieved 100% in 2026
- Question 2 showed improvement
    - 2026: 100%, 2025: 99%, 2024: 97% (increase over both prior years)
- Question 3 improved compared to 2025 and matched prior peak performance
    - 2026: 100%, 2025: 99%, 2024: 100%
- Question 7 improved from 2025 and returned to prior levels
    - 2026: 100%, 2025: 99%, 2024: 100%
- Question 1 experienced a decline
    - 2026: 97%, compared to 2025 (99%) and 2024 (100%)

Department Overall

- 33/34 staff tested
    - One leave of absence
    - Two staff members retook the test and passed with a 100% score after the refresher training
- 60.6% of respondents scored 100% compared to 67.5% in 2025
- 39.4% of respondents scored 93% compared to 32.5% in 2025

Quality & Accuracy Member Complaints

For the 2025-2026 evaluation period, Partnership experienced a total of 385 member complaints against Partnership staff. Of the 385 nine (9) were related to misinformation regarding either “Referrals and Authorizations”, “Eligibility and Benefits”, and “Member Financial Responsibilities” (1 in the 2024– 2025 period). For the purpose of this report, our G&A Department references these types of complaints as an “RAFR” complaint. When comparing this result to the previous evaluation period (2024-2025), there were 309 total complaints, with one (1) related to the RAFR reasoning.

Upon review of the RAFR complaints in this reporting period, member grievances primarily reflected communication gaps, incorrect information, and administrative delays across Transportation, G&A, Care

Coordination, Community Supports, and Behavioral Health. Corrective actions focused on targeted staff training, workflow improvements, and enhanced quality oversight. A notable delay in meal services was traced to a processing oversight, which was addressed through retraining and process reinforcement. The coaching and other resolution details are documented within the Resolution Column of Table 5.

Table 5

2025-2026			
Date Received	**Date Closed**	**Issue**	**Resolution**
12/6/24	1/2/25	Member believes PHC TS unit mishandled her request for GMR; they would not allow her to submit documentation that would potentially support a medical need for the requested TRE. This led to an eventual denial of the GMR / TRE.	The member's concerns were reported to the Transportation Department's supervisor for further review. Phone calls were reviewed and identified as addressed appropriately, it was disclosed that the transportation specialist never informed the member they could not submit documentation regarding their GMR, meals, & lodging request; it was asserted the member's denial derived from policy guidelines and the Medical Director's determination based on information presented for the request. Reportedly, the member did not mention information regarding potential complications that could arise from the procedural and only disclosed the procedure was outpatient format.
1/31/25	2/28/25	Member is not happy that GCA did not completely help to get reimbursement. The GCA did not provide all the information about when to expect payment for GMR due since August 2024.	Supervisors reviewed call and grievance. GCA was provided with feedback and training on how to improve customer service and how best to follow up when the member asks for further information, if she does not have the answers at the time of the call.
2/7/25	3/7/25	Mom Meals informed the member that meal deliveries are starting. The member requested this service in August after surgery but did not receive meals until now. Mom Meals stated they received approval two weeks ago. The member wants to know if the delay was caused by the Partnership Community Supports Program or Moms Meals. They are also concerned about accessing meal services after their next back surgery and want assurance that they will receive help when needed.	The TAR for Moms Meals was received on 1/29/25 and approved on 2/4/25. Community Supports confirmed the member requested meal services after surgery on 9/17/24. Community Supports needed more information on how the meals would help the member and gathered this during a call on 10/18/24 but the representative missed sending the information for processing, causing a 60-day delay. This was corrected immediately when it was identified. The delay was due to human error, and the representative has since received additional training. Both Community Supports and Moms Meals are committed to improving service, ensuring timely processing for future meal requests. We apologized for the oversight and any inconvenience it caused. Member was encouraged to continue to work with their Care Coordination case manager for help with access-to-care barriers and for help and follow-up when they need to request meal services again following an upcoming back surgery.
7/7/25	7/28/25	Member is not happy with services provided by two Care Coordination staff. Both staff told staff that a referral and TAR was needed for physical therapy	Review of the recorded calls showed that both staff shared incorrect information. Additional training has been provided to both staff members.
8/7/25	8/26/25	During a call on an unrelated grievance, a G&A GCA gave the member incorrect information on Medi-Cal Rx ability to write prescriptions for members between establishing new providers for emergency purposes.	Supervisor of the GCA reviewed the call and found the GCA did give the incorrect information to the member during the call. The GCA was provided with a training opportunity

			and this issue will be monitored ongoing for future occurrences.
10/6/25	10/14/25	Member was told his ride for 10/6 was approved, but in fact it was denied due to being somewhere that cannot bill Medi-Cal.	TS Supervisor reviewed the call and confirmed the employee made this mistake. Supervisor attempted to reach the member to discuss further but only got the VM. TS Supervisor addressed the issue with the staff member.
10/14/25	11/13/25	Member is upset G&A representative did not offer he appeal rights regarding her COC denial on 9/17/2025. Instead the representative filed a grievance.	The member confirmed she wanted to file a case regarding her COC denial. The representative confirmed the COC denial and did not offer to file an appeal for the member. Feedback has been given to the representative's supervisor to provide additional training on documentation and case types.
11/12/25	12/10/25	Member was unhappy with the Transportation Department regarding their response to Grievance 65124. Member states they incorrectly assumed that he used a taxi, but instead was driving by his friend, and that changes the resolution of that grievance, if they had listened to the recorded phone call.	Transportation Dept listened to the recorded call and stated their rep should have provided the correct procedure for requesting a GMR but did not. Process information was shared with the member via this resolution.
11/19/25	12/18/25	Member believes PHC TS unit mishandled her request for GMR; they would not allow her to submit documentation that would potentially support a medical need for the requested TRE. This led to an eventual denial of the GMR / TRE.	The member's concerns were reported to the Transportation Department's supervisor for further review. Phone calls were reviewed and identified as addressed appropriately, it was disclosed that the transportation specialist never informed the member they could not submit documentation regarding their GMR, meals, & lodging request; it was asserted the member's denial derived from policy guidelines and the Medical Director's determination based on information presented for the request. Reportedly, the member did not mention information regarding potential complications that could arise from the procedural and only disclosed the procedure was outpatient format.

Table 6

2024-2025			
Date Received	**Date Closed**	**Issue**	**Resolution**
4/13/24	5/9/24	The member is unhappy with her care coordinator and feels she is not helpful and did not return her call. Feels she was given wrong information regarding one of the providers not accepting her as a patient/ The member is needing a referral to specialists for ophthalmology and rheumatology.	The care coordinator's supervisor states the specialist provider would accept the member only if the member was also assigned there for PCP, however, also documents there were training opportunities found in that the care coordinator could benefit from. The supervisor was able to get the 2 referrals approved and reassigned the member to a new care coordinator.

Table 7

2023-2024			
Date Received	**Date Closed**	**Issue**	**Resolution**
2/14/23	2/16/23	The member is upset because he feels he is receiving conflicting information regarding a TAR from different people at PHC. The Grievance staff said it was approved and the CC staff said it was denied.	The MSR educated the member regarding the denial of the TAR in question, advised him that his CM in CC would follow up with him, and offered to file a Grievance. The member declined to file a standard Grievance, so an exempt Grievance was filed.

7/31/23	8/15/23	Member was unhappy with the TS Unit representative who provided her information about the GMR process. Member had a long trip scheduled, which would include a hotel and meal reimbursement. The representative did not specifically tell member that the meal is something they must pay for and request a reimbursement for. Member usually has very little money and she was under the impression PHC would send meal ticket/vouchers.	PHC TS Unit listened to recorded call and agreed the rep did not explain the process well enough. They provided education and feedback to their staff so that better explanations of the process are given to members. Member asked for help on how to get her receipts to PHC. She lives in Eureka, so I shared the physical address. Member stated she would drop these off at the office.
9/22/23	10/17/23	Member dissatisfied that it took 10 months for billing issue to be resolved. Staff member did not know the correct information.	MS Enrollment unit reviewed the concerns. They have implemented a process to monitor timeframes for billing issues. Staff member has been counseled. The process will be reviewed at their department trainings and added to their desktops.
10/6/23	10/9/23	The member had communication issues with the MSR who initially assisted her with her referral issue.	The member declined to file a standard Grievance. An exempt Grievance was filed. Supervisor reviewed call and found a training opportunity around referrals / authorizations for palliative care. Feedback was given.

In addition, Member Services has continued to use the tracking mechanism of RAFR complaints per 1,000 members to monitor the trend of RAFR complaints. The membership used for this calculation was obtained through our internal analytics platform, Tableau, and reflects membership data as of December 31, 2025. Consistent with the overall increase in RAFR-related grievances, the rate per 1,000 members increased from 0.001 in the prior reporting period to 0.010 in 2025–2026, reflecting both a shift in performance and the impact of targeted quality initiatives, including enhanced monitoring. This tracking method will continue to be assessed and included in the analysis of our Quality and Accuracy of Information Report.

Table 8

	# Of Grievances	Membership Base	# of Grievances - Per 1,000 Members
2025-2026 RAFR Grievances	9	895,311	**0.010**
2024-2025 RAFR Grievances	1	906,993	**0.001**

Website Self-Service Quality and Accuracy

The results of the current reporting period overall performance continue to exceed the predetermined categorical threshold of 3.00. Additionally, we experienced an increase in results. As shown in Table 9, the “Quality” domain experienced approximately a 15.0% increase from 2025 (3.80) to 2026 (4.37), while the “Accuracy” domain experienced approximately a 2.4% increase from 2025 (4.13) to 2026 (4.23). It’s important to reiterate that not only did we exceed our established threshold, but we also demonstrated measurable improvement year over year. The improvement in performance is attributed to enhancements made to the Member Portal experience and ongoing efforts to improve access to referral, authorization, and financial responsibility information.

Table 9

Domain Area	2025	2026

Quality	3.80	4.37
Accuracy	4.13	4.23

Table 10

Year 2026

Changing Primary Care Practitioner:		Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Quality	Was it easy to do?	5.00	5.00	4.00	5.00	5.00	4.00	4.00	4.00	3.00	5.00	4.40
Accuracy	Was the staff member able to change a PCP?	5.00	5.00	4.00	5.00	5.00	4.00	5.00	1.00	5.00	5.00	4.40
Accuracy	Was it completed in one attempt?	5.00	5.00	4.00	5.00	5.00	4.00	4.00	1.00	2.00	5.00	4.00

Determine How/When to obtain Referrals/Authorization:		Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Quality	Was it easy to find?	5.00	3.00	4.00	5.00	5.00	5.00	4.00	4.00	3.00	5.00	4.30
Quality	Was the staff member able to determine how and when to obtain referrals and authorizations for specific services?	5.00	5.00	4.00	5.00	5.00	5.00	5.00	3.00	3.00	5.00	4.50
Accuracy	Was it completed in one attempt?	5.00	4.00	4.00	5.00	5.00	5.00	4.00	2.00	3.00	5.00	4.20
Quality	Was the information provided useful?	5.00	5.00	4.00	5.00	5.00	5.00	5.00	3.00	3.00	5.00	4.50

Determine benefits and financial responsibility of a service:		Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Quality	Was it easy to find?	4.00	4.00	4.00	5.00	5.00	5.00	4.00	5.00	2.00	5.00	4.30
Quality	Was the staff member able to find the language that stated that members have no financial responsibility?	5.00	4.00	1.00	5.00	5.00	5.00	5.00	5.00	2.00	5.00	4.20
Accuracy	Was it completed in one attempt?	4.00	4.00	3.00	5.00	5.00	5.00	5.00	5.00	2.00	5.00	4.30

Table 11

Year 2025

Changing Primary Care Practitioner:		Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Quality	Was it easy to do?	4.00	4.00	5.00	2.00	5.00	3.00	5.00	5.00	2.00	5.00	4.00
Accuracy	Was the staff member able to change a PCP?	5.00	4.00	5.00	4.00	5.00	3.00	5.00	5.00	4.00	5.00	4.50
Accuracy	Was it completed in one attempt?	5.00	4.00	5.00	3.00	5.00	3.00	5.00	5.00	3.00	5.00	4.30

Determine How/When to obtain Referrals/Authorization:		Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Quality	Was it easy to find?	1.00	3.00	5.00	1.00	5.00	4.00	5.00	5.00	3.00	5.00	3.70
Quality	Was the staff member able to determine how and when to obtain referrals and authorizations for specific services?	2.00	3.00	5.00	2.00	4.00	3.00	3.00	5.00	3.00	5.00	3.50
Accuracy	Was it completed in one attempt?	4.00	3.00	5.00	2.00	4.00	3.00	5.00	5.00	3.00	5.00	3.90
Quality	Was the information provided useful?	3.00	3.00	5.00	2.00	5.00	3.00	5.00	5.00	3.00	5.00	3.90

Determine benefits and financial responsibility of a service:		Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Quality	Was it easy to find?	3.00	3.00	5.00	5.00	3.00	4.00	5.00	3.00	2.00	5.00	3.80
Quality	Was the staff member able to find the language that stated that members have no financial responsibility?	3.00	3.00	5.00	5.00	3.00	3.00	4.00	4.00	4.00	5.00	3.90
Accuracy	Was it completed in one attempt?	3.00	3.00	5.00	5.00	3.00	3.00	5.00	4.00	2.00	5.00	3.80

Upon thorough analysis of the results across all categories, it is evident that each reporting category experienced a positive trend compared to the previous year. Additionally, the improvement in scoring appears to be linked to enhancements made to the Help page feature on the Member Portal and continued efforts to improve how information is presented to users. While some respondents still reported minor challenges navigating to the Help page, overall feedback indicates improved success in locating referrals, authorization, and financial responsibility information.

To further enhance the user experience of the Member Portal, Member Services will continue to partner with the IT Web Team to refine the instructional language that guides users on the "Help" screen icon. Additionally, to improve the Website Self-Service Quality and Accuracy process for the 2025-2026 review period. In addition to the above, we have organized additional year-over-year comparisons at the domain and web functionality level.

Quality Domain (6 Questions)

- All questions experienced an increase over 2025 results
  - Average improvement for this domain was +0.57 (2026: 4.37 vs. 2025: 3.80)
- The Quality questions within the "Determine How/When to obtain Referrals/Authorization" functional area averaged a +0.73 improvement versus the previous year, representing the most significant gain among functionality categories

Accuracy Domain (4 Questions)

- Three of the four Accuracy domain questions experienced an increase over 2025 results
  - Average improvement for this domain was +0.10 (2026: 4.23 vs. 2025: 4.13)
- The "Was it completed in one attempt" quality questions were up +0.17 in comparison to the previous year

Overall, Web Functionality

- Total average rating increased by 10% (2026: 4.30 vs. 2025: 3.93)
- Changing Primary Care Practitioner: +1% (2026: 4.27 vs. 2025: 4.20)
- Determine How/When to obtain Referrals/Authorization: +15% increase (2026: 4.38 vs. 2025: 3.77)
- Determine Benefits and Financial Responsibility of a Service: +10% increase (2026: 4.27 vs. 2025: 3.82)

Email Accuracy and Timeliness

During our recent assessment, we reviewed results of the current period and compared them to the previous period (Tables 12–14). Through this review, we noted a continued rise in total volume of email inquiries received. We logged an annual increase of 100 email inquiries compared to the prior period. We attribute this increase to continued member utilization of email as a preferred communication channel, as well as ongoing efforts to promote accessible and convenient service options.

Table 12

		2025								2026				
Email Inquiries	**Goal**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**Total**
Total Email Inquiries Received	N/A	77	75	60	56	81	80	63	91	142	77	122	110	1034
# of Submissions Audited Per Month	10 or 10% of # Inquiries Received	10	10	10	10	10	10	10	10	14	11	12	11	128
% of Quality of Information	95%	99%	97%	100%	100%	99%	100%	99%	100%	100%	100%	100%	100%	100%
% of Emails Responded to Within 1 Business Day	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 13

		2024								2025				
Email Inquiries	**Goal**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**Total**
Total Email Inquiries Received	N/A	101	89	89	85	73	93	50	52	97	62	72	71	934
# of Submissions Audited Per Month	10 or 10% of # Inquiries Received	10	10	10	10	10	10	10	10	10	10	10	10	120
% of Quality of Information	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
% of Emails Responded to Within 1 Business Day	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 14

		2023								2024				
Email Inquiries	**Goal**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**Total**
Total Email Inquiries Received	N/A	57	41	56	57	55	53	30	35	113	124	67	105	793
# of Submissions Audited Per Month	10 or 10% of # Inquiries Received	5	5	5	5	5	9	9	9	11	12	8	10	93
% of Quality of Information	95%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	98%	99.8%
% of Emails Responded to Within 1 Business Day	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Despite the increase in volume of email inquiries since the 2024-2025 period, we observed positive results across all aspects of email communication with our members. This includes response timeliness, and the accuracy of resolutions provided. Our Quality and Training team will continue to conduct monthly audits and report the findings to the intra-departmental workgroup as part of the annual assessment. Additional quantitative findings are presented below:

- Total Email Inquiries Received
  - +10.7% over the previous reporting period
  - 2025–2026: 1,034 vs. 2024–2025: 934
  - +30% over the 2023-2024 period
- % of Quality of Information
  - Remained stable against the previous reporting period
  - 2025-2026: 100% vs. 2024-2025: 100%
  - +0.02% over the 2023-2024 period
- # of Emails Responded to within 1 Business Day
  - Results (100%) remained stable with no change observed during the previous reporting periods

Summary

Barriers

Overall results demonstrate that Partnership continues to maintain high levels of quality, accuracy, and timeliness across all service channels. No significant barriers were identified during the 2025–2026 reporting period. Despite increased operational demands, including a 10% rise in email inquiry volume, standards were sustained or improved across most measures.

Opportunities for Improvement

Opportunities within the Quality domain are primarily focused on improving consistency in telephonic interactions and continuing to enhance the user experience across digital platforms. The decline in telephonic Quality indicates a need for ongoing coaching and reinforcement of training, particularly related to referrals, authorizations, and specialty care communication. Continued refinement of training materials, including incorporating staff feedback, will support alignment with procedures.

Website Self-Service results demonstrated significant improvement (3.80 to 4.37), presenting an opportunity to further build on these gains by simplifying navigation, improving Help page guidance, and ensuring consistent usability across all functionalities. Email Quality remains strong at 100%, with an opportunity to sustain this performance through continued auditing and proactive monitoring as volumes increase.

Accuracy performance remains a key strength, but opportunities exist to improve consistency across departments as indicated by RAFR grievance trends. While telephonic Accuracy reached 99.7% and Website Self-Service Accuracy improved to 4.23, the increase in RAFR-related grievances highlights the need for strengthened cross-departmental alignment and clearer communication of policies and procedures. Targeted training for Member Services staff, workflow improvements, and enhanced monitoring will support improved consistency in information provided to members. Additionally, maintaining Email Accuracy and timeliness at 100% will require continued adherence to established audit processes and performance standards.

Prioritization and Next Steps

Moving forward, Member Services will focus on maintaining strong performance in the Accuracy domain while driving targeted improvements within the Quality domain. Efforts will focus on continued telephonic coaching, refresher training, and enhancements to training materials to improve communication consistency. Member Services will also continue to collaborate with the IT Web Team to build on Website Self-Service improvements, focusing on navigation, Help page functionality, and user experience optimization. Additionally, RAFR monitoring will remain a priority, with continued cross-departmental collaboration, and targeted training when needed for Member Services staff to reduce variability in information provided to members. The Quality & Training team will maintain thorough audit practices across all service channels to ensure sustained compliance with performance standards and timely identification of emerging trends to proactively identify areas of opportunity.

Quality in Grand Analysis

QI TRILOGY

NCQA - Grand Analyses

Partnership has established a strong foundation and framework to engage and build community partnerships with our members, health providers and organizations that serve the tenets of our organizational mission of ***"To help our members, and the communities we serve, be healthy,"*** and vision of ***"To be the most highly regarded managed care plan in California."*** Our commitment of continuous quality improvement is summarized within the six (6) Grand Analyses herein and in addition the complete analyses are provided in the appendices.

Under the 2025 NCQA Health Plan Accreditation Standards, the Continuity and Coordination of Behavioral Health (QI4) report and the Continuity and Coordination of Medical Care (QI3) Report are retired.

Access and Availability (NET3) Report

Partnership is meeting access standards for primary care (adult/pediatrics, newborn, urgent appointments, and telephone and after-hours accessibility) and four of six specialty care, high-volume and high-impact specialties (urgent, telephone, and after hours), based on data from our provider surveys and additional internal analysis.

Partnership has experienced a downward trend for adult and pediatric primary care as well as specialty care appointments meeting the appointment standard across both regions since 2020. This coincides with the start of the pandemic. We are experiencing a continued trend of decreasing numbers of providers for multiple reasons including retirement of the baby boomer generation, decreased enrollment into medical schools across the nation, and higher burnout of physicians leading to reduction in available office hours.

While Partnership failed to meet the 15-day appointment standard for Dermatology and Obstetrics Gynecology, this is not due to a lack of contracting with an available service provider. Currently there are no additional qualified providers who are enrolled in Medi-Cal practicing in these geographic areas with whom to contract. Partnership monitors appointment access each quarter and works with individual providers who fail to meet the standard to identify strategies for improvement. Partnership requests and receives approval from DHCS for Alternative Access Standards (AAS) on an annual basis for the geographical areas that fail to meet the standard. If a member lives in an area where services are not covered, Partnership will help those members with making the appointment and arrange transportation to see the specialists that are not within the time or distance standard.

Opportunity

Appointment access to non-urgent primary care decreased by 13% in the southern region. Appointment access for obstetrics and gynecology in the southern region decreased by 19.5%. Partnership has identified the need to increase the number of contracted primary care and women's health specialty care practitioners to the network, particularly in the southern region.

Partnership has chosen primary care and women's health provider recruitment as equal high priority opportunities.

- *Planned Action:* Partnership has updated the Provider Recruitment Program (PRP) that offers a sign-on bonus for providers that are new to the Partnership network. If they are a currently practicing provider, they must come from outside of the Partnership 24 county service area. Providers completing a training

program within the Partnership service area qualify for consideration for an award from the program. This updated program is active between January 2024 – June 2025 with the bonuses being paid out over multiple payments over a 60-month term for physicians, NPs, and PAs, 24 months for behavioral health clinicians, and 12 months for certified SUD counselors. The strategy is to recruit and hold providers in place longer term.

  - Effectiveness of Action: To date there has been an increase in accepted offers with 168 awards approved on average over 12 months, (as compared to a historical average going back to 2014 of 86 awards per year). Family Medicine has been the majority provider specialty awarded, representing nearly 57% of the program awards to date. Partnership was able to recruit 208 new primary care practitioners to the network between January 2024 – April 2025, with 5 of them recruited to 4 of our most rural counties, including Sierra, Modoc, Plumas, and Trinity, whose geographic area is 75% or more rural (according to the US Census Bureau definition). Initial recruitment and retention details look favorable, but we may not know completely until the 60-month time period and further payments take place.

- *Planned Action:* Partnership continued to expand its efforts to strengthen recruitment for specialty providers, including obstetrics providers (physicians, women's health nurse practitioners, certified nurse midwives) whose clinical care focuses on perinatal care, including labor and delivery, to the 2024 PRP.
  - Effectiveness of Action: Fifteen obstetrics providers have been awarded since January 2024.
- *Planned Action:* Partnership launched a provider retention initiative (PRI) pilot in January 2024. The PRI is intended to recognize primary care clinicians, those who offer perinatal services (including labor and delivery) and/or obstetrics/gynecology, who have devoted their careers to the safety net, while helping to incentivize additional years of service from them. Our hope is that the PRI will help preserve institutional knowledge and clinical leadership and mentorship within our network, while an emerging generation of providers can learn from and train with these committed health professionals.
  - Effectiveness of Action: Since January 2024, 65 providers have been awarded and have committed to practice for 3 additional years.

Opportunity

Partnership has identified a need to improve member experience associated with access to care. The Adult Composite score for getting needed care decreased from 76.4% to 74.0% and getting care quickly decreased from 69.5% to 68.1%. Both failed to meet the benchmark for the second year in a row.

- *Planned Action:* To leverage more real time data (i.e., Grievance & Appeals [G&A] and Population Health Management [PHM] community engagement responses) on a quarterly basis to examine and respond timelier to topical themes identified directly from our members, including complaints about the health plan and providers. This enhanced method will provide the CAHPS Goal Team more real-time opportunity to measure intervention effectiveness against targeted barriers

Please see Appendix (A) Access and Availability (NET3) Report for a complete review of the quantitative and qualitative analyses for the learnings while trying to meet the stated goals for each measure noted above.

Pharmacy & Utilization Management (UM1G) Report: Utilization Management

The Annual Utilization Management (UM) Program Evaluation analyzes all aspects of data related to the UM program, identifies gaps and opportunities for improvement, and updates the program as necessary to ensure the program remains current and appropriate.

Key elements in this annual evaluation include program structure, program scope, processes, and information sources, as well as level of involvement of senior-level physicians and designated behavioral healthcare practitioners in the UM program.

In addition, data for member and practitioner experience with the UM process is evaluated to identify improvement and actionable opportunities. This report does not contain Kaiser Permanente or Carelon Behavioral Health data for evaluation of the UM program. Kaiser Permanente and Carelon Behavioral Health are NCQA accredited, and as such, reports from Kaiser Permanente and Carelon Behavioral Health are reviewed through the delegation oversight process.

For 2025, identified opportunities for improvement in the areas of consistency in applying UM criteria, Staffing Oversight, and Provider Education. Overall, it was concluded that Partnership's UM program functions effectively and efficiently through a solid program structure, comprehensive set of policies, and robust support, guidance, and engagement from senior level physicians and advisory committee members.

Please see Appendix (B) Pharmacy & Utilization Management – UM1G Report: Utilization Management for a complete review of the quantitative and qualitative analyses for the learnings while trying to meet the stated goals for each measure noted above. AND Appendix (B) Pharmacy & Utilization Management (UM1B) Supplemental TAR Report.

Member Experience (ME7 C-D) Report

This evaluation highlights year-over-year trends and reflects Partnership's ongoing commitment to listen, learn, and lead efforts that improve the member experience. As a member-centered organization, Partnership recognizes that member experience is fundamental to delivering high-quality, accessible, and equitable care.

To ensure this commitment is met, member experience is systematically measured and evaluated through coordinated, cross-departmental efforts that capture both perception and performance.

What We Measured and Why It Matters

Partnership assesses member experience through two primary channels that provide complementary insights into satisfaction, access, and service delivery:

- **Annual Member Experience Surveys (CY 2024–2025):** CAHPS survey results offer standardized, comparative insights into how members perceive their care, including access, communication, and provider engagement.
- **Grievance and Appeals Reporting (CY 2024–2025):** These data provide real-time, experience-based feedback that highlights barriers, unmet needs, and opportunities for improvement across the delivery system.

Together, these measures form the foundation of the ME 7C-D Grand Analysis, enabling the organization to identify trends, understand root causes, and prioritize actions that improve member satisfaction and overall care experience.

Please see Appendix C: Member Experience (ME7 C-D) Report for a complete review of the prior analysis and associated interventions, including those implemented and proposed for the current program year. For a more current assessment, the next ME7 Grand Analysis Report will be available in early fall 2026.

Health Equity (HE6) Report

The HE 6: Reducing Health Care Disparities is an NCQA standard that examines how Partnership stratifies measures by race, ethnicity, language, and sexual orientation, as well as the prioritization and action taken, as necessary, to improve identified inequities. More specifically, the HE 6 report summarizes the work of Partnership to analyze potential disparities within the member population through an analysis of race and ethnicity, language, and gender data, as well as Partnership's effort to implement impactful interventions to reduce inequities and improve any Culturally and Linguistically Appropriate Services (CLAS) identified through the analysis. The measures of focus for the Grand Analysis report are:

1. Controlling High Blood Pressure (CBP)
2. Hemoglobin A1c Control for Patients with Diabetes (HBD)
3. Prenatal and Postpartum Care (PPC)
4. Child and Adolescent Well Care Visits (WCV)

Partnership completed this Grand Analysis in September 2024 as an element of Health Equity Accreditation (HEA), utilizing MY2023 Health Plan Accreditation (HPA) and MY2023 Managed Care Accountability Set (MCAS) final rates. Partnership completed another Grand Analysis in September 2025 utilizing MY2023 Managed Care Accountability Set (MCAS) final rates.

After Partnership's assessment for statistically significant inequities for the measures of focus, the following disparity classification system was developed to aid in prioritizing disparities based upon measure findings. This is based upon the Strength of recommendation taxonomy used in various clinical guidelines to stratify recommendations:

Disparity Classification
Strong Disparity (Disparity is clearly present when compared to comparator group or goal) • Meets at least <u>three (3)</u> of any of following factors below o MCAS Sample Measure ▪ One group is performing statistically worse in at least one region when compared to the comparator group ▪ Absolute average percentage deficit between group and comparator (minimum performance level) is at least 10% (multiple regions) or 15% in single region in MCAS/HEA measure. ▪ <u>Multiple regions (≥2)</u> where specific group falls below 25th percentile per MCAS measure ▪ At least 1 region where group falls below 25th percentile ▪
Moderate Disparity (Disparity is moderately present when compared to comparator group or goal) • Meets at least <u>three (3)</u> of any of the following factors o MCAS Sample Measure

▪ Absolute Average Percentage deficit between group and comparator (minimum performance level) is at least 10% (multiple regions) or 15% in single region ▪ No group is performing significantly better than comparator group yet at least one (1) group is performing significantly worse per MCAS measure ▪ Multiple regions (≥2) where group falls below 50th percentile ▪ At least one (1) region where group falls below 25th percentile
Weak Disparity (Disparity is uncertain when compared to comparator group or goal) • Meets at least two (2) of any of the following factors: o MCAS Sample Measure ▪ No statistical difference between groups in a region ▪ Absolute Average Percentage deficit between group and comparator (minimum performance level) is at least 5% (multiple regions) or 7% in single region ▪ Only one (1) region where group falls below 50th percentile and no group falls below 25th percentile

No inequities were identified when stratifying the measures of focus by language or gender. After developing this disparity classification system, Partnership identified the following areas of focus:

HEALTH INEQUITIES AREAS OF FOCUS							
Group	Key Measure	MCAS Number of Regions with Statistically Worse Disparity	MCAS Number of Regions with disparity (below 25th)	MCAS Number of additional Regions with disparity (below MPL – 50th)	Absolute Percent Average BELOW MPL across regions below 50th percentile	Category of Dsparity	Number of Years with Same Disparity
White	Controlling Blood Pressure	-	1	0	-1.21%	WEAK	N/A
	Poor HbA1c Control (>9%)	-	0	1	-6%	WEAK	N/A
	Postpartum Care	-	0	0		N/A	N/A
	Timeliness of Prenatal Care	-	0	1	-4.33%	WEAK	N/A
	Well Child Visits (WCV)	-	1	3	-6.02%	MODERATE	N/A
Native Hawaiian and Other Pacific Islander	Controlling Blood Pressure	0	1	0	-61.00%	MODERATE	N/A
	Poor HbA1c Control (>9%)	0	2	0	-12%	STRONG	N/A
	Postpartum Care	0	-	-	-	N/A	N/A
	Timeliness of Prenatal Care	0	-	-	-	N/A	N/A
	Well Child Visits (WCV)	1	3	1	-11.16%	STRONG	N/A
Hispanic or Latino	Controlling Blood Pressure	0	0	1	-4.22%	WEAK	N/A
	Poor HbA1c Control (>9%)	0	0	1	-1%	WEAK	N/A
	Postpartum Care	0	0	0	N/A	NONE	N/A
	Timeliness of Prenatal Care	0	0	0	N/A	NONE	N/A
	Well Child Visits (WCV)	0	0	1	-3.08%	WEAK	N/A

HEALTH INEQUITIES AREAS OF FOCUS							
Group	Key Measure	MCAS Number of Regions with Statistically Worse Disparity	MCAS Number of Regions with disparity (below 25th)	MCAS Number of additional Regions with disparity (below MPL – 50th)	Absolute Percent Average BELOW MPL across regions below 50th percentile	Category of Dsparity	Number of Years with Same Disparity
Black or African American	Controlling Blood Pressure	0	0	0	N/A	NONE	N/A
	Poor HbA1c Control (>9%)	0	1	1	12%	STRONG	N/A
	Postpartum Care	0	0	0	N/A	NONE	N/A
	Timeliness of Prenatal Care	0	2	0	-30.12%	STRONG	N/A
	Well Child Visits (WCV)	1	2	2	-6.57%	STRONG	N/A
Asian	Controlling Blood Pressure	0	0	2	-0.17%	WEAK	N/A
	Poor HbA1c Control (>9%)	0	0	0	N/A	NONE	N/A
	Postpartum Care	0	0	1	-6.71%	WEAK	N/A
	Timeliness of Prenatal Care	0	1	0	-30.12%	WEAK	N/A
	Well Child Visits (WCV)	0	0	4	-6.57%	WEAK	N/A
American Indian and Alaska Native	Controlling Blood Pressure	0	2	0	-11.26%	MODERATE	N/A
	Poor HbA1c Control (>9%)	1	1	2	N/A	STRONG	N/A
	Postpartum Care	1	0	2	-15.57%	STRONG	N/A
	Timeliness of Prenatal Care	1	3	0	-21.78%	STRONG	N/A
	Well Child Visits (WCV)	1	1	3	-5.91%	MODERATE	N/A

While all of the above were identified as areas of focus, Partnership prioritized the following:

1. Timeliness of Prenatal Care (PPC-Pre): Black/African American Members
2. Timeliness of Prenatal Care (PPC-Pre): American Indian/Alaska Natives
3. Timeliness of Postpartum Care (PPC-Post): American Indian/Alaska Natives
4. Well Care Visits (WCV): All Pediatric Members

Partnership first conducted a barrier and root cause analysis for these measures and populations and also identified interventions to reduce the disparities. This is highlighted in the table below:

Group(s) of Focus	Black/African American Members
Percentage Below Minimum Performance Level (MPL)	*NE Region: 9.28% below* *NW Region:50.97* % below Non-Weighted Average: 30.12%
Goal for Specific Group	Improve prenatal visits by at least 5% in the NE or NW region in the Black/African American Member Population within 12 months with the global goal of improvement by 30% in the next 5 years.
Root Cause Analysis	Timely prenatal care is recommended to promote healthy pregnancies via screening and preventative management of a woman's risk factors. Unfortunately, various studies have suggested that fewer timely prenatal visits are associated with poorer pregnancy outcomes such as severe maternal morbidity, maternal death, and infant mortality (Howell, 2018). Research has suggested that insurance availability, transportation, and access to specific providers are key driving factors for receiving timely prenatal care. Partnership identified inequities for Black/African American members in the Northeast and Northwest regions for Timeliness of Prenatal Care.
Barrier Analysis	For prenatal care, researchers found that policy changes that improved eligibility for individuals, made insurance coverage more comprehensive, and improved maternity reimbursement rate was associated with greater attendance in postpartum visits (Saldanha et al., 2023). There has been limited research evaluating prenatal care and postpartum interventions in specific patient groups—namely Black/African American patients. Currently, Black/African American women are at least 3x more likely to experience a pregnancy-related death when compared to White women and have the largest disparity among all the conventional population perinatal health measures (Howell, 2018). However, partnership is currently exploring interventions to positively impact their prenatal and postpartum care. In 2023, the Department of Health Care Services (DHCS) added doula services as a covered benefit. In 2023, Sobczak et al. conducted a literature review of 16 studies (cohort and randomized trials) to evaluate the benefits of utilizing a doula. Their findings suggested that doula support decreased incidence of cesarean or premature labor, low birth weight, and epidural/medical pain management. Finally, Partnership conducted a focus-group-like survey of Black prenatal and postpartum members (n=12) to conduct a survey to better understand if the member attended their appointments, as well as to understand the barriers faced, if any at the Solano County Family Health Services site—which has the largest population of Black/African American members. Overall, the members highlighted that they didn't attend their visits due to one of the following three categories: (1) Incorrect Staff Actions, (2) Schedule Unavailability, (3) Lack Of Transportation. This has motivated Partnership to explore utilizing group visits to streamline staff actions, schedule availability, and coordinate transportation. In 2017, Byerley and Hass conducted a systematic review of 38 studies (8 randomized trials, 23 nonrandomized studies, 6 reports of group outcomes without controls) to evaluate group prenatal care in 20,000+

	women. Overall, Byerley et al. (2017) found a significant increase in rates of breastfeeding and satisfaction in Black/African American members after implementing group prenatal care interventions. Partnership may explore whether clinical site locations will be interested in conducting a pilot to validate the efficacy of utilizing such group visits with Doulas. Long-term, Partnership will explore utilizing a combination of interventions to likely meet the large threshold of members who are not meeting the goal.
Actions for Direct Clinical/Service Measure Improvement	**Intervention #1: Contracting Doulas in Partnership Network:** Partnership is also investigating what education doulas share with utilizing members, to ensure members are receiving appropriate information on the importance of early access to prenatal care as well as postpartum care. Partnership has worked to add doulas to the network and has at least one doula in each region of the network. The health equity officer and other staff have ventured into various community events to help with recruiting various Doulas. **Intervention #2: Increase Diversity of OB GYNs:** Partnership is investigating how to improve the diversity among Obstetrics-Gynecology doctors. To this, Partnership is exploring how to do a baseline assessment of the race and ethnicity demographics of OBs within the network to assess. Partnership will then share this information with respective HR departments to provide guidance to the provider recruitment team at Partnership and incentivize increasing diversity hiring throughout the network to reflect the populations served. Partnership has launched a new provider retention initiative. Specifically, partnership will provide $45,000 award to a Doctor of Medicine/Doctor of Osteopathic Medicine (DO) or $30,000 award to a nurse practitioner/physician assistant for a 3-year commitment. This intervention will be applicable to all clinical sites—especially OB/GYN sites that inhabit locations that serve a large Black/African American population. **Intervention #3: Encourage Clinical Sites to Utilize Dyadic Care Models** Dyadic care models are considered effective for optimizing the care of both the mother and infant. Dyadic care is considered when a provider provides care for a birthing mother and their infant during the same visit. Specifically, the American Academy of Pediatrics recommends prenatal visits to establish pediatric medical homes and postnatal depression screening for the birthing person during pediatric visit (Choy et al. *PLoS One*. 2024 Apr 16;19(4):e0298927). This is based upon the postnatal period being seen as a critical time to support and improve health outcomes of birthing people and their infants. Unfortunately, pregnancy-related morbidity and mortality often occurs within the 6-week postpartum period, and this has been attributed to difficulty in accessing care. Partnership will continue to advocate for sites to adopt dyadic care models—especially in regions where there are limited OB/GYNs and primary care providers.

Group(s) of Focus	American Indian/Alaska Native
Prenatal Percentage Below	*NE Region: 9% Below* *NW Region:* 22% below

Minimum Performance Level (MPL)	*SW Region:* 34% below *Non-Weighted Average:* 21.78% Below
Goal for Specific Group	Improve prenatal visits by at least 5% in the NE or NW region in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement of 22% in the next 5 years.
Postpartum Percentage Below Minimum Performance Level (MPL)	*NE Region: 28% Below* *NW Region:* 3% below *SW Region:* 3% below *Non-Weighted Average:* 11.4% Below
Goal for Specific Group	Improve postpartum visits by at least 5% in the NE region in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement by 12% in the next 5 years.
Root Cause Analysis	Currently, majority of our American Indian/Alaska Native members are located in Humboldt, Mendocino, and Shasta Counties in our NW and NE regions. Tertiary research has suggested that there is a significantly higher rate of maternal morbidity and mortality among this group due to centuries of human rights violations (e.g. massacres, forced relocation, boarding schools) which has translated into generational trauma via epigenetics (Burns et al. *Soc Sci Med*. 2023 Jan;317:115584.). In addition, researchers has identified the following predictors of maternal mortality: older maternal age, pre-existing conditions, prior cesarean section, transportation issues, travel time, administrative burdens which limit Medicaid enrollment and prenatal care update; and various structural racism incidents during healthcare interactions.
Barrier Analysis	Research suggests that there are structural barriers that are exacerbating poor outcomes in our American Indian/Alaska Native community. For example, there are purported to be transportation infrastructure, family welfare system, poor prenatal care infrastructure, and blatant racism that are the key upstream factors that are acting as barriers for improving disparities. Within Partnership's service landscape, the region that is experiencing the greatest disparity for this measure is the NW rural region. Currently, many of Partnership's AI/AN members inhabit this area and likely are experiencing lack of clinic access for all providers. Also, various tribal centers utilize various are held financially accountable to government performance and results act (GPRA) versus HEDIS measures—which are considered less stringent. Therefore, various tribal centers do not have the financial incentive to be intensive with hypertension treatments versus non-tribal health centers. To improve relations, Manage Care Organizations (MCOs) and Partnership specifically, has explored hiring tribal health center liaisons to improve the collaboration between MCOs and tribal centers.
Actions for Direct Clinical/Service Measure Improvement	**<u>Intervention #1: Tribal Health Liaison Hiring and Hosting Tribal Center Event</u>** Partnership has hired a full-time Tribal health liaison to positively impact relationships with tribal health centers, tribal health community members, and provide guidance to help support Tribal member needs. Partnership has recognized partnering with the Tribal community as an organizational initiative and is working to positively impact all

	care received by Tribal members through this partnership and communication with Tribal Health Centers within the network at this time. This work has the potential to improve the member experience of American Indian/Alaska Native members, ensure they are receiving culturally appropriate care, and positively impacting the care received by members who identify with this group. Also, the tribal health liaison will be able to conduct various focal group interviews and possibly identify community-based organizations to able to provide tele-nutrition counseling sessions, funds for delivery of DASH-diet aligned foods. **Intervention #2: Contracting Doulas in Partnership Network:** Partnership is also investigating what education doulas share with utilizing members, to ensure members are receiving appropriate information on the importance of early access to prenatal care as well as postpartum care. Partnership has worked to add doulas to the network and has at least one doula in each region of the network. The health equity officer and other staff have ventured into various community events to help with recruiting various Doulas. In addition, Partnership is trying to contract with doulas in the NE/NW regions to ensure that we are able to outreach to our Tribal community members. **Intervention #3: Advertisements of Transportation Benefit with Translation into Tribal Languages:** Partnership is also investigating what education we can share with utilizing members, to ensure members are receiving appropriate information on the importance of early access to prenatal care as well as postpartum care. For example, partnership has recognized that many members are unaware of the transportation benefit afforded to them. Therefore, they may be unaware that Partnership is able to pay for the lodging fees and transportation for a tribal member anywhere they would like to go if they are seeking prenatal/postpartum care in a separate county. Finally, Partnership would like to engage with and survey members to assess whether they should advertise certain education materials into different languages to ensure they are receptive to our various tribal communities.
Group(s) of Focus	American Indian/Alaska Native Black/African American White
Goal for Specific Group	Improve Well Care Visit attendance by at least 2.5% across multiple regions or at least 5% in 1 single region in any group (e.g.) Black/African American, American Indian/Alaska Native, White within 12 months with global goal of improvement by 5% in the next 5 years.
Root Cause Analysis	Per the DHCS Bold goals, the state is looking to close all racial/ethnic disparities in WCVs by 50% by 2025. Currently, WCVs are low for all populations. A proposed hypothesis of the root cause is that there is a significant shortage of pediatrician

	providers—who are able to conduct the WCVs. Therefore, there is a limitation in conducting the absolute number of visits for all pediatric members—regardless of race/ethnicity/gender identity. Also, by having certain members miss at least 1 visit, this will likely cause a shift to make it impossible to attain the key number of visits by a certain age. Currently, the American Academy of Pediatrics recommends at least 13 well-child visits between birth and 6 years of life.
Barrier Analysis	Overall, researchers found that Well Care Visits (WCV) was the clinical measure that majority of race/ethnic groups have a disparity of not meeting the minimum performance threshold throughout the regions. This suggests that the low WCV rate is more of a quality concern versus a demographic specific concern. Within the American Indian/Alaska Native community, there is a community concern of children being reported for child protective services referrals. Historically, AI/AN children were consistently removed from their homes to adopt western cultures. This has resulted in various family members being concerned with exposing their child to unfamiliar members of the community. Also, Partnership tribal health centers have a challenge with engaging with members due to the ongoing difficulties with recruitment and consistent retention of health workers and leadership. This is due to the Indian health serves being consistently underfunded, leading to rationing of needed services and a crumbling infrastructure. Therefore, Partnership may consider helping with provider recruitment and retention since tribal centers are unlikely to financially compete with other centers. Within the Black/African American community, there is an association with low well child visit attendance due to low levels of maternal education, low income, and poor prenatal care (Wolfe et al., 2018). Partnership can explore implementing interventions to improve tailored interventions to improve well-child care in African American/Black groups. For example, in a systematic review of well care visit redesigns researchers highlighted the efficacy of doing group WCVs. (Coker et al., 2013)
Actions for Direct Clinical/Service Measure Improvement	**Intervention #1: Provider Recruitment Program and Provider Retention Initiatives** Partnership has launched a new provider retention initiative. Specifically, Partnership will provide $45,000 award to a Doctor of Medicine/Doctor of Osteopathic Medicine (DO) or $30,000 award to a nurse practitioner/physician assistant for a 3-year commitment. This intervention will be applicable to all of clinical sites—especially Partnership's tribal centers and sites that inhabit locations that serve a large Black/African American population. **Intervention #2: Group Well Child Visits** Partnership is conducting a pilot with a clinical site to start group well-child visits in a clinical site in Solano county—which has the greatest diversity among Partnership's 14 counties. Long-term, Partnership can explore utilizing a combination of interventions to likely meet the large threshold of members who are not meeting the goal throughout the network. **Intervention #3: Increase Access to BIPOC-related children's book regarding improving immunizations and attending WCVs**

	Partnership's HEO previously published a children's book, Andres Armor, which teaches BIPOC children the importance of vaccines using knight and dragon analogies. He is exploring donating copies of the book and videos to clinical sites to hopefully increase the number of children wanting to attend WCVs and watching the free information play during their provider visits.

In Partnership's assessment of opportunities to improve Culturally and Linguistically Appropriate Services (CLAS), Partnership met or performed better than the member satisfaction target of maintaining member abrasion or dissatisfaction below 1/10th of one percent (0.10%). The 2023 case filings yielded a score of 0.03% relative to language service utilization and were slightly above the threshold target of (1/10th of one percent) 0.10%. The analysis workgroup established a priority ranking based on the number of case filings by category. The Language Barrier/Limited English Proficiency category type resulted in roughly 60% of the total grievances within the 2023 Annual Grievance & Appeals Priority by Category Type, which highlights an opportunity for improvement.

Based on member satisfaction with language-related services and the HE 6 Case Analyses, Member Services and Quality Improvement will implement an intervention in the form of an inter/intradepartmental workgroup. This workgroup will place an emphasized focus on analyzing the leading causes of member dissatisfaction as it relates to CLAS. As a result of the associated grievance volume, the Language Barrier/Limited English Proficiency category type will serve as the basis through which Partnership's intervention workgroup will develop improvement activities.

Furthermore, Partnership's Population Health Department will address this unmet goal by addressing the need to provide written materials to members in their choice of format (such as large print, Braille, audio format, or other) to ensure vision-impaired members are able to understand the information Partnership shares. This goal is monitored through the annual C&L Work Plan. This will be done to provide a more proactive approach for language services.

The completed Grand Analysis report will be submitted with all other Health Equity Accreditation documents for review in June 2025. Partnership will continue completing a Grand Analysis report each year, adjusting to meet the needs of the organization's missing and Health Equity Accreditation standards.

Please see Appendix (D) Health Equity (HE 6) Report for a complete review of the assessment for statistically significant inequities for the measures of focus.

Evaluation Conclusion

QI TRILOGY

Evaluation Conclusion

The 2025-2026 Quality Improvement Program Evaluation demonstrates that Partnership's Quality Improvement (QI) Program remained effective in supporting organizational priorities and fulfilling its responsibility to monitor, assess, and improve the quality, safety, and experience of care delivered to members across its 24-county service area. Throughout the year, the QI Program maintained a strong infrastructure for oversight and accountability while adapting to continued regulatory change, operational growth, data system evolution, and preparation for future product line expansion. Overall, the program's structure, resources, committee oversight, and cross-functional collaboration were sufficient to support the broad scope of activities described in this evaluation.

This evaluation reflects a year of meaningful advancement in several core areas. Partnership sustained organizational readiness for NCQA Health Plan Accreditation renewal and successfully achieved NCQA Health Outcomes Accreditation, while also building a longer-term framework for ongoing accreditation compliance. The QI Program continued to align quality measurement, provider engagement, quality incentive programs, and performance improvement activities with DHCS Managed Care Accountability Set (MCAS) priorities, NCQA requirements, and member experience goals. Partnership also strengthened the data and analytic capabilities needed to support quality reporting, provider improvement work, and readiness for the future implementation of HealthRules Payer® (HRP®) and Partnership Advantage, its Dual Eligible Special Needs Plan (D-SNP).

The evaluation also highlights the importance of Partnership's provider-facing and community-connected improvement model. Regional performance improvement teams, quality measure workgroups, provider coaching, training programs, and value-based incentive structures continued to support improvement in priority clinical measures and reinforce stronger collaboration with provider organizations. At the same time, work related to CAHPS®, access, transportation, and member understanding of benefits reinforced that member experience improvement remains a multi-year priority requiring sustained coordination across departments. Health equity work similarly continued to mature through disparity analysis, cross-functional planning, and integration with the broader Quality Improvement and Health Equity Transformation Program.

While the program was successful overall, this evaluation also confirms the need for continued focus in several areas, including standardization of regional approaches, data completeness, policy review efficiency, and adaptation to changing state and federal requirements. The postponement of the D-SNP go-live date to January 2028 shifted some implementation timelines, but the work completed during FY 2025-2026 strengthened organizational readiness and clarified future quality oversight needs. As Partnership moves into FY 2026-2027, the QI Program is well positioned to build on this year's progress by sustaining accreditation readiness, improving quality and member experience outcomes, supporting targeted provider interventions, strengthening data integrity, and preparing for future operational and regulatory demands. Based on the findings summarized in this evaluation, Partnership concludes that its Quality Improvement Program remains a strong, responsive, and effective framework for advancing quality, safety, equity, and accountability across the organization.

Appendices

QI TRILOGY

NETWORK ADEQUACY REPORT

ASSESSMENT OF NETWORK ADEQUACY

NET 3, ELEMENT A, B: ASSESSMENT OF MEMBER EXPERIENCE ACCESSING THE NETWORK & OPPORTUNITIES TO IMPROVE ACCESS TO NON-BEHAVIORAL HEALTHCARE SERVICES

Table of Contents

Section 1: Objective 3

Section 2: Methodology 4

Section 3: Quantitative Analysis: 6

Member Grievances: 6

CAHPS Composite Scores: 12

Out-of-Network Referrals: 14

Practitioner Availability Results: (Net 1, Element B, C: Practitioners Providing Primary Care & Specialty Care Ratio, Geographic Distribution of Practitioners) 15

Practitioner Accessibility Results: (Net 2 Element A, C: Access to Primary Care & Specialty Care) 236

Section 4: Qualitative Analysis 45

Section 5: Summary of Findings 46

Section 6: Opportunities for Improvement 47

Section 1: Objective

The purpose of this report is to evaluate all aspects of data related to Network Adequacy to ensure Partnership HealthPlan of California (Partnership) provides members with adequate network access for needed healthcare services. The provider types covered include primary care clinicians, medical specialists, and hospitals. Partnership follows the NCQA Network Management Standard requirements, and this report will present those findings.

Partnership HealthPlan of California (PARTNERSHIP) is a managed Medi-Cal Health Plan in Northern California. PARTNERSHIP expanded from 14 counties in 2023 to 24 counties in 2024. Our service area is divided into 6 regions with 13 counties designated as rural, 7 designated as small, and 4 designated as medium by DHCS.

Utilizing access data from our current network, this report evaluates and summarizes the following:

- Member Grievance (Complaints) appeals and member experience about network adequacy for non-behavioral healthcare services from ME7: Element C and D.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results from the ME 7 report.
- Utilization of out-of-network services.
- High Volume and High Impact specialty geographic distribution and Practitioner Ratios (NET 1 Practitioner Availability of Services - Elements B and C).
- Routine Primary Care, Urgent Care, Non- Urgent Specialty Care Practitioner (NET 2 - Accessibility of Services - Elements A and C).
- Analysis from factors 1-3 to determine if there are gaps in the network specific to geographic areas or types of practitioners or providers.

The Network Services Manager of Compliance, Associate Directory of Workforce Development, and the Workforce Development Liaison, are responsible for conducting and summarizing the qualitative analysis.

The report is reviewed and approved by a multi-disciplinary team made up of the Chief Medical Officer, Director of Provider Relations, Senior Director of Member Services & Grievance and Appeals, Director of Network Services, Director of Provider Relations, Associate Directory of Provider Relations, Compliance Manager of Network Services, and Network Services Compliance Program Managers.

Opportunities for improvement are identified by the Chief Medical Officer, Associate Director of Workforce Development, and the Workforce Development Liaison. Decisions and actions are reviewed and approved by the Quality Committee.

Section 2: Methodology

The following data sources were used to evaluate Network Adequacy:

***Member Grievance*:** From the full volume of member grievances evaluated annually, this analysis includes a subset of those grievances that are specifically focused on network adequacy or access to care. Grievance category used was “access”, which includes all grievances related to appointment access or availability within the network.

Member Appeals: Member appeals and second level grievances data (retired in 2025).

2024-2025 CAHPS: Survey results from the ME 7 report for Adult and Child.

***Out of Network (OON) Request/Referral and Utilization*:** Partnership has two distinct types of members, Direct and Non-Direct. For Non-Direct Members, a request for a referral to see an OON specialist must be submitted and prior authorization (approval) are required prior to seeing the specialist. Direct Members do not need to submit a request for a referral or receive prior authorization (approval) before seeing an OON specialist. The ability of Direct Members to self-refer accounts for the number of OON requests and approved referrals being lower than the number of OON claims. Claims data is pulled to determine utilization. Out of network request and claims are analyzed per 1, 000 members. Requests and claims counts are analyzed at the Plan level.

***Practitioner Availability: (Net 1, Element B, C: Practitioners Providing Primary Care & Specialty Care Ratio, Geographic Distribution of Practitioners*):**

Partnership obtained data for contracted primary care, high volume, and high impact specialties from our Data Warehouse which then populates Quest Analytics software to evaluate geographic distribution compared to our established geographic standards set forth in policy (MPNET 100) that were in effect at the time of production. Additionally, practitioner ratios were evaluated for primary care, high volume, and high-impact specialty practitioners. The analysis is based on a comparison of our established standards.

***Practitioner Accessibility: (Net 2 Element A, C: Access to Primary Care & Specialty Care)*:**

The Third Next Available (3NA) survey is a cross-sectional, one-time call during business hours, to provider offices, to evaluate access. This survey is used to evaluate primary care and high volume/high impact specialty appointment access using the following performance standards:

Routine Primary Care Appointments	**< 10 Business Days of Request**
Prenatal Care Appointments	**< 10 Business Days of Request**
Newborn Appointments	**< 48 hours of Discharge of Request**

Urgent Care Appointments	**< 48 hours of Request of Request**
Non-Urgent Specialty Care Appointments	**< 15 Business Days of Request**

The survey is administered by Partnership's provider relations staff annually during the months of March and April and includes all PCP sites and identified high volume/high impact specialists that meet a set threshold of 200 unique member visits a year.

Member Grievances: from the full volume of member grievances evaluated annually, this analysis includes a subset of those grievances that are specifically focused on network adequacy or access to care. The grievance category is used as the "access" category, which includes all grievances related to appointment access for primary care and specialty care providers.

***BEHAVIORAL HEALTH PRACTITIONER AVAILABILITY AND ACCESSIBILITY*:** Behavioral health data is analyzed in the Annual Behavioral Health Report. Additionally, Carelon Behavioral Health is Partnership's delegated entity, and are NCQA accredited.

Section 3: Quantitative Analysis:

MEMBER GRIEVANCES:

TOTAL ACCESS MEMBER GRIEVANCES:

The trending data includes reporting periods; January 1, 2025 – December 31, 2025, and the previous year, January 1, 2024 – December 31, 2024.

In 2024, there were a total of 5,477 grievances submitted by our members. The analysis attributes 42% of all cases to Access.

In comparison to the 2025 reporting period, there were a total of 5,638 grievances submitted by our members. The analysis attributes 46% of all cases to Access.

Grievances Reporting Period: Annual 2024 vs 2025								
	Previous Period: 2024			Current Period: 2025				
NCQA Category	Grievances	Avg Mship	Grievances p/1,000	Grievances	Avg Mship	Grievances p/1,000	Threshold	Threshold Met?
ACCESS	2,567	905,570	2.83	2,570	901,645	2.85	3.12	Yes

- **Notable Findings:** Partnership met the established 3.12 grievances per 1,000 member threshold, having 2.85 grievances per 1,000 members in 2025. This number represented a 0.02 increase in grievances per 1,000 members when compared to the 2.83 grievances per 1,000 members in 2024.

MEMBER APPEALS:

The trending data includes reporting periods; January 1, 2025 – December 31, 2025, and the previous year, January 1, 2024 – December 31, 2024.

In 2024, the health plan received 672 Appeals and Second Level Grievance cases, with Access contributing 66% of the total.

In comparison to the 2025 reporting period, the health plan received a total of 848 Appeals and Second Level Grievances cases with Access contributing 75% of the total.

Appeals Reporting Period: Annual 2024 vs 2025								
	Previous Period: 2024			Current Period: 2025				
NCQA Category	Appeals & SLG	Avg Mship	Appeals & SLG p/1,000	Appeals & SLG	Avg Mship	Appeals & SLG p/1,000	Threshold	Threshold Met?
ACCESS	442	905,570	0.49	634	901,645	0.70	0.54	No

Notable Findings: Partnership did not meet the access Appeals and Second Level Grievances threshold for 2025.

Partnership membership decreased by 0.4% from 905,570 to 901,645. The total number of grievances filed per 1,000 members increased to 6.25 from 6.05, a 3.3% increase. Partnership met the minimum threshold for Access related Grievances in 2025 with the total number holding steady as compared to 2024. Over 43.4% of the reported concerns pertained to transportation services. Common complaints include missed rides, delayed driver arrivals, and scheduling inconsistencies.

Partnership did not meet the threshold for Access Appeals in 2025 with a 30% increase from 2024. The total number of cases filed per 1,000 members increased from 0.49 – 0.70. Grievance and Appeals experienced a steady increase in appeals each quarter in 2025. This is primarily attributed to an increase in Community Supports-related appeals, specifically the Medically Tailored Meals benefit. Partnership released a new Community Supports policy in August 2025 outlining the eligibility criteria for each of the benefits available, including Medically Taylored Meals. This led to members being suddenly denied after having received 2-3 rounds of the service previously.

PRIMARY CARE ACCESS MEMBER GRIEVANCE

Partnership analyzes total access grievances by region and practitioner group to determine if there are access trends. Grievance data utilized for the analysis is for the calendar year, January 1st - December 31st.

Region	Appt. Availability	Office Availability	Telephone Availability	Total
Auburn	18	0	4	22
Chico	23	1	2	26
Eureka	13	0	2	15
Fairfield	65	0	13	78
Redding	18	1	4	23
Santa Rosa	17	0	2	19
Totals	154	2	27	183

Member Grievances Primary Care (Everest Data, 2024)

Region	Appt. Availability	Office Availability	Telephone Availability	Total
Auburn	36	0	17	53
Chico	18	1	5	24
Eureka	22	0	4	26
Fairfield	30	0	7	37
Redding	12	1	4	17
Santa Rosa	18	0	1	19
Totals	136	2	38	176

Member Grievances Primary Care (Everest Data, 2025)

The threshold for review is based on the total number of grievances of two or more in any one category and a rate of 4/1000 members.

Primary Care Access Grievance Data (January 1 – December 31)								
Region	**County**	**Provider Name**	**Appt. Availability**	**Office Availability**	**Telephone Availability**	**Total**	**Total Members Assigned to Provider**	**Rate per 1000 Members**
	Placer	Chapa-De Indian Health	1		2	3	5,743	0.5
		WellSpace Health Roseville	12		3	15	6,826	2.2
		WellSpace Health Sunrise	5		1	6	3,311	1.8
Chico	Butte	Ampla Health Chico	7		1	8	15,244	0.5
Eureka	Humboldt	Fortuna Family Medicine	2		1	3	2,264	1.32
	Lake	Adventist Health Clearlake	2			2	6,318	0.3
Fairfield	Solano	La Clinica North Vallejo	3			3	10,036	0.3
		Solano County Health Services Vallejo	3		3	6	12,246	0.5

Member Complaints Primary Care (Everest Data, 2025)

- **Notable findings:** In 2025, the access to specialty care member grievances decreased from 183 in 2024 to 176. Appointment availability remains the most common type of grievance.

  - WellSpace Health Roseville had the highest appointment availability, telephone availability, and overall total grievances with a rate of 2.2 per 1000 members. The rating is within the standard and requires no further action.
  - Ampla Health Chico had the second highest grievances in appointment availability with a rate of 0.5. The rating is within the standard. No further action is currently required.
  - WellSpace Sunrise had the third highest number of grievances for appointment availability with a rating of 1.8. The rating is within the standard. No further action is currently required.

A trend could not be established due to low the low number of member grievances over the course of a year. No further action is currently required.

SPECIALTY CARE MEMBER GRIEVANCE:

Partnership analyzes total access complaints by region and practitioner group to determine if there are access trends. Grievance data utilized for the analysis is for the calendar year, January 1st - December 31st.

Region	Appt. Availability	Office Availability	Telephone Availability	Total
Auburn	2			2
Chico	6			6
Eureka	1			1
Fairfield	4			4
Redding	2			2

Santa Rosa	1			1
Totals	16			16

Member Complaints Specialty Care (Everest Data, 2024)

Region	Appt. Availability	Office Availability	Telephone Availability	Total
Auburn	2			2
Chico	6			6
Eureka	1			1
Fairfield	4			4
Redding	2			2
Santa Rosa	1			1
Totals	16			16

Member Grievances Specialty Care (Everest Data, 2025)

The threshold for review is based on the total number of grievances of two or more in any one category.

Specialty Care Access Grievance Data (January 1, 2025 – December 31, 2025)							
Region	County	Provider Name	Appt. Availability	Office Availability	Telephone Availability	Total	High Volume or High Impact Specialty
Eureka	**Humboldt**	North Pacific Dermatology	**2**			**2**	High Volume Specialty

Specialty Care Access Grievance Data (Everest, 2025)

- **Notable findings:** In 2025, the access to specialty care member grievances decreased from 16 to 14. Appointment availability remains the most common type of grievance. Six high-volume specialties had one appointment grievance each for the reporting year and one had two appointment grievances.
  - North Pacific Dermatology: Despite having two grievances for appointment availability, the provider was within appointment standards with the 3NA survey. A trend could not be established. No further action is currently required.

Cultural, Ethnic, Racial, LGBTQ+ Discrimination Grievances

Partnership looks at network adequacy for issues pertaining to race, ethnicity, and language to ensure practitioners are meeting member needs. This report identifies member-reported grievances which are classified into four discrimination categories which include: Cultural, Ethnic, Racial (CE&R), and LGBTQ+. For Language grievances, we identify language discrimination and language barriers.

The table below outlines the summary of discrimination grievances for 2024.

Discrimination Grievances (January 1, 2024 - December 31, 2024)						
Region	County	Provider	Specialty	Discrimination Grievances		
				CE&R	Linguistic	LGBTQ+
Auburn	Placer	Baird, Rowan Chantel MD	Family Medicine		1	
Auburn	Placer	Jahangir Mahmoudi, MD	Endocrinology	1		
Chico	Yuba	Angeli Duran, MD	Internal Medicine	1		
Chico	Butte	Enloe General & Colorectal Surgery	Multi-Specialty Group		1	
Fairfield	Solano	Bay Area Ortho Surgery	Orthopedic Surgery		1	
Fairfield	Solano	Rashid Iqbal Gastro Office	Gastroenterology	1		
Redding	Siskiyou	Nicholas Schulack, DO	Emergency Medicine	1		
Redding	Shasta	Hill Country – Center of Hope	Family Medicine		1	
Redding	Shasta	Lassen Medical Center-Red Bluff	Family Medicine			1

Source: 2024 Discrimination Grievances Data: 1Q25 Grievance and Appeals PULSE Report

The table below outlines the summary of discrimination grievances for 2025. The 2024 Linguistic category was separated into Language Discrimination and Language Barrier.

Discrimination Grievances (January 1, 2025 - December 31, 2025)							
Region	County	Provider	Specialty	Discrimination Grievances			
				CE&R Discrim	LGBTQ+ Discrim	Language Discrim	Language Barrier
Auburn	Placer	WellSpace Health Roseville	Family Medicine			1	
Auburn	Placer	Capital Allergy & Respiratory	Allergy & Immunology			1	
Auburn	Nevada	Blue Stone Health and Wellness	Family Medicine	1			
Chico	Butte	Enloe Medical Center	Multi-Specialty and Internal Medicine		2		
Eureka	Mendocino	Adventist Health Mendo Coast	Family Medicine	1			
Eureka	Humboldt	Titanium Healthcare	Family Medicine	1			
Fairfield	Solano	Teodoro Pedro Nissen, MD	Orthopedic Surgery			1	
Fairfield	Yolo	Sutter Medical Center Sacramento	Family Medicine	1			
Fairfield	Solano	Jayesh Patel, MD	Internal Medicine			2	
Fairfield	Solano	Center for Primary Care-Vacaville	Family Medicine			2	
Fairfield	Yolo	Hearing Pathways	Speech Pathologist			2	
Redding	Shasta	Thomas Russ, MD	Internal Medicine & Cardiovascular disease		1		
Redding	Shasta	Shasta Regional Medical Group	Family Medicine			2	
Redding	Siskiyou	Mercy Medical Center	General Acute Care Hospital		2		
Redding	Tehama	Tarichi Primary Care	Family Medicine			1	
Redding	Tehama	Joseph Eischen	Family Medicine		1		
Santa Rosa	Sonoma	Accent Care of California	Home Health			1	

Source: 2025 Discrimination Grievances Data: 1Q26 Grievance and Appeals PULSE Report

- **Notable Findings:** The most common reported problem was alleged discrimination due to language. The second most common was alleged discrimination due to LGBTQ+. All concerns were addressed by the usual grievance process. Further action is not required.

  An examination of discrimination cases from 2024 to 2025 showed a significant increase of 60%. This is particularly disheartening as there was previously a two-year decline in overall cases.

  Partnership implemented a comprehensive approach in handling cases of alleged discrimination whereby, upon identification of instances where discrimination is most likely to have occurred, G&A initiates a proactive measure of implementing a Soft-Warning Letter aimed at fostering awareness and corrective action within the provider community. These letters serve as a formal communication channel providing educational resources that are tailored to assist in understanding and implementing practices that promote inclusiveness and prevent discrimination against our members.

2023- 2024 CAHPS Composite Scores:

CAHPS Results from ME7 Report: Adult Response

Below is a year-by-year comparison of the Composite scores for measurement year 2023 and measurement year 2024 for the Adult Survey. In Year 2024-2025, we received 1 more complete survey than in Year FY 2023-2024. All questions met the 100 sample size criteria for both measurement periods.

	ADULT CAHPS Composite	2023-2024 (15.3% Response Rate) Sample Size 3,375 Total Returns 510	2023 Percentile Rate	Partnership Benchmark	PHC Benchmark Met?	2024-2025 (15.3% Response Rate) Sample Size 3,375 Total Returns 511	2024 Percentile Rate	Partnership Benchmark	PHC Benchmark Met?
Composite Measure	Getting Needed Care (% Always or Usually)	74.0%	7th	≥ 33rd	No	74.5%	5th	≥ 33rd	No
	Getting Care Quickly (% Always or Usually)	68.1%	<5th	≥ 33rd	No	74.0%	11th	≥ 33rd	No

Notable Findings: The Adult Composite score for getting needed care increased by 0.5% to 74.5% and getting care quickly increased from 68.1% to 74.0%. Both failed to meet the benchmark.

The Adult survey response relative to Partnership covered members indicates we continue to have dissatisfaction with member access which influences health plan ratings. Stakeholders determined that continued intervention focused on; Getting Needed Care and Getting Care Quickly composite measures and Rating of Health Plan would be in scope for the CAHPS® Score Improvement (CSI) Goal for FY 2025-2026.

CAHPS Results from ME7 Report: Child Response

Below is a year-by-year comparison of the Composite scores for measurement year 2023 and measurement year 2024 for the Child Survey. In Year 2024-2025, we received 124 more complete surveys than in Year FY 2023-2024. All questions met the 100 sample size criteria for both measurement periods.

	CHILD CAHPS Composite	2023-2024 (16.1% Response Rate) Sample Size 4,125 Total Returns 659	MY 2023 Percentile Rate	Partnership Benchmark	Benchmark Met?	2024-2025 (15.8% Response Rate) Sample Size 5,00 Total Returns 783	MY 2024 Percentile Rate	Partnership Benchmark	Benchmark Met?
Composite Measure	Getting Needed Care (% Always or Usually)	77.1%	14th	≥ 33rd	No	77.9%	13th	≥ 33rd	No
	Getting Care Quickly (% Always or Usually)	78.9%	9th	≥ 33rd	No	80.0%	13th	≥ 33rd	No

- **Notable Findings:** The Child composite score for Getting Needed Care increased from 77.1% to 77.9% and Getting Care Quickly increased from 78.9% to 80.0%. However, both measures failed to meet the benchmark.

  The Child survey responses relative to Partnership covered members indicate we continue to have dissatisfaction with member access and correlating impact to member experience which influences health plan ratings. Stakeholders determined that continued intervention focused on; Getting Needed Care and Getting Care Quickly composite measures would be in scope for the CAHPS® Score Improvement (CSI) Goal for FY 2025-2026.

QUALITATIVE ANALYSIS FOR MEMBER SATISFACTION: GRIEVANCE, APPEALS, AND CAHPS

Our expanded service area revealed important insights about how healthcare needs and experiences vary across Northern California communities. CAHPS® survey results highlighted differences in how adult and child populations experience care across regions, with Tehama County demonstrating the most significant variations. These regional differences deepen our understanding of how service delivery and member satisfaction interact across diverse geographic areas.
These service delivery challenges reflect broader healthcare system constraints, as California continues to experience workforce shortages across clinical and non-clinical positions. This staffing environment, combined with Partnership's significant growth, likely will continue ongoing pressure on appointment availability and service delivery.

Looking ahead, additional external factors may significantly influence member experience. The implementation of H.R.1, the One Big Beautiful Bill Act (HR1) changes are expected to impact Medi-Cal eligibility and coverage transitions, in particular Adults 19 years of age or older. These mandates, coupled with ongoing redetermination processes, could affect how adult members perceive and access healthcare services. As communities navigate these changes, member satisfaction scores may reflect both system-wide adjustments and individual challenges in maintaining continuous care.

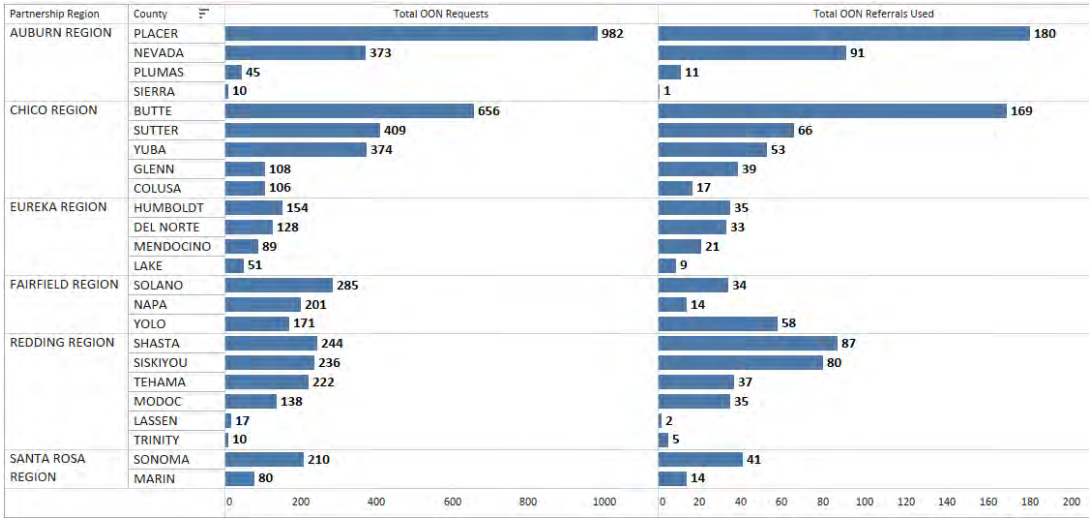
Barriers identified: Grievance and Appeals experienced a increase in access appeals due to a change in program elibility criteria that has since been rectified.

Partnership is aware there is a national and regional shortage of clinical professionals and aging clinical professionals retiring. The fluctuation of Access measure performance identified coupled with performance not improving to pre-COVID, indicates inconsistency with access to care and service delivery.

Out-of-Network Requests:

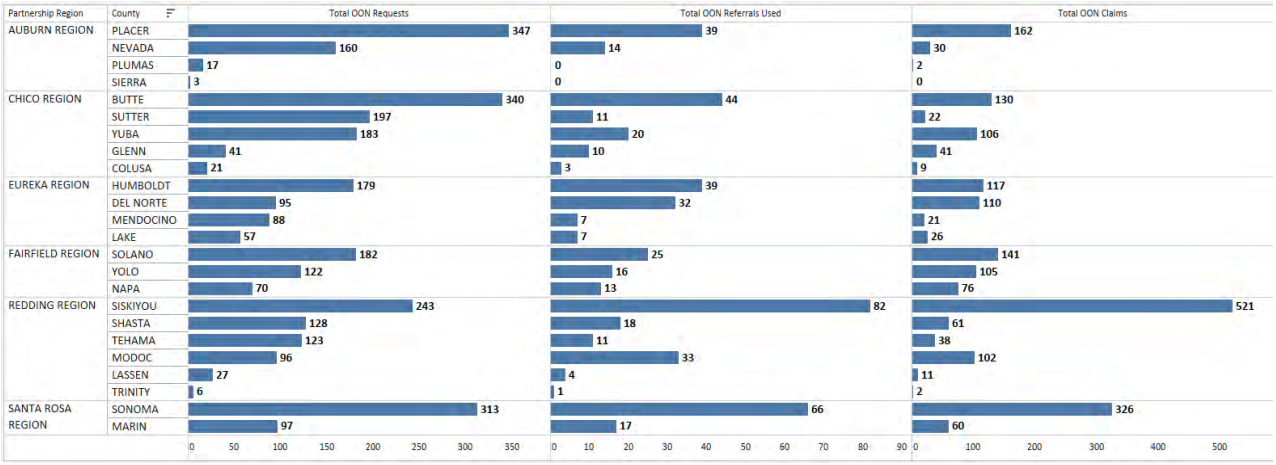
The out of network requests per 1,000 members' threshold is less than or equal to 20. The Threshold for out of network utilization is less than or equal to 10 per 1,000 members.

	AUBURN REGION	CHICO REGION	EUREKA REGION	FAIRFIELD REGION	REDDING REGION	SANTA ROSA REGION	Grand Total
Distinct Members	95,974	189,666	146,315	183,081	133,122	158,709	906,867
Total OON Requests	1,410	1,653	422	657	867	290	5,299
OON Requests per 1,000 Members	14.7	8.7	2.9	3.6	6.5	1.8	5.8
Approved OON Requests	996	1,089	268	508	672	166	3,699
Approved OON Requests per 1,000 M..	10.4	5.7	1.8	2.8	5.0	1.0	4.1
Denied OON Requests	414	564	154	149	195	124	1,600
Denied OON Requests per 1,000 Members	4.3	3.0	1.1	0.8	1.5	0.8	1.8
Total OON Referrals Used	283	344	98	106	246	55	1,132
Total OON Claims	1,546	1,341	538	466	1,426	339	5,656
OON Claims per 1,000 Members	16.1	7.1	3.7	2.5	10.7	2.1	6
Approved OON Claims	1,126	1,075	322	386	729	219	3,857
% Approved OON Claims	72.8%	80.2%	59.9%	82.8%	51.1%	64.6%	68.2%
Denied OON Claims	420	266	216	80	697	120	1,799
% Denied OON Claims	27.2%	19.8%	40.1%	17.2%	48.9%	35.4%	31.8%



Notable findings: For the period of January 2024 – December 2024, Partnership met performance goals for requests and utilization.

	AUBURN REGION	CHICO REGION	EUREKA REGION	FAIRFIELD REGION	REDDING REGION	SANTA ROSA REGION	Grand Total
Distinct Members	96,193	189,682	141,579	182,974	129,273	155,574	895,275
Total OON Requests	527	782	419	374	623	410	3,135
OON Requests per 1,000 Members	5.5	4.1	3.0	2.0	4.8	2.6	3.5
Approved OON Requests	175	362	188	130	361	208	1,424
Approved OON Requests per 1,000 M..	1.8	1.9	1.3	0.7	2.8	1.3	1.6
Denied OON Requests	352	420	231	244	262	202	1,711
Denied OON Requests per 1,000 Members	3.7	2.2	1.6	1.3	2.0	1.3	1.9
Total OON Referrals Used	53	88	85	54	149	83	512
Total OON Claims	194	308	274	322	735	386	2,219
OON Claims per 1,000 Members	2.0	1.6	1.9	1.8	5.7	2.5	2
Approved OON Claims	154	221	197	241	467	192	1,472
% Approved OON Claims	79.4%	71.8%	71.9%	74.8%	63.5%	49.7%	66.3%
Denied OON Claims	40	87	77	81	268	194	747
% Denied OON Claims	20.6%	28.2%	28.1%	25.2%	36.5%	50.3%	33.7%



Notable findings: For the period of January 2025 – December 2025, Partnership met performance goals for requests and utilization.

The number of OON Requests decreased from 5,299 in 2024 to 3,135 in 2025. The number of OON Claims decreased from 5,656 in 2024 to 2,219 in 2025.

January 2024 – December 2024:

Requests: As a plan, Partnership met the goal of less than 20 per 1,000 members for requests. Out of 5,299 OON Referral submitted (5.8 per 1,000 members) in 2024, 3,699 (70%) were approved. The counties with the highest number of requests included Placer County with 19%, Butte County with 12%, and Sutter County with 8%. Some requests were due to excessive appointment wait times or excessive driving distance, and approvals were

allocated in those instances. Where services were available in network, those requests were denied. Of the 5,299 requests submitted, 1,600 (30%) of requests were denied.

Utilization: There was 5,656 OON Claims submitted (6 per 1,000 members) meeting the 10 or less per 1,000 members performance goal for utilization. This appears to demonstrate that authorization review processes are effectively identifying and redirecting out-of-network requests to qualified in-network providers and practitioners. The three specialties with the highest OON requests included: Oncology/Hematology with 48% of requests used, Dermatology with 7% of requests used, and Optometry with only .8% of requests used. Of the 5,656 OON Claims submitted, 3,857 (68%) were approved and 1,799 (32%) were denied. Of the 3,699 approved requests Plan wide, 1,132 (31%) were used. A closer look at the Auburn Region shows that Placer County had the highest utilization with the total OON Claims per 1.000 members at 17.7. The most requested referral was Gastroenterology with 3.7% being Out of Network.

January 2025 – December 2025:

Requests: Partnership met the goal of less than 20 per 1,000 members for requests. Out of the 3,135 OON Requests submitted (2.6 per 1,000 members) in 2025, 1,424 (45%) were approved and 1,711 (55%) of requests were denied. The counties with the highest number of requests included Placer County with 11.2%, Butte County with 10.8%, and Sonoma County with 10%. Some requests were due to excessive appointment wait times or excessive driving distance, and approvals were allocated in those instances. Where services were available in network, those requests were denied.

Utilization: There was 2,219 OON Claims submitted (2 per 1,000 members) meeting the 10 or less per 1,000 members performance goal for utilization. Of the 2,219 OON Claims submitted, 1,425 (66%) were approved and 794 (38%) were denied. This appears to demonstrate that authorization review processes are effectively identifying and redirecting out-of-network requests to qualified in-network providers and practitioners. Of the 794 approved requests Plan wide, 512 (64%) were used. The three specialties with the highest OON requests included: Dermatology with 54% of requests used, General Surgery with 38% of requests used, and Plastic/Reconstructive Surgery with 38% of requests used. Analysis of data on paid claims did not reveal additional insights related to the practitioner network.

PRACTITIONER AVAILABILITY RESULTS: (NET 1, ELEMENT B, C: PRACTITIONERS PROVIDING PRIMARY CARE & SPECIALTY CARE RATIO, GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS

The following table summarizes the findings for Primary Care practitioners for 2024.

Practitioner Ratios: Primary Care – Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure: Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Primary Care Practitioner Overall	1,272	915,046	Primary Care Practitioner to Member (adult and children)	1:719	1:≤ 2,000	MET
Family or General Practice	741	915,046	Family or General Practice Practitioner to Member (adult and children)	1:1,235	1:≤ 2,000	MET
Pediatrics	296	334,640	Pediatricians to Members (children)	1:1,130	1:≤ 2,000	MET
Internist	235	580,406	Internists to Members (adult)	1:2,469	1:≤ 3,000	MET

Practitioner Ratios: Primary Care (April 2024)

The following table summarizes the findings for Primary Care practitioners for 2025.

Practitioner Ratios: Primary Care – Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure: Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Primary Care Practitioner Overall	1,185	903,499	Primary Care Practitioner to Member (adult and children)	1:762	1:≤ 2,000	MET
Family or General Practice	664	903,499	Family or General Practice Practitioner to Member (adult and children)	1:1,361	1:≤ 2,000	MET
Pediatrics	264	283,146	Pediatricians to Members (children)	1:1,073	1:≤ 2,000	MET
Internist	257	620,353	Internists to Members (adult)	1:2,414	1:≤ 3,000	MET

Practitioner Ratios: Primary Care (April 2025)

Notable findings: The Plan met the standard for all Primary Care Practitioners in 2025 without any significant changes from 2024. Interventions are not currently indicated

- The primary care overall ratio exceeded the performance goal. There was a 5.7% decrease from 2024.

- The family or general practice care ratio exceeded the performance goal. There was a 9.3% decrease from 2024.
- The pediatric primary care ratio exceeded the performance goal. There was a 5% improvement from 2024.
- The internal medicine ratio exceeded the performance goal. There was a 2.2% improvement from 2024.

The DHCS standard for primary care is a provider to member ratio of 1:2000 that combines Family Medicine with Internal Medicine for adults and Family Medicine with Pediatric Medicine for children. NCQA looks at all three types of primary care providers separately.

The following table summarizes the findings for High Volume Specialists for 2024.

Practitioner Ratios: High Volume Specialists - Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Obstetrics/Gynecology	523	379,253	OB-GYN to Member	1:725	1: ≤ 5,000	MET
Cardiology	459	915,046	Cardiologist to Member	1:1,994	1: ≤ 10,000	MET
General Surgery	413	915,046	General Surgery to Member	1:2,216	1: ≤ 10,000	MET
Orthopedic	356	915,046	Orthopedic Surgeon to Member	1:2,570	1: ≤ 10,000	MET
Ophthalmology	261	915,046	Ophthalmologist to Member	1:3,506	1: ≤ 10,000	MET
Dermatology	212	915,046	Dermatologist to Member	1:4,316	1: ≤ 15,000	MET

Practitioner Ratios: Tableau Dashboard - High Volume Specialist (April 2024)

The following table summarizes the findings for High Volume Specialists for 2025.

Practitioner Ratios: High Volume Specialists - Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Obstetrics/Gynecology	581	371,707	OB-GYN to Member	1:640	1: ≤ 5,000	MET
Cardiology	505	903,499	Cardiologist to Member	1:1,789	1: ≤ 10,000	MET

General Surgery	442	903,499	General Surgery to Member	1:2,044	1: ≤ 10,000	MET
Orthopedic	393	903,499	Orthopedic Surgeon to Member	1:2,299	1: ≤ 10,000	MET
Ophthalmology	275	903,499	Ophthalmologist to Member	1:3,285	1: ≤ 10,000	MET
Dermatology	220	903,499	Dermatologist to Member	1:4,107	1: ≤ 15,000	MET

Practitioner Ratios: Tableau Dashboard - High Volume Specialist (April 2025)

- **Notable findings**: The six high-volume specialties remained unchanged from 2024. Partnership comfortably met the provider ratio standards for all high-volume specialist providers. Interventions are not currently indicated.

  - The obstetrics/gynecology provider ratio exceeded the performance goal with a 11.7% increase from 2024.
  - The cardiology provider ratio exceeded the performance goal with a 10.0% increase from 2024.
  - The general surgery provider ratio exceeded the performance goal with a 7.8% increase from 2024.
  - The orthopedic provider ratio exceeded the performance goal with a 10.5% increase from 2024.
  - The ophthalmology provider ratio exceeded the performance with a 6.3% increase from 2024.
  - The dermatology provider ratio exceeded the performance goal with a 4.2% increase from 2024.

The following table summarizes the findings for High Impact Specialists for 2024.

Practitioner Ratio: High Impact Specialists - Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure: Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Oncology Hematology	230	915,046	Oncology Hematology to Member	1:3,978	1: ≤ 25,000	MET

Practitioner Ratio: Tableau Dashboard -High Impact Specialists (April 2024)

The following table summarizes the findings for High Impact Specialists for 2025.

Practitioner Ratio: High Impact Specialists - Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure: Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Oncology Hematology	254	903,499	Oncology Hematology to Member	1:3,557	1: ≤ 25,000	MET

Practitioner Ratio: Tableau Dashboard -High Impact Specialists (April 2025)

- **Notable findings:** The total number of oncology/hematology practitioners in the network increased from 2024. The provider to member ratio also improved by 10.6%. No plan-wide interventions are currently indicated.

GEOGRAPHIC DISTRIBUTION: PRIMARY CARE PRACTITIONERS

The following table summarizes the 2024 findings for Primary Care Practitioners

Geographic Distribution of Primary Care – Standards and Performance Goals				
Practitioner Type	**Standard: Geographic Distribution**	**Results**	**Performance Goal**	**Goal Met?**
Primary Care Practitioner Overall	1 within 10 miles or 30 minutes from the member's residence	97.59%	≥ 95%	MET
Family Medicine or General Practitioner	1 within 10 miles or 30 minutes from the member's residence	99.9%	≥ 95%	MET
Pediatrician	1 within 10 miles or 30 minutes from the member's residence	96.0%	≥ 95%	MET
Internal Medicine	1 within 10 miles or 30 minutes from the member's residence	96.6%	≥ 95%	MET

Geographic Distribution of Primary Care (Quest Analytics, December 2024)

The following table summarizes the 2025 findings for Primary Care Practitioners

Geographic Distribution of Primary Care – Standards and Performance Goals				
Practitioner Type	**Standard: Geographic Distribution**	**Results**	**Performance Goal**	**Goal Met?**
Primary Care Practitioner Overall	1 within 10 miles or 30 minutes from the member's residence	96.8%	≥ 95%	MET
Family Medicine or General Practitioner	1 within 10 miles or 30 minutes from the member's residence	99.8%	≥ 95%	MET
Pediatrician	1 within 10 miles or 30 minutes from the member's residence	97.2%	≥ 95%	MET
Internal Medicine	1 within 10 miles or 30 minutes from the member's residence	96.2%	≥ 95%	MET

Geographic Distribution of Primary Care (Quest Analytics, November 2025)

➢ **Notable findings:** Partnership met the plan-wide geographic distribution of "Primary Care Practitioner Overall" standard and the individual performance standard for each PCP specialty. No interventions are currently indicated.

- The primary care practitioner overall geographic distribution remained stable from 2024 to 2025 with a 0.8% decrease.
- The family medicine practitioner geographic distribution had a 0.1% decrease from 2024.
- The pediatrician geographic distribution had a 1.2% increase from 2024.
- The internal medicine geographic distribution remained stable with a 0.4% decrease from 2024

Geographic Distribution of Primary Care by County – Standards and Performance Goals						
Region	**County**	**Specialty Type**	**Standard: Geographic Distribution**	**Result**	**Performance Goal**	**Goal Met?**
Redding	Lassen	Internal Medicine	1 within 10 miles or 30 minutes	83.3%	≥ 95%	Not MET
		Family Practice		90.1%		Not MET
		Pediatrics		83.3%		Not MET
	Modoc	Internal Medicine	1 within 10 miles or 30 minutes	67.4%	≥ 95%	Not MET
		Family Practice		98.6%		MET
		Pediatrics		0%		Not MET
	Shasta	Internal Medicine	1 within 10 miles or 30 minutes	93.9%	≥ 95%	Not MET
		Family Practice		99.9%		MET
		Pediatrics		93.9%		Not MET
	Siskiyou	Internal Medicine	1 within 10 miles or 30 minutes	52.3%	≥ 95%	Not MET
		Family Practice		99.6%		MET
		Pediatrics		86.4%		Not MET
	Trinity	Internal Medicine	1 within 10 miles or 30 minutes	16.5%	≥ 95%	Not MET
		Family Practice		98.5%		MET
		Pediatrics		88.5%		Not MET
	Tehama	Internal Medicine	1 within 10 miles or 30 minutes	99.6%	≥ 95%	MET
		Family Practice		99.9%		MET
		Pediatrics		99.5%		MET
Eureka	Humboldt	Internal Medicine	1 within 10 miles or 30 minutes	95.4%	≥ 95%	MET
		Family Practice		100%		MET
		Pediatrics		99.6%		MET
	Del Norte	Internal Medicine	1 within 10 miles or 30 minutes	99.9%	≥ 95%	MET
		Family Practice		99.9%		MET
		Pediatrics		99.9%		MET
	Mendocino	Internal Medicine	1 within 10 miles or 30 minutes	96.7%	≥ 95%	MET
		Family Practice		100%		MET
		Pediatrics		91.6%		Not MET
	Lake	Internal Medicine	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
		Family Practice		100%		MET
		Pediatrics		100%		MET
Chico	Butte	Internal Medicine	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
		Family Practice		100%		MET
		Pediatrics		100%		MET
	Sutter	Internal Medicine	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
		Family Practice		100%		MET
		Pediatrics		100%		MET

	Yuba	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
		Family Practice		100%		MET
		Pediatrics		100%		MET
	Glenn	Internal Medicine	1 within 10 miles or 30 minutes	99.0%	≥ 95%	MET
		Family Practice		99.6%		MET
		Pediatrics		99.6%		MET
	Colusa	Internal Medicine	1 within 10 miles or 30 minutes	99.4%	≥ 95%	MET
		Family Practice		99.7%		MET
		Pediatrics		99.7%		MET
Auburn	Placer	Internal Medicine	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
		Family Practice		100%		MET
		Pediatrics		100%		MET
	Nevada	Internal Medicine	1 within 10 miles or 30 minutes	99.9%	≥ 95%	MET
		Family Practice		100%		MET
		Pediatrics		99.9%		MET
	Plumas	Internal Medicine	1 within 10 miles or 30 minutes	0.9%	≥ 95%	Not MET
		Family Practice		100%		MET
		Pediatrics		0.9%		Not MET
	Sierra	Internal Medicine	1 within 10 miles or 30 minutes	89.6%	≥ 95%	Not MET
		Family Practice		100%		MET
		Pediatrics		76.1%		Not MET
Fairfield	Napa	Internal Medicine	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
		Family Practice		100%		MET
		Pediatrics		100%		MET
	Solano	Internal Medicine	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
		Family Practice		100%		MET
		Pediatrics		100%		MET
	Yolo	Internal Medicine	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
		Family Practice		100%		MET
		Pediatrics		100%		MET
Santa Rosa	Marin	Internal Medicine	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
		Family Practice		100%		MET
		Pediatrics		100%		MET
	Sonoma	Internal Medicine	1 within 10 miles or 30 minutes	99.9%	≥ 95%	MET
		Family Practice		100%		MET
		Pediatrics		99.8%		MET

Geographic Distribution of Primary Care by County (Quest Analytics, November 2025)

Notable findings: A breakdown of the data at the county level shows Lassen County as not meeting the time or distance standard for primary care for both children and adults. Out of 7,879 Partnership members in Lassen County, 779 do not meet the time or distance standard despite the Family Practice to member ratio in Lassen County being 1:1,313.

A deeper dive into the three categories of Primary Care shows that despite a ≥95% coverage by Family Practice Physicians, there are five counties that lack Pediatricians and Internal Medicine providers, and one that lacks Pediatricians. This is indicative of a rural county, where the population is widely dispersed, and the providers are in, or near, towns and cities.

Rural areas generally have family physicians that serve as primary care physicians, as the population is not sufficient to sustain pediatric and internal medicine specialists. Taking the

presence of family physicians into account, there is sufficient geographic access to primary care physicians for each county outside of Lassen.

Continued general support of the primary care workforce, like our primary care recruitment program and our primary care Quality Incentive Program, are prudent to maintain and grow our current primary care network.

PART V: GEOGRAPHIC ACCESS: SPECIALISTS

County Size Categories by Population			
Size Category	**Population Density**	**# of Counties**	**PARTNERSHIP Counties**
Rural	**≤50 people per square mile**	**13**	**Colusa, Del Norte, Glenn, Humboldt, Lassen, Mendocino, Modoc, Plumas, Shasta, Sierra, Siskiyou, Tehama, and Trinity**
Small	**51 to 200 people per square mile**	**7**	**Butte, Lake, Napa, Nevada, Sutter, Yolo, and Yuba**
Medium	**201 to 599 people per square mile**	**4**	**Marin, Placer, Solano, and Sonoma**

County Size Categories by Population (DHCS, Standard for County Size by Population, 2025)

The following table summarizes the 2024 findings for High Volume and High Impact Specialists

Geographic Distribution of Specialty Care – Standards and Performance Goals				
High Volume Practitioner Type	**Standard: Geographic Distribution**	**Results**	**Performance Goal**	**Goal Met?**
Cardiology	**Standard: % of members whose residence is within a distance (miles) or time (minutes) from a specialist's office.** **Rural = 60 miles or 90 minutes** **Small= 45 miles or 75 minutes** **Medium= 30 miles or 60 minutes**	**100%**	**≥90%**	**MET**
Dermatology		**100%**	**≥90%**	**MET**
General Surgery		**100%**	**≥90%**	**MET**
Obstetrics/Gynecology		**99.9%**	**≥90%**	**MET**
Ophthalmology		**99.3%**	**≥90%**	**MET**
Orthopedics		**99.3%**	**≥90%**	**MET**
High Impact Practitioner Type		**Results**	**Performance Goal**	**Goal Met?**
Oncology/Hematology		**99.1%**	**≥80%**	**MET**

Geographic Distribution of Specialty Care - High Volume and High Impact (Quest Analytics, Nov 2024)

The following table summarizes the 2025 findings for High Volume and High Impact Specialists

Geographic Distribution of Specialty Care – Standards and Performance Goals				
High Volume Practitioner Type	**Standard: Geographic Distribution**	**Results**	**Performance Goal**	**Goal Met?**
Cardiology	Standard: % of members whose residence is within a distance (miles) or time (minutes) from a specialist's office. Rural = 60 miles or 90 minutes Small= 45 miles or 75 minutes Medium= 30 miles or 60 minutes	100%	≥90%	MET
Dermatology		99.7%	≥90%	MET
General Surgery		100%	≥90%	MET
Obstetrics/Gynecology		99.7%	≥90%	MET
Ophthalmology		99.3%	≥90%	MET
Orthopedics		99.7%	≥90%	MET
High Impact Practitioner Type		**Results**	**Performance Goal**	**Goal Met?**
Oncology/Hematology		97.3%	≥80%	MET

Geographic Distribution of Specialty Care - High Volume and High Impact (Quest Analytics, Nov 2025)

➢ **Notable findings:** The geographic distribution of all High Volume and High Impact Specialties met the access standard plan wide. Interventions are not currently indicated.

- The geographic distribution for cardiology remained at 100% exceeding the standard
- The geographic distribution for dermatology had a 0.3% decrease while exceeding the standard
- The geographic distribution for general surgery remained at 100% exceeding the standard
- The geographic distribution for obstetrics/gynecology had a 0.2% decrease while exceeding the standard.
- The geographic distribution for ophthalmology remained at 99.3% exceeding the standard.
- The geographic distribution for orthopedics had a 0.4% increase exceeding the standard.
  The geographic distribution for oncology/hematology experienced a 1.8% decrease exceeding the standard.

When the data is broken down to the county level, four rural counties did not meet the 60 miles, or 90 minutes standard for access to specialists.

Geographic Distribution of Specialty Care – Standards and Performance Goals						
Region	**County**	**Specialty Type**	**Standard: Geographic Distribution**	**Result**	**Performance Goal**	**Goal Met?**
Redding	Modoc	Ophthalmology	Rural standard: % of members' residence is 60 miles or 90 minutes from a specialist's office.	14.5%	≥ 90%	Not MET
	Modoc	Hematology/Oncology		0.8%	≥ 80%	Not MET
	Siskiyou	Hematology/Oncology		69.6%	≥ 80%	Not MET
	Lassen	Ophthalmology		86.5%	≥ 90%	Not MET
Eureka	Del Norte	Hematology/Oncology		5.7%	≥ 80%	Not MET

Geographic Distribution of Specialty Care - Not Met Score by County (Quest Analytics, Nov 2025)

Partnership contracts with all available high-volume specialists that practice within our rural counties. Modoc, Siskiyou, Lassen, and Del Norte are sparsely populated and have an insufficient population to sustain a practice for many specialties. Currently, there are no qualified specialists who are enrolled in Medi-Cal practicing in these geographic areas with whom to contract. Partnership will assist members in making appointments and arrange transportation for members to see a specialist that is outside of the time or distance standards.

Partnership continues to review all sources of data related to access to specialty care, for monitoring trends and implementing focused strategies on the area of greatest need. This includes a robust telemedicine and e-Consult program. Many telehealth specialties are available to members via video appointments arranged at primary care offices. In addition, direct-to-member video telehealth between specialist providers and members is available through Partnership's contract with TeleMed2U.

PRACTITIONER ACCESSIBILITY RESULTS: (NET 2 ELEMENT A, C: ACCESS TO PRIMARY CARE & SPECIALTY CARE)

The data for assessing regular and routine care, urgent care, and after-hours care is collected by Partnership's Provider Relations staff using the Third Next Available (3NA) methodology for appointment access and the after-business hours' survey for telephone and triage services. All PCPs are surveyed (no sampling).

Third Next Available (3NA) Survey Results - Primary Care Routine Appointment Accessibility

The following table summarizes the findings of the Third Next Available Survey for 2024.

Third Next Available (3NA) Survey Findings												
Provider Type	Standard	Median Days for Established PCP Appt.				Percentage of Clinics Meeting PCP Standards				Goal	Goal Met?
		North	South	East	Plan	North	South	East	Plan		
Primary Care Adult	Non-urgent care primary care appointments within 10 business days of request	3.0	5.0	2.5	3.5	94.4%	78.7%	91.3%	88.1%	≥ 90%	Not Met
Primary Care Pediatrics	Non-urgent care primary care appointments within 10 business days of request	3.0	4.0	2.5	3.2	93.6%	85.1%	96.4%	91.7%	≥ 90%	Met
Newborn Appointments	Newborn appointments within 48 hours of discharge	1.0	1.0	1.0	1.0	100%	99.0%	93.2%	97.4%	≥ 90%	Met
Primary Care Urgent Care	Urgent care appointments within 48 hours of request	1.0	1.0	0.0	0.7	97.9%	97.4%	95.4%	96.9%	≥ 90%	Met

Third Next Available (3NA) Primary Care Survey Findings (PR Reps Survey, 2024).

The following table summarizes the findings of the Third Next Available Survey for 2025.

Third Next Available (3NA) Survey Findings									
	Median Days for Established PCP Appointment					Percentage of Clinics Meeting PCP Standards			
Region	Adult ≤ 10 bus. days	Peds ≤ 10 bus. days	Newborn ≤ 48 hrs.	Urgent ≤ 48 hrs.		Adult	Peds	Newborn	Urgent
Auburn	2	2	1	0		76.7%	82.5%	92.3%	83.0%
Chico	2	2	1	0		86.0%	90.9%	97.2%	96.8%
Eureka	3	3	1	0		74.6%	82.7%	82.1%	93.8%
Fairfield	5	3	1	0		75.6%	71.1%	85.3%	94.0%
Redding	3	4	1	0		89.4%	93.1%	84.6%	93.8%
Santa Rosa	4	3	1	1		76.7%	87.8%	85.3%	90.4%
Plan Average	**3**	**3**	**1**	**0**		**79.8%**	**84.7%**	**87.8%**	**92.0%**
					Goal	≥ 90%	≥ 90%	≥ 90%	≥ 90%
					Goal Met?	Not MET	Not MET	Not MET	MET

Third Next Available (3NA) Primary Care Survey Findings (PR Survey, 2025).

- **Notable findings:** The 3NA survey results show that Plan wide we did not meet our 2025 performance goal for non-urgent adult, pediatric, or newborn primary care appointments.
    - Non-urgent Adult Primary Care Provider appointments fell short of the goal for the second year in a row with a 7.0% decrease from 2023 to 2024 and an additional decrease of 6.4% in 2025.
    - Non-urgent Pediatric appointment access did not meet the goal with a 6.7% decrease from 2024
    - Newborn appointment access failed to meet the performance goal with a 9.6% decrease from 2024.
    - Urgent primary care access met the performance goal. However, there was a 4.9% decrease in score from 2024.

THIRD NEXT AVAILABLE (3NA) SURVEY RESULTS - PRIMARY CARE TELEPHONE ACCESSIBILITY:

Third Next Available (3NA) Survey Findings (Primary Care)					
Measurements	**Standard**	**Median Performance Rate**	**Percentage of Clinics Meeting PCP Standards**	**Goal**	**Goal Met?**
# Rings before phone answered	≤ 5 rings	1	100%	≥ 90%	Met
Minutes on hold	≤ 5 minutes	1	95.2%	≥ 90%	Met
Average wait time before seeing a provider	≤ 30 minutes	10	99.7%	≥ 90%	Met
Return call within 30 minutes	≤ 30 minutes	Yes	98.9%	≥ 90%	Met

Third Next Available (3NA) Primary Care Telephone Accessibility (PR Rep Survey, 2024).

Third Next Available (3NA) Survey Findings (Primary Care)					
Measurements	**Standard**	**Median Performance Rate**	**Percentage of Clinics Meeting PCP Standards**	**Goal**	**Goal Met?**
# Rings before phone answered	≤ 5 rings	1	97.6%	≥ 90%	Met
Minutes on hold	≤ 5 minutes	2	88.1%	≥ 90%	Not Met
Average wait time before seeing a provider	≤ 30 minutes	10	99.7%	≥ 90%	Met
Return call within 30 minutes	≤ 30 minutes	Yes	78.9%	≥ 90%	Met

Third Next Available (3NA) Primary Care Telephone Accessibility (PR Rep Survey, 2025).

- **Notable findings:** The 3NA survey results show that as a plan we met three out of four of our 2025 performance goal of 90% telephone accessibility and wait time measurements.
    - o 97.6% of the primary care offices answered their phone within 5 rings or less

- o 88.1% of the primary care offices had a hold time of 5 minutes or less. This represents a 7.1% decrease from 2024
- o 99.7% of the primary care offices reported a wait time of 30 minutes or less before seeing a provider
- o 78.9% of the primary care offices returned phone calls within 30 minutes or less

SURVEY RESULTS - PRIMARY CARE AFTER BUSINESS HOURS

The following table summarizes the findings of the After Business Hours Survey for 2024.

After Business Hours Survey Findings Primary Care				
Measurements	**Standard**	**2024**	**Goal**	**Goal Met?**
Answering Machine/ Answering Services	Access to answering machine, or service	100%	≥ 90%	Met
Instructions to call 911/ER	Provision of instructions to call 911/ER	99.6%	≥ 90%	Met
Instructions to reach MD or Advice Nurse	Provision of instructions to reach MD/Advice Nurse	98.6%	≥ 90%	Met
Wait time for screening or triage services	≤ 30 minutes	98.5%	≥ 90%	Met

Survey Results Primary Care After Business Hours (PR Rep Survey, 2024).

The following table summarizes the findings of the After Business Hours Survey for 2025.

After Business Hours Survey Findings Primary Care				
Measurements	**Standard**	**2025**	**Goal**	**Goal Met?**
Answering Machine/ Answering Services	Access to answering machine, or service	99.0%	≥ 90%	Met
Instructions to call 911/ER	Provision of instructions to call 911/ER	96.4%	≥ 90%	Met
Instructions to reach MD or Advice Nurse	Provision of instructions to reach MD/Advice Nurse	86.3%	≥ 90%	Not Met
Wait time for screening or triage services	≤ 30 minutes	85.1%	≥ 90%	Not Met

Survey Results Primary Care After Business Hours (PR Rep Survey, 2025).

- ➢ Notable findings: The survey results show that as a plan Partnership met two out of four goals for the 2025 Primary Care After-Business Hours Accessibility Measurements.

- 99.0% of PHC primary care practitioners (PCP) provided members with access to an answering machine or answering service, exceeding the 90% goal with a 1% decrease from 2024.
- 96.4% of PCPs provided members with access to instructions to call 911 or go to the ER for emergencies. This rate exceeded the 90% goal but experienced a 3.2% decrease from 2024.
- 86.3% of PCP offices provided instructions to reach an MD or Advice Nurse, failing to meet the 90% goal. The rate represents a 12.3% decrease from 2024.
- 85.1% of members waited 30 minutes or less for screening or triage services when calling for after-hours care, failing to meet the 90% goal. This rate represents a 13.4% decrease from 2024.

3NA Survey Results - Access to Primary Care by County

The data for assessing access to care by county is pulled from the 3NA survey results. The 2025 3NA findings below summarize the access by county.

Primary Care Appointment Access by County- 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Adult Primary Care**
Auburn	Placer	Elica Health Centers – V Street Medical Center	46
		Elica Health Centers – Marysville	35
		Elica Health Centers – North Highlands	43
		Elica Health Centers – Mack Road	35
		Elica Health Centers – Cadilac Drive	32
		Elica Health Centers – Franklin	16
		Elica Health Centers – Arden Arcade	15
		Elica Health Centers – J Street Suite 201	12
		Sacramento Community Clinic – El Camino	12
Chico	Butte	Ampla Health Orvoville Medical	61
		Ampla Health – Paradise Clinic	26
		Ampla Health South Chico Medical	51
	Glenn	Ampla Health- Hamilton City Medical	39
	Yuba	Harmony Health Medical Clinic and Family Resource	12
Eureka	Humboldt	Mad River Healthcare Clinic Ste 3 Family Medicine	24
		Arcata Community Health Center	18
		Providence Family Practice	13
		K'imaw Medical Center	13

Primary Care Appointment Access by County- 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Adult Primary Care**
	Lake	Lakeview Health Center	77
		Adventist Health Clearlake – South Main	76
		Adventist Health Clearlake – 11th St	22
		Lake County Tribal Health Consortium	30
		Lake County Tribal Health Southshore Clinic	14
	Mendocino	Adventist Health Ukiah Valley – Hospital Dr. Ste. 204	35
		Hillside Health Center	33
		Adventist Health Ukiah Valley – Hospital Dr. Ste.103	32
		Dora Street Health Center – Clinic	31
		Point Arena Community Health Center	15
		Anderson Valley Health Center	14
		Mendocino Coast Clinic	12
Fairfield	Napa	Ole Health – Hartle Clinic	32
		Ole Health – St. Helena	25
		Providence Medical Group – 1100 Trancas Ste 256	15
		Providence Medical Group – 1100 Trancas Ste 201	15
		Ole Health Calistoga	11
	Solano	La Clinica – North Vallejo	32
		SCFH&SS – Fairfield Courage	24
		Communicare Ole Travis	18
		Ole Health- Fairfield B Gale	17
	Yolo	Elica Health Centers – 15 St.	37
		Winters Healthcare Foundation	16
Redding	Lassen	Lassen Indian Health Center	46
		Northeastern Rural Health Clinic	19
Redding cont.	Modoc	Canby Family Practice	42
	Shasta	Enterprise Family Health & Dental Center	11

Primary Care Appointment Access by County- 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Adult Primary Care**
	Tehama	Rolling Hills Clinic – Corning	49
		Ampla Health Los Molinos Medical	12
Santa Rosa	Marin	Marin Community Clinics – Campus	42
		Marin Community Clinics- South Novato	36
		Marin Community Clinics – San Rafael	29
		Marin Community Clinics – Novato	29
		Marin Community Clinics – Larkspur	27
		Marin Community Clinics – Greenbrae	27
		Marin Community Clinics – Downtown San Rafael	15
	Sonoma	Alliance Medical Center – Healdsburg	33
		Providence Medical Group – Lakewood	11
		Providence Medical Group Washington	28

- **Notable Findings:** When the 3NA data is broken down by county we find 57 sites failed to meet the appointment standards.

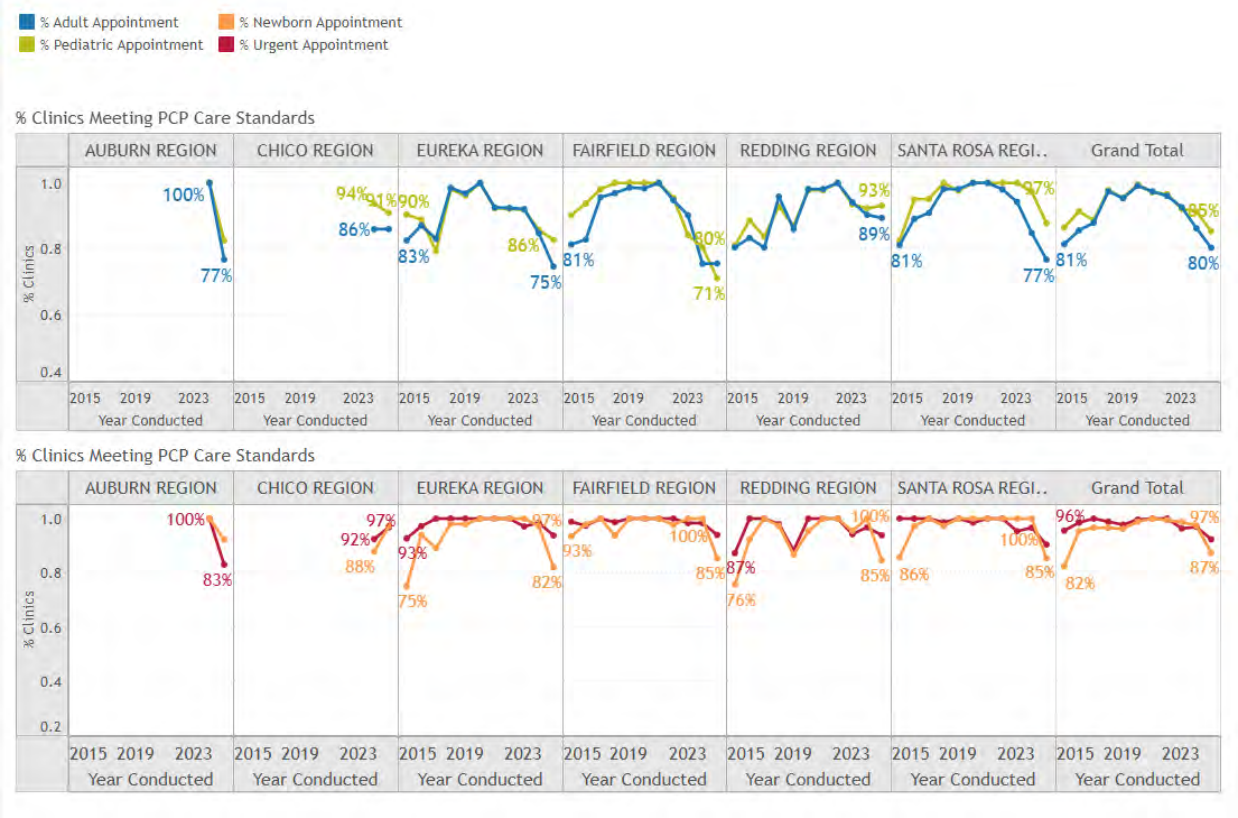
  Providers identified as not meeting timely access standards continue to be actively engaged by Partnership. Outreach efforts are focused on identifying underlying access barriers and providing targeted education, resources, and support. These providers have been escalated to Provider Relations leadership for additional review and coordination to ensure appropriate interventions are implemented and progress is monitored

  - Ampla Health Centers - Added 40 providers, opened 4 new clinics, to address the access barriers.
  - Alliance Medical Centers - They offer same-day appointments for urgent/emergent issues.
  - Canby Family Practice - Currently no barriers, they have plenty of availability, including appointments available today and through next week.
  - CommuniCare OLE – Barrier to access felt, increase of new patients; new phone system. Now, they have same-day availability and stand-by even for new patients. They have an additional doctor come 1 day per week dedicated to standby, and nurses on staff who could talk with patients as someone clinical to give advice.
  - Dora Street Health Center Clinic – Barriers to access felt, provider turnover or out on vacation/extended leaves. To support, they've opened more slots for hospital

follow-ups and same-day visits to give better access. They've also added new providers. They offer appointment offloading to Hillside site if patient is willing. They believe these barriers have improved recently.

- Elica Health Centers – Barriers to access felt, provider turnover in 2025 and staffing turnover. High demand for number of providers available; no-call no-shows. Currently, they have a recruitment and onboarding project ongoing regarding provider and staffing. They do member education with chronic (3+ times) no call-no show members.

Trends for PCP Appointments Meeting Targets



- **Notable Finding:** There has been a downward trend for adult and pediatric PCP appointments across the Partnership service area since 2020, and newborn since 2024.

3NA SURVEY RESULTS - ACCESS TO PRENATAL CARE

The following table summarizes the findings of the Third Next Available Survey for 2024.

Third Next Available (3NA) Survey Findings			
Region	Median Days for Established. Appt ≤ 10 business days		% Clinics Meeting Standards
Auburn	2.2		100%
Chico	3.9		93%
Eureka	3.8		82.3%
Fairfield	13.4		70%
Redding	3.9		100%
Santa Rosa	7.5		66.5%
Plan Average	**5.8**		**85.3%**
		Goal	≥ 90%
		Goal Met?	Not MET

3NA Survey Results Prenatal Care Region and Plan (PR Rep 3NA Survey, 2024)

The following table summarizes the findings of the Third Next Available Survey for 2025.

Third Next Available (3NA) Survey Findings			
Region	Median Days for Established Appt ≤ 10 business days		% Clinics Meeting Standards
Auburn	1		84.2%
Chico	3.9		84.0%
Eureka	6.8		90.9%
Fairfield	6.4		100%
Redding	6.6		100%
Santa Rosa	5.7		81.8%
Plan Average	**5.1**		**90.2%**
		Goal	≥ 90%
		Goal Met?	MET

3NA Survey Results Prenatal Care Region and Plan (PR Rep 3NA Survey, 2025)

- **Notable Findings:** The 3NA survey results show that, as a plan, we met the 2025 performance goal for prenatal care appointments with a 4.9% increase in access from 2024
    - The Auburn Region experienced a 15.8% decrease from 2024
    - The Chico Region experienced a 9% decrease from 2024
    - The Eureka Region experienced a 8.6% increase from 2024
    - The Fairfield Region experienced 30% increase from 2024
    - The Redding Region stayed steady with no change from the previous year
    - The Santa Rosa Region experienced a 15.3% increase from 2024

Prenatal Appointment Access by County- 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Prenatal Appointment**
Chico	Butte	Enloe Women's Services – Esplanade	15
		Enloe Women's Services- South	10
		Oroville Women's Health – Midwifery	14
	Yuba	Peach Tree Healthcare	37
Eureka	Humboldt	UIHS – Potawot Health Village	20
	Lake	Adventist Health Clearlake – Bush St	19
	Mendocino	Adventist Health Ukiah Valley	37
		Adventist Health Ukiah Valley – N State	18
		Hillside Health Center	13
		Little Lake Health Center	16
		Point Arena Community Health Center	19
Fairfield	Solano	Center for Primary Care- Vacaville	37
		Community Medical Centers – Vacaville	14
		NorthBay Women's Health – Fairfield	43
	Yolo	Sutter Medical Group – 202 Sutter Pl St 2023	20
		Woodland Clinic – Cottonwood St OB/GYN	16
Santa Rosa	Marin	Marin Community Clinics – Campus Clinic	11

Notable Findings: When breaking down Prenatal Appointment Access by County we find that seventeen providers failed to meet the standard within 10 business days.

- Prenatal providers were included in targeted outreach efforts to assess timely access to care. Overall, outreach findings indicate mixed access across prenatal providers, with several offices reporting the ability to accommodate patients within standard timeframes, while others continue to experience access challenges.
- Common barriers identified include provider shortages, high patient volume, and scheduling constraints, particularly in areas with limited obstetric coverage. Some providers reported implementing mitigation strategies such as adding clinic days,

adjusting provider schedules, and prioritizing urgent or newly established prenatal patients.

- In certain instances, appointment availability could not be consistently validated through standard outreach methods, due to call handling or scheduling access limitations.
- Partnership is continuing targeted engagement with prenatal providers to support access improvements through education, resource coordination, and ongoing monitoring. Providers with ongoing access concerns and/or validation barriers have been escalated to Provider Relations leadership for further review and intervention.

ACCESS TO SPECIALTY CARE

The data for assessing access to specialty care is collected by Partnership's Provider Relations staff using the 3NA methodology for appointment access and the After Business Hours survey for telephone and triage services. Data results for urgent care and after business hours' survey findings are not required by NCQA, however, they are included in this report to meet DHCS requirements. The 3NA high-volume, high-impact specialists are selected from a list of all specialty offices that served 200 or more unique members in the measurement year. If a county does not meet the 200 unique members seen, the provider with the highest unique members seen is selected to ensure we account for all counties.

The following table summarizes the findings of the Third Next Available Survey for 2024.

Third Next Available (3NA) Survey Findings					
	Average Days for Specialty Care Appointment Access			Percentage of Clinics Meeting PCP Standards	
Region	Non-Urgent ≤ 15 bus. days	Urgent ≤ 48 hrs.		Non-Urgent ≤ 15 bus. days	Urgent ≤ 48 hrs.
Auburn	10	2.5		91.2%	82.4%
Chico	39.6	16.5		72.3%	83.1%
Eureka	17.0	3.9		83.3%	92.4%
Fairfield	36.1	19.4		60.7%	89.7%
Redding	12.7	3		93.0%	98.2%
Santa Rosa	26.4	2.5		84.5%	98.5%
Plan Average	**23.6**	**8.0**		**80.8%**	**90.7**
			Goal	≥ 80%	≥ 90%
			Goal Met?	MET	MET

3NA Survey Specialty Care Overall (PR Rep Survey, 2024)

The following table summarizes the findings of the Third Next Available Survey for 2025.

Third Next Available (3NA) Survey Findings					
	Average Days for Specialty Care Appointment Access			Percentage of Clinics Meeting PCP Standards	
Region	Non-Urgent ≤ 15 bus. days	Urgent ≤ 48 hrs.		Non-Urgent ≤ 15 bus. days	Urgent ≤ 48 hrs.
Auburn	14.3	2.8		86.4%	64.7%
Chico	11.5	8.5		80.4%	76.5%
Eureka	7.3	2		91.9%	80.6%
Fairfield	13.3	2		76.4%	83.6%
Redding	9	5.7		79.2%	78.7%
Santa Rosa	13.5	7.7		69.0%	80.4%
Plan Average	**11.5**	**4.8**		**80.6%**	**77.4%**
			Goal	≥ 80%	≥ 90%
			Goal Met?	MET	Not MET

3NA Survey Specialty Care Overall (PR Rep Survey, 2025)

- **Notable Finding:** As a Plan, we did not meet the 2025 goal for urgent specialty care appointments with an overall decrease of 13.3% from 2024.
  - The Auburn Region suffered a 17.7% decrease.
  - The Chico Region experienced a 6.6% decrease
  - The Eureka Region suffered a 11.8% decrease
  - The Fairfield Region experienced a 6.1% decrease
  - The Redding Region suffered a 19.5% decrease
  - The Santa Rosa Region suffered a 18.1% decrease

As a Plan, we met the 2025 goal for non-urgent specialty care appointments with an overall decrease of 0.2%.

- The Fairfield Region fell short of the goal despite an increase of 15.7% from 2024
- The Redding Region decreased by 13.8%.
- The Santa Rosa Region decreased by 15.6%.

Trends for Specialty Appointments Meeting Targets

- **Notable Finding**: Appointment availability showed a slight improvement in the Chico, Eureka, and Fairfield regions while all regions showed a continued decrease in specialty urgent care appointments.

High Volume Specialties Third Next Available Survey Results

The following table summarizes the findings of the Third Next Available Survey for 2024.

	Percentage of Clinics Meeting Specialty Care Appointment Standards ≤ 15 business days					
Region	**Cardiology**	**Dermatology**	**General Surgery**	**Obstetrics Gynecology**	**Ophthalmology**	**Orthopedic Surgery**
Auburn	100%	100%	100%	100%	100%	66%
Chico	78%	66%	66%	54%	83%	85%
Eureka	63%	100%	100%	78%	87%	75%
Fairfield	77%	14%	87%	42%	81%	93%
Redding	85%	100%	100%	100%	77%	100%
Santa Rosa	77%	50%	100%	91%	90%	100%
Plan Average	**80.0%**	**71.7%**	**92.2%**	**77.5**	**86.3%**	**86.5%**
Goal	**≥ 80.0%**	**≥ 80.0%**	**≥ 80.0%**	**≥ 80.0%**	**≥ 80.0%**	**≥ 80.0%**
Goal Met?	MET	Not MET	MET	Not MET	MET	MET

3NA Survey High Volume Specialties (PR Rep Survey, 2024)

The following table summarizes the findings of the Third Next Available Survey for 2025.

2025 Third Next Available (3NA) Survey Findings						
	Percentage of Clinics Meeting Specialty Care Appointment Standards ≤ 15 business days					
Region	**Cardiology**	**Dermatology**	**General Surgery**	**Obstetrics Gynecology**	**Ophthalmology**	**Orthopedic Surgery**
Auburn	80%	100%	100%	100%	100%	100%
Chico	80%	100%	100%	80%	100%	100%
Eureka	100%	100%	88%	71%	100%	100%
Fairfield	57%	75%	100%	85%	77%	83%
Redding	100%	33%	100%	87%	85%	83%
Santa Rosa	60%	0%	100%	90%	50%	75%
Plan Average	**79.5%**	**68%**	**98%**	**85.5%**	**85.3%**	**90.2%**
Goal	**≥ 80.0%**	**≥ 80.0%**	**≥ 80.0%**	**≥ 80.0%**	**≥ 80.0%**	**≥ 80.0%**
Goal Met?	Not MET	Not MET	MET	MET	MET	MET

3NA Survey High Volume Specialties (PR Rep Survey, 2025)

Notable finding: As a plan, two high-volume specialties fell below the established median 15-day appointment goal in 2025.

- Cardiology did not meet the 2025 goal with a 0.5% increase from 2024
- Dermatology did not meet the goal three years in a row with a 10% decrease in 2023 and additional 3.7% in 2025.
- General Surgery met the 2025 goal and had a 5.8% increase from 2024
- Obstetrics Gynecology met the 2025 goal with an increase of 8% from 2024
- Ophthalmology met the 2025 goal with a 1% decrease from 2024
- Orthopedic Surgery met the 2025 goal with a 3.7% increase from 2024

High Volume: Cardiology 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Cardiology Appointment**
Fairfield	**Solano**	**NorthBay Heart and Vascular Center – Fairfield, Pennsylvania**	**34**
		NorthBay Heart and Vascular Center – Fairfield Business Center	**34**
		NorthBay Health Wound Care – Vacaville	**33**
Santa Rosa	**Marin**	**MarinHealth Medical Network Cardiology**	**64**
		Providence Medical Group, Sonoma-500 Doyle Park Dr Ste 103	**68**

- **Notable finding:** When breaking down the Cardiology Appointment Access by Region we found that five providers failed to meet the standard within 15 business days.
  - Cardiology providers were included in targeted outreach efforts to assess timely access to specialty care. Outreach findings indicate ongoing access challenges across cardiology providers, primarily driven by high patient demand and limited specialist availability.
  - Common barriers identified include provider shortages, high referral volumes, and scheduling constraints, with some offices reporting extended wait times due to the complexity of cases and prioritization of urgent or high-acuity patients. In certain instances, delays in referral and authorization workflows also contributed to scheduling limitations.
  - Some providers reported efforts to improve access through provider recruitment, expanded clinic availability, and prioritization of urgent cases.
  - Partnership is continuing targeted engagement with cardiology providers to support access improvements through education, resource coordination, and ongoing monitoring. Providers with ongoing access concerns and/or validation barriers have been escalated to Provider Relations leadership for further review and intervention.

High Volume: Dermatology 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Dermatology Appointment**
Fairfield	**Solano**	**Solano Dermatology Associates-Vallejo**	**51**
Redding	**Shasta**	**Ronald E. Reece, MD**	**67**
	Tehama	**Lassen Medical Clinic – Red Bluff**	**42**
Santa Rosa	**Sonoma**	**Santa Rosa Community Health -Vista Campus**	**28**
		Redwood Family Dermatology – Santa Rosa	**126**

- **Notable finding:** When breaking down the Dermatology Appointment Access by Region we find that five providers failed to meet the standard within 15 business days.
  - Dermatology providers were included in targeted outreach efforts to assess timely access to specialty care. Outreach findings indicate ongoing access challenges across dermatology providers, primarily driven by limited provider availability and high patient demand.
  - Common barriers identified include provider shortages, extended scheduling timeframes, and high volumes of routine and specialty referrals, including dermatologic conditions requiring ongoing management. Some offices reported prioritizing urgent or high-acuity cases, which may impact availability for routine appointments.
  - Several providers reported efforts to improve access through ongoing recruitment, utilization of part-time or locum providers, and adjustments to scheduling practices.
  - Partnership is continuing targeted engagement with dermatology providers to support access improvements through education, resource coordination, and ongoing monitoring. Providers with ongoing access concerns and/or validation barriers have been escalated to Provider Relations leadership for further review and intervention.

High Volume: Obstetrics Gynecology 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Obstetrics Gynecology Appointment**
Eureka	Lake	Adventist Clearlake	39
	Mendocino	Little Lake Health Center	16

- **Notable finding:** When breaking down the OB GYN Appointment Access by Region we find that two providers failed to meet the standard of 15 business days.
  - OB/GYN providers were included in targeted outreach efforts to assess timely access to women's health and obstetric care services. Outreach findings indicate mixed access across OB/GYN providers, with some offices reporting the ability to accommodate patients within standard timeframes, while others continue to experience access challenges.
  - Common barriers identified include provider shortages, high patient demand, and scheduling constraints, particularly in regions with limited obstetric and gynecologic provider availability. Some providers reported prioritizing urgent, prenatal, and high-risk patients, which may impact availability for routine gynecologic appointments.
  - Several providers reported efforts to improve access through provider recruitment, expanded clinic availability, and scheduling adjustments.
  - Partnership is continuing targeted engagement with OB/GYN providers to support access improvements through education, resource coordination, and ongoing monitoring. Providers with ongoing access concerns and/or validation barriers have been escalated to Provider Relations leadership for further review and intervention.

High Volume: Ophthalmology 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Ophthalmology Appointment**
Fairfield	Solano	Solano Eye Specialists -Fairfield	109
	Yolo	Woodland Clinic	69
Santa Rosa	Sonoma	Shalini Yalamanchi, MD	22
		Schachar, Ira Hyman MD	22
		Stephen A. Meffert, MD	22
		North Bay Eye Associates Inc. Santa Rosa	89
		Mathew A. Powers, MD	22

- **Notable finding:** When breaking down the Ophthalmology Appointment Access by Region we find that seven providers failed to meet the standard within 15 business days.
  - Ophthalmology providers were included in targeted outreach efforts to assess timely access to specialty vision care services. Outreach findings indicate ongoing access challenges across ophthalmology providers, primarily driven by limited specialist availability

and high referral volumes, particularly for routine and chronic condition management such as diabetic eye exams.

- Common barriers identified include provider shortages, high patient demand, and scheduling constraints, with some offices reporting significant volumes of referrals impacting appointment availability. Several providers noted prioritization of urgent or high-acuity cases, which may contribute to extended timeframes for routine appointments.
- Some providers reported efforts to improve access through provider recruitment, increased patient throughput, and scheduling adjustments
- Partnership is continuing targeted engagement with ophthalmology providers to support access improvements through education, resource coordination, and ongoing monitoring. Providers with ongoing access concerns and/or validation barriers have been escalated to Provider Relations leadership for further review and intervention.

High Volume: Orthopedic Surgery 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Orthopedic Surgery Appointment**
Santa Rosa	**Sonoma**	**Weiss Orthopedics – Sonoma**	**34**
		Klein, Roger A. MD	**22**

- **Notable finding:** When breaking down the Orthopedic Surgery Appointment Access by Region we find that two providers failed to meet the standard within 15 business days.
  - Orthopedic providers were included in targeted outreach efforts to assess timely access to specialty care services. Outreach findings indicate ongoing access challenges across orthopedic providers, primarily driven by high patient demand, limited provider availability, and referral volume for injury and musculoskeletal conditions.
  - Common barriers identified include provider shortages, high volumes of referrals, and scheduling constraints, with some offices reporting prioritization of urgent injuries, post-operative care, and high-acuity cases, which may impact availability for routine or non-urgent appointments. In certain instances, delays in referral and authorization workflows also contributed to scheduling limitations.
  - Several providers reported efforts to improve access through provider recruitment, expanded clinic hours, and scheduling adjustments.
  - Partnership is continuing targeted engagement with orthopedic providers to support access improvements through education, resource coordination, and ongoing monitoring. Providers with ongoing access concerns and/or validation barriers have been escalated to Provider Relations leadership for further review and intervention.

HIGH IMPACT SPECIALTY THIRD NEXT AVAILABLE SURVEY RESULTS

The following table summarizes the findings of the Third Next Available Survey for 2024.

3NA Survey Results – Specialty Care: Routine Non-Urgent Care (Standard = 15 Days)										
High Impact Specialty	Median Days for Established Specialist Appointment				% of Clinics Meeting Specialty Care Standards				Goal	Goal Met?
	North	South	East	Plan	North	South	East	Plan		
Oncology Hematology	5.5	4.5	2	4	100%	93%	75%	89%	≥ 80.0%	Met

3NA Survey High Impact Specialty Region and Plan (PR Rep Survey, 2024)

- **Notable finding:** The 3NA survey results show that as a plan we met the 2024 performance goal for oncology appointments despite a 5% decrease from 2023.

Data for 2025 was not collected due to the Provider Relations department reorganization and loss of survey subject matter expert. Data from March of 2026 was gathered to assess the high impact specialty for this report.

The following table summarizes the findings of the Third Next Available Survey for 2026.

3NA Survey Results – Specialty Care: Routine Non-Urgent Care (Standard = 15 Days)				
High Impact Specialty	Median Days for Established Specialist Appointment	% of Clinics Meeting Specialty Care Standards	Goal	Goal Met?
	Plan Wide	Plan Wide		
Oncology Hematology	6.0	17%	≥ 80.0%	NOT Met

3NA Survey Results High Impact Specialty Region and Plan (PR Rep 3NA Survey, 2026)

- **Notable Findings:** The 3NA survey results show that as a plan we failed to meet the 2026 performance goal for oncology care appointments. Despite the median days for established specialist appointments falling well within the 15-day standard, there was a drastic 72% decrease in the number of clinics meeting that goal.

High Impact: Oncology Hematology - 3NA Results (Outside Performance Standards)			
Region	County	Service Location	Days to Orthopedic Surgery Appointment
Fairfield	Napa	Adventist Health St. Helena	56
Chico	Yuba	UC Davis Medical Group – Rideout Cancer Center	20
Outside of Core Service Area	Sacramento	Sutter Medical Group – Sacramento 1020 29th St	20
		Sutter Medical Group – Sacramento 2800 L St	42

- **Notable Findings:** When breaking down the Oncology Hematology Appointment Access by Region we find that four providers failed to meet the standard within 15 business days.

- Outreach efforts identified ongoing access challenges across oncology and hematology providers, driven by limited specialist availability, high referral volumes, and scheduling constraints. Referral workflow variability and prioritization of high-acuity cases further impacted access. Targeted outreach and escalation efforts are ongoing to support access improvements and ensure compliance.

3NA Survey Results: Specialty Care Accessibility

Third Next Available (3NA) Survey Findings (Specialty Care)					
Measurements	**Standard**	**Median Performance Rate**	**Percentage of Clinics Meeting PCP Standards**	**Goal**	**Goal Met?**
# Rings before phone answered	≤ 5 rings	2	100%	≥ 90%	Met
Minutes on hold	≤ 5 minutes	1	99.2%	≥ 90%	Met
Average wait time before seeing a provider	≤ 30 minutes	10	100%	≥ 90%	Met
Return call within 30 minutes	≤ 30 minutes	Yes	99.6%	≥ 90%	Met

3NA Survey Specialty Care Accessibility Survey Results (PR Rep Survey, 2024)

Third Next Available (3NA) Survey Findings (Specialty Care)					
Measurements	**Standard**	**Median Performance Rate**	**Percentage of Clinics Meeting PCP Standards**	**Goal**	**Goal Met?**
# Rings before phone answered	≤ 5 rings	1	98.9%	≥ 90%	Met
Minutes on hold	≤ 5 minutes	1	95.4%	≥ 90%	Met
Average wait time before seeing a provider	≤ 30 minutes	10	97.0%	≥ 90%	Met
Return call within 30 minutes	≤ 30 minutes	Yes	74.6%	≥ 90%	Not Met

3NA Survey Specialty Care Accessibility Survey Results (PR Rep Survey, 2025)

- **Notable Finding:** As a plan, we met three out of four of the 2025 goals for telephone access to specialty care providers. There was a 25% decline in the category of Return Call Within 30 Minutes, dropping us below the goal threshold of ≥ 90%.
  - A deeper analysis of those providers who failed to return a call for screening or triage within 30 minutes found that delays were primarily associated with staffing constraints, high call volumes, and reliance on voicemail or message-based workflows for after-hours call management. In several instances, calls required manual routing or follow-up by on-call staff, contributing to variability in response times. Additionally, limitations in call handling processes and lack of real-time triage support impacted the ability to consistently meet required timeframes.

Survey Results: After Business Hours Specialty Care

The after-business hour's survey includes all specialty care providers (no sampling).

The following table summarizes the findings of the After Business Hours Survey for 2024

After Business Hours Survey Findings Primary Care				
Measurements	**Standard**	**2024**	**Goal**	**Goal Met?**
Answering Machine/ Answering Services	Access to answering machine, or service	96.8%	≥ 90%	Met
Instructions to call 911/ER	Provision of instructions to call 911/ER	96.8%	≥ 90%	Met
Instructions to reach MD or Advice Nurse	Provision of instructions to reach MD/Advice Nurse	96.7%	≥ 90%	Met
Wait time for screening or triage services	≤ 30 minutes	96.7%	≥ 90%	Met

Survey Results: After Business Hours Specialty Care Accessibility (PR Rep Survey, 2024)

The following table summarizes the findings of the After Business Hours Survey for 2025

After Business Hours Survey Findings Primary Care				
Measurements	**Standard**	**2025**	**Goal**	**Goal Met?**
Answering Machine/ Answering Services	Access to answering machine, or service	99.4%	≥ 90%	Met
Instructions to call 911/ER	Provision of instructions to call 911/ER	95.1%	≥ 90%	Met
Instructions to reach MD or Advice Nurse	Provision of instructions to reach MD/Advice Nurse	84.8%	≥ 90%	Not Met
Wait time for screening or triage services	≤ 30 minutes	84.7%	≥ 90%	Not Met

Survey Results: After Business Hours Specialty Care Accessibility (PR Rep Survey, 2025)

- **Notable Findings:** As a plan, we did not meet the 2025 After Business Hours Accessibility Specialty Care goals for all four categories.
  - Analysis of those providers who failed to provide instructions to reach a Medical Doctor or Advice Nurse found that after-hours calls were often directed to voicemail systems, automated messaging, or third-party answering services that did not consistently include clear or direct guidance for reaching clinical support. In some cases, messaging lacked specificity or required multiple steps to navigate, creating barriers to timely access to appropriate care.

- Analysis of those providers who did not meet the wait time standard for screening or triage services found that delays were primarily driven by staffing constraints, high call volumes, and reliance on manual call-back processes during after-hours operations. Additionally, call routing inefficiencies and limited real-time triage support contributed to extended response times and variability in meeting required timeframes.

Section 4: Qualitative Analysis

ACCESS TO PRIMARY CARE

As a plan, Partnership did not meet the 90% performance goal for Primary Care Provider appointments for adults, pediatrics, and newborn. Non-urgent Adult Primary Care Provider appointments fell short of the goal for the second year in a row. Non-urgent Pediatric and Newborn appointments fell short of the goal for the first time in several years. We did meet the goal for prenatal and urgent care appointments. When breaking down the primary care access standard 3NA survey data by percentages of clinics in the county that meet the standard we find sixteen out of twenty-four had at least one provider site that failed to meet the appointment compliance standard. This is an increase from the 2024 results. Partnership is continuing targeted engagement with providers to support access improvements through education, resource coordination, and ongoing monitoring. The total number of member grievances regarding access decreased between 2024 and 2025 with appointment availability being the most common type of access grievance. Primary care grievances decreased by 3.8% compared to 2024. The rating per 1000 members was within the standard. No further action is currently required.

Barriers were evaluated, taking into consideration those related to members, providers, and health plan systems and processes. Key barriers identified included:

- Contracted provider groups experiencing open positions and a shortage of practitioners from which to fill those positions.
- No known qualified primary care providers within Partnership's service area to contract with to increase access for members.

ACCESS TO SPECIALTY CARE

As a Plan, we met our ≥ 80% appointment access performance goal for four of the six identified high-volume specialties. Two high-volume specialties fell below the established median 15-day appointment goal. Dermatology fell short for the second year in a row with a 3.7 decrease from 2024. Cardiology sat right at the threshold in 2024 and dipped just below the standard in 2025 at 79.5%. Obstetrics Gynecology had the largest decrease with a drop of 23% in 2024, however bounced back with a 8% increase in 2025 meeting the standard at 85.5%. Despite the median days for established specialist appointments for high-impact specialty of Oncology Hematology falling well within the 15-day standard, there was a drastic 72% decrease in the number of clinics meeting the goal from 2024 to 2026. Providers with ongoing access concerns and/or validation barriers have been escalated to Provider Relations leadership for further review and intervention.

Access to specialty care member grievances were low. Six high-volume specialties had one appointment grievance each for the reporting year and one had two appointment grievances. A trend

could not be established due to the low number of member grievances. No further action is currently required.

Barriers were evaluated, taking into consideration those related to members, providers, and health plan systems and processes. Key barriers identified included:

- Decreasing numbers of qualified, Medi-Cal approved, specialists for Cardiology and Dermatology with whom to contract within the service area. Whereas Dermatology works well with telemedicine as an option to improve access, Cardiology is not especially amenable, as it often requires specialized equipment for testing.

Section 5: Summary of Findings

There were no identified gaps in the provider ratios overall. We have been able to maintain access to primary care for all ages by having a stable Family Medicine network. The Provider Recruitment Program provides incentives for Primary Care practitioners to join our network, and Partnership is continuously recruiting for all categories of Primary Care, specifically in our rural counties that traditionally have a lower number of providers.

While some members were outside the time or distance standards for primary care, specialty care, and hospital services, this is not due to lack of contracting with available service providers. There are no new provider sites in these geographic areas with whom to contract as the geography and lack of larger towns limits the ability to reduce time or distance to a provider office. Partnership requests and receives approval for Alternative Access Standards (AAS) from the Department of Health Care Services on an annual basis for the geographical areas that fail to meet the standard. If a member lives in an area where services are not covered, Partnership will help those members with making the appointment and arrange transportation to see the specialists that are not within the time or distance standard.

Partnership did not meet access standards for three of the four types of primary care (adult, pediatrics, & newborn). Partnership did meet access standards for four of six high-volume specialty care providers, as well as telephone and after-hours access based on data from our provider surveys and additional internal analysis.

Partnership has experienced a downward trend for adult and pediatric primary care as well as specialty care appointments meeting the appointment standard across all regions since 2020. We are experiencing a continued trend of decreasing numbers of providers for multiple reasons including retirement of the baby boomer generation, decreased enrollment into medical schools across the nation, and higher burnout of physicians leading to reduction in available office hours.

While Partnership failed to meet the appointment standard for Dermatology and Cardiology, this is not due to a lack of contracting with an available service provider. Currently there are no additional qualified providers who are enrolled in Medi-Cal practicing in these geographic areas with whom to contract. Partnership monitors appointment access annually and works with individual providers who fail to meet the standard to identify strategies for improvement.

The 2024 - 2025 CAHPS data from the ME7 (Member Experience) report indicates performance below the thirty-third percentile benchmark for getting care quickly and getting care needed for Adult and Child. Although both Adult and Child scores experienced a slight improvement from 2023 -2024, they both failed to meet the benchmark.

Partnership met the minimum threshold for Access related Grievances in 2025 with the total number holding steady as compared to 2024. Over 43.4% of the reported concerns pertained to transportation services. Common complaints include missed rides, delayed driver arrivals, and scheduling inconsistencies.

Partnership did not meet the minimum threshold for Appeals in 2025 with a 30% increase from 2024. The total number of cases filed per 1,000 members increased from 0.49 to 0.70. This is attributed primarily to a change in program elibility criteria that has since been rectified.

Section 6: Opportunities for Improvement

Partnership operates in a broad service area encompassing urban, suburban, and rural settings. Improving member access to care is consistently the number one opportunity for improvement and top priority for leadership. Partnership's provider network is challenged by a national shortage of providers, competition from other entities, and an aging provider community. The following opportunity with planned actions, in priority order, were identified.

Opportunity: Appointment access to non-urgent primary care fell short of the goal for the second year in a row with a 6.7% decrease from 2023 to 2024 and an additional decrease of 6.4% in 2025.

- *Planned Action:* Partnership extended and refined the Provider Recruitment Program (PRP) to incentivize providers to join and remain in the Partnership network. The PRP offers sign-on bonuses to providers who are new to the Partnership network, including providers practicing outside of Partnership's 24-county service area as well as graduates completing training programs within the service area.

  The current PRP cycle is active from July 2025 through June 2026. Incentive payments are structured over longer commitment periods to promote retention: 60 months for physicians, nurse practitioners, and physician assistants; 24 months for behavioral health clinicians; and 12 months for certified SUD counselors.

  - Effectiveness of Action: During calendar year (CY) 2025, Partnership approved 185 PRP awards, an increase from 163 awards approved in CY 2024. Family Medicine remained the most frequently awarded specialty, accounting for approximately 51 percent of awards compared to 57 percent in CY 2024.
    Between January and December 2025, 185 new primary care clinicians were recruited to the network. Three of these providers were recruited to Sierra and Trinity Counties, two of Partnership's most rural counties, where 75 percent or more of the geographic area is classified as rural under U.S. Census Bureau definitions. Early recruitment and retention indicators are favorable, though long-term outcomes will continue to be assessed over the full incentive payment periods.

- Planned Action: Partnership continued targeted recruitment efforts for specialty providers, with a particular focus on obstetrics and perinatal care, including obstetricians, women's health nurse practitioners, and certified nurse midwives.
    - Effectiveness of Action: In CY 2025, nine obstetrics providers, including five advanced practice clinicians and four physicians, received PRP awards to support labor, delivery, and perinatal services across the network

- Planned Action: Partnership launched a Provider Retention Initiative (PRI) pilot in January 2024 and extended it through 2025. The PRI recognizes long serving safety net providers, including primary care clinicians, obstetrics and perinatal providers, and psychiatrists, and incentivizes additional years of service. The program is intended to preserve institutional knowledge, clinical leadership, and mentorship while stabilizing care delivery during generational workforce transitions.
    - Effectiveness of Action: Since program inception, 75 providers have received PRI awards. Fifty-nine awards were approved in CY 2024 and 14 in CY 2025. Seventy-three percent of the providers awarded were in Family Medicine. The year over year decline in awards was expected, as eligibility is tied to reaching a 15 year practice milestone.

Opportunity: Partnership identified a need to improve member experience associated with access to care.

- Planned Action: The QI CAHPS® framework continues to drive a coordinated, multi-disciplinary approach to enhance member experience through targeted initiatives and health equity integration. As part of a recent strategic realignment, Access initiatives have been separated from Member Experience and placed under the HR Workforce Development team to lead the FY 24-25 Access Strategic and Tactical plans in alignment with Organizational Goal #2: Network Optimization. Concurrently, the QI Department remains focused on advancing Member Experience improvements through the Strike-Team Pilot - an initiative designed to identify, prioritize, and eliminate service delivery barriers in real time.

Annual Utilization Management (UM) Program Evaluation

NCQA UM Standard 1 Element G

Evaluation Period
January 1, 2025 – December 31, 2025

Production Date: April 3, 2026

Prepared by: Tony Hightower, CPhT, Associate Director of UM Regulations
Kory Watkins, Director of Grievance & Appeals
Latrice Innes, Manager of Grievance & Appeals Compliance
Andrea Ocampo, Pharm.D., Clinical Pharmacist
Lady Lyn Carlos, CPhT, Pharmacy Technician II
Anna Campbell, MPH, Policy Analyst, UM Regulations
Kandice Dixon, Program Manager, UM Regulations
Emmanuel Gabriel, Health Services Analyst, UM Regulations

Table of Contents

RELATED REPORTS: **3**

EXECUTIVE SUMMARY: **3**

METHODOLOGY / DATA: **3**

I. PROGRAM EVALUATION 4
A. PROGRAM STRUCTURE 4
1. STAFFING OVERSIGHT 4
2. STAFFING WORKLOAD 5
3. EVALUATION OF THE PARTNERSHIP ADVISORY COMMITTEE STRUCTURE 7
B. PROGRAM SCOPE 9
1. POLICY REVIEW 9
C. PROGRAM PROCESS 9
1. UM RATES 9
2. CONSISTENCY OF APPLYING UM CRITERIA 10
3. APPROPRIATE CARE: MONITORING FOR OVER/UNDERUTILIZATION 10
D. INFORMATION SOURCE USED TO DETERMINE BENEFIT COVERAGE AND MEDICAL NECESSITY 14
E. PRIOR AUTHORIZATION REQUIREMENTS 14
F. INVOLVEMENT OF SENIOR LEVEL PHYSICIANS IN THE UM PROCESS 14
G. ASSESSING EXPERIENCE WITH THE UM PROCESS 15
1. IMPROVING PRACTITIONER EXPERIENCE WITH THE UM PROCESS 15
2. MEMBER EXPERIENCE WITH THE UM AND PHARMACY PROCESS 17
II. CONCLUSION: 17

APPENDIX A: EVALUATION OF UTILIZATION MANAGEMENT RATES **20**

I. OBJECTIVE 20
II. METHODOLOGY 20
III. RESULTS 21
IV. QUANTITATIVE ANALYSIS: 26
V. QUALITATIVE ANALYSIS: 27
VI. ACTIONS TAKEN / OPPORTUNITIES FOR IMPROVEMENT: 28
VII. SUMMARY 29

APPENDIX B: PHYSICIAN SATISFACTION SURVEY **30**

APPENDIX C: MEMBER EXPERIENCE WITH THE UM PROGRAM **32**

Related Reports:

1. Consistency in Applying Criteria Report – NCQA UM Standard 2 Element C
2. Evaluation of Utilization Management Rates – NCQA UM Standard 1 Element F (**Appendix A**)
3. Physician Satisfaction Survey (**Appendix B**)
4. Member Grievance and Appeals (G&A) PULSE Report (**Appendix C**)

Executive Summary:

The Annual Utilization Management (UM) Program Evaluation analyzes all aspects of data related to the UM program, identifies gaps and opportunities for improvement, and updates the program as necessary to ensure the program remains current and appropriate. Key elements in this annual evaluation include program structure, program scope, processes, and information sources, as well as level of involvement of senior-level physicians and designated behavioral healthcare practitioners in the UM program. This evaluation also reviews UM rates, criteria and prior authorization requirements to determine if they remain current and appropriate.

Methodology / Data:

As outlined below, Partnership HealthPlan of California (Partnership) collects all aspects of data related to the UM program and evaluates key elements and performance indicators of the UM program against its established goals and thresholds. From this evaluation, Partnership determines if any gaps exist in particular program activities or structure, identifies opportunities for improvement, prioritizes those opportunities, and takes actions that will improve the UM program in order to better serve our members. The evaluation was conducted as a collaboration between UM, Pharmacy, Quality Improvement, Provider Relations, Member Services and Grievances and Appeals.

The information noted below is used to complete the UM Program evaluation and is discussed further within this document.

Program Structure

- Physician to Nurse ratio
- Physician to Pharmacist ratio
- Staff to Treatment Authorization Request (TAR) ratio

Program scope, processes, and information sources used to determine benefit coverage and medical necessity

- Monitoring and evaluation of services and updates to policies and procedures (P&P), as appropriate, but at least annually
- Utilization Management activities to ensure appropriate care
- TAR timeliness
- Inter-Rater Reliability (IRR)
- Level of care

Level of involvement of senior level physician and designated behavioral healthcare practitioner in the UM program

- Advisory committee structure and participation

Member and Practitioner experience with the UM program

- Physician Satisfaction Survey
- Member Grievance & Appeals Pulse Report

I. PROGRAM EVALUATION

A. PROGRAM STRUCTURE

1. STAFFING OVERSIGHT

Physician to Nurse and Physician to Pharmacist ratios are assessed annually to evaluate the adequacy of staffing levels and the sufficiency of clinical oversight for authorizations requiring Medical Director review within the UM program. In 2025 and previous years, Partnership established a minimum threshold of Medical Directors to Nurses at 1:5 (0.20) and Medical Directors to Pharmacists at 1:5 (0.20). A ratio falling below Partnership's established threshold will require an evaluation of the current staffing structure and UM processes to determine if changes will be implemented. Staff count is an average of the total number of FTEs in each staff category at the end of each month.

Staffing Oversight												
2025	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**
Nurses	70	72	73	75	77	78	81	81	83	81	83	83
Pharmacists	5	5	5	5	6	6	5	5	5	6	6	6
MDs	**14**	**15**	**16**	**16**	**16**	**16**	**16**	**16**	**16**	**16**	**16**	**16**
MD: Nurse Ratio	**.200**	**.208**	**.219**	**.213**	**.208**	**.205**	**.198**	**.198**	**.193**	**.198**	**.193**	**.193**
MD: Pharmacist Ratio	2.80	3.00	3.20	3.20	2.67	2.67	3.20	3.20	3.20	2.67	2.67	2.67

Partnership's Physician to Pharmacist ratios met the threshold goal of 1:5 (0.20) for all months in 2025. Physician to Nurse ratios did not meet the threshold goal from July through December 2025. In 2025, Partnership's senior-level physicians and Utilization Management (UM) leadership collaborated to evaluate opportunities to improve authorization efficiency in anticipation of fiscal challenges at the state and federal levels. Through a review of TAR requirements, opportunities were identified, leading to a decision to relax certain requirements. This approach was intended to reduce physician workload, enhance provider and member satisfaction, decrease administrative friction with network providers, and improve timely access to care for members. For 2026, Partnership plans to re-assess and monitor our staffing ratios and recommends updating the established threshold from 1:5 (0.20) to 1:6 (0.167). This updated ratio accurately reflects Partnership's current staffing/hiring methodology while continuing to reflect a responsible clinical oversight model that allows for continued responsible utilization decision making. This recommendation will bring the Physician to Nurse ratio back within an appropriate threshold.

2. STAFFING WORKLOAD

Staff-to-TAR ratios are measured and monitored monthly to evaluate the level of staffing to ensure Partnership has adequate and appropriate staffing to meet the daily workload demands and comply with standards and requirements set forth by Partnership policy and procedure.

The UM and Pharmacy departments monitor and evaluate TAR to FTE ratios to assess staffing adequacy. A 20% change in the month-over-month ratio is established as the UM and Pharmacy Departments' threshold for further assessment of staffing model and to determine if an intervention is necessary. Calculation used is the month-to-month difference between TARs/staff/day divided by the TARs/staff/day from the preceding month. Example below is the inpatient number for TARs/Nurse/day in January = 12.4 and February = 12.6. The difference between the two months is .2 and the January Staff-to-TAR ratio is 12.4. The change in the month-over-month ratio is calculated as .2/12.4 = 0.01691 for a 1.61% change. A variance over the 20% threshold is shown in red.

Utilization Management:

Inpatient TARs – All Regions												
2025	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**
Nurse FTE (Inpatient)	22	22	22	24	25	25	26	26	28	26	26	26
Total TARs	5737	5266	5266	5240	5699	5620	5592	5569	5526	5470	4776	5617
Working days	21	19	21	22	21	21	22	21	21	23	18	20
TARs per nurse per day	**12.4**	**12.6**	**11.4**	**9.9**	**10.9**	**10.7**	**9.8**	**10.2**	**9.4**	**9.1**	**10.2**	**10.8**

Outpatient TARs – All Regions												
2025	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**
Nurse FTE (Outpatient)	38	40	42	42	43	43	44	44	44	44	46	46
Total TARs	20,134	18,724	20,606	21,507	20,753	20,102	21,161	19,736	19,982	21,430	16,812	18,503
Working days	21	19	21	22	21	21	22	21	21	23	18	20
TARs per nurse per day	**25.2**	**24.6**	**23.4**	**23.3**	**23.0**	**22.3**	**21.9**	**21.4**	**21.6**	**21.2**	**20.3**	**20.1**

SNF/LTC TARs – All Regions												
2025	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**
Nurse FTE (SNF/LTC)	10	10	9	9	9	10	11	11	11	11	11	11
Total TARs	2211	1815	1839	1666	1771	2025	2108	1814	1987	1999	1574	2002
Working days	21	19	21	22	21	21	22	21	21	23	18	20
TARs per nurse per day	**10.5**	**9.6**	**9.7**	**8.4**	**9.4**	**9.6**	**8.7**	**7.9**	**8.6**	**7.9**	**7.9**	**9.1**

For calendar year (CY) 2025, the UM department processed a total of **327,639** Treatment Authorization Requests (TARs) that included requests for outpatient settings, inpatient acute hospital settings, durable medical equipment, and skilled nursing/long term care facilities. This is a 4.95% decrease in total TAR volume compared to CY 2024. On a business daily average, Partnership's UM department processed 1310.6 TARs. Nurse full-time employees (FTEs) are defined by the total number of FTEs at the end of the month. Partial FTEs are the result of leave of absence and/or cross-coverage of staffing over different review types. TARs per staff ratios are expressed as the daily average of TARs per nurse FTE.

For UM staffing adequacy, month-to-month TAR to FTE ratios remained within the 20% variance threshold across all categories for every month, indicating that interventions implemented in 2024 were successful in stabilizing fluctuations in TAR volume and staffing associated with Partnership's 10-county expansion.

Pharmacy:

Pharmacy TARs – All Regions												
2025	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**
Total TARs	1047	872	917	906	1060	987	1099	1008	1011	1049	853	963
Working days	21	19	21	22	21	21	22	21	21	23	18	21
Tech FTE	7	7	7	7	7	7	7	7	7	8	8	8
TARs per Tech per day	**7.1**	**6.6**	**6.2**	**5.9**	**7.2**	**6.7**	**7.1**	**6.9**	**6.9**	**5.7**	**5.9**	**6.0**
RPh FTE	5	5	5	5	6	6	5	5	5	6	6	6
TARs per RPh per day	**10.0**	**9.2**	**8.7**	**8.2**	**8.4**	**7.8**	**10.0**	**9.6**	**9.6**	**7.6**	**7.9**	**8.0**

Pharmacy Technician and Clinical Pharmacist full-time employees (FTEs) are defined by the total number of respective FTEs at the end of the month. TARs per staff ratios are expressed as the daily average of TARs per Technician and Pharmacist FTE.

For CY 2025, Partnership's Pharmacy department processed a total of 11,772 TARs, which includes requests for Physician Administered Drugs (PADs). This is a 9.43% increase in total TAR volume compared to CY 2024. On a business daily average, Partnership's Pharmacy department processed 47 TARs.

In CY 2025, month-to-month TAR to FTE ratios outside of the 20% variance threshold were identified for Clinical Pharmacists from June to July due to an 11% increase in TAR volume coupled with the retirement of a full-time Clinical Pharmacist, and from September to October due to the hiring of an additional Clinical Pharmacist. The Pharmacy department hired one FTE Clinical Pharmacist in Q4 to address staffing gap seen in the July variance. A minor month-to-month variance outside of the 20% threshold was identified for Pharmacy Technicians from April to May due to normal fluctuations in TAR volume and the number of working days per month. Department leadership continued to monitor timeliness and inter-rater reliability (IRR) on a quarterly basis to ensure the Pharmacy department had adequate staffing levels to meet daily workload demands.

3. EVALUATION OF THE PARTNERSHIP ADVISORY COMMITTEE STRUCTURE

Physician Advisory Committee (PAC)

The PAC is responsible for oversight and monitoring of the quality and cost-effectiveness of medical care provided to Partnership members. The PAC reviews the activities of the Quality/Utilization Advisory Committee (Q/UAC), Pharmacy and Therapeutics (P&T) Committee, the Quality Improvement Program (QIP) Advisory Group, the Pediatric Quality Committee (PQC), and the Credentials Committee. The PAC then makes recommendations and assists Partnership in other ways as defined in Partnership's policies and procedures. The PAC meets at least ten (10) times a year, and may not convene in the months of July or December, with the option to add additional meetings if needed. Only committee members who are not Partnership staff may vote. The Chief Medical Officer (CMO) serves in a tie breaking capacity as necessary. A quorum is the majority of members of the committee or subcommittee, as described in the Partnership by-laws. Committee attendees include external primary care physicians (PCPs), board certified high-volume specialists and non-physician clinicians from medical centers serving Partnership Members. A voting provider member of the committee chairs PAC. Partnership monitors and evaluates meeting the quorum to ensure the UM program and policies are reviewed and approved by this Partnership advisory committee in compliance with Partnership policies and procedures.

2025	JAN	FEB	MAR	APR	MAY	JUN	AUG	SEPT	OCT	NOV
Total voting members in attendance	15	16	14	14	12	17	12	13	12	15
Total voting members	21	21	20	20	20	20	20	20	20	21
Quorum	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

A total of 10 PAC meetings were held in 2025. Quorum requirements were met for all 10 meetings. Review of the committee's activities confirm it executed the responsibilities of its functions. No further action or change to this aspect of the program was deemed necessary.

Quality/Utilization Advisory Committee (Q/UAC)

The Q/UAC is responsible for monitoring the quality of medical care and services provided to Partnership members. The Q/UAC annually reviews, recommends, and approves the UM Program Description submitted by the UM unit of the Health Services (HS) Department and provides recommendations to the PAC. The Q/UAC meets at least 10 times a year and may be convened in the months of July or December if needed. The Q/UAC is chaired by the Partnership Chief Medical Officer (CMO) and is comprised of formal voting representatives from community primary and specialty care practices, as well as consumer representative(s). The physician members represent licensed providers from hospitals, medical groups, and practice sites in geographic sections of Partnership's service area. The consumer representative(s) must be a consumer from one of the counties served by Partnership. A quorum is the majority of members of the committee or subcommittee as described in the Partnership by-laws. Voting members with annual attendance of less than 50 percent are evaluated for termination from the Q/UAC. Partnership monitors and evaluates meeting quorum to ensure the UM program and policies are reviewed and approved by this Partnership advisory committee in compliance with Partnership policies and procedures.

Quality/Utilization Advisory Committee (Q/UAC)

2025	JAN	FEB	MAR	APR	MAY	JUN	AUG	SEP	OCT	NOV
Total voting members in attendance	13	12	11	8	10	9	11	11	11	7
Total voting members	13	13	13	13	13	13	13	13	13	13
Quorum	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

A total of 10 Q/UAC meetings were held in 2025. Quorum requirements were met for all 10 meetings. Review of the committee's activities confirms it executed the responsibilities of its functions. No further action or change to this aspect of the program was deemed necessary.

Pharmacy & Therapeutics Committee (P&T)

The P&T Committee is chaired by Partnership's Chief Medical Officer (CMO), or designee such as the Director of Pharmacy, and is comprised of Partnership's Pharmacy Director, Associate and Regional Medical Directors, Partnership staff, and practicing members from the community including pharmacists, primary care physicians, behavioral health and other specialists. P&T makes decisions and recommendations on development and review of Physician Administered Drugs (PADs) provided under the medical drug benefit, medication policy and procedures, and drug approval criteria. P&T Committee also serves as Partnership's Drug Utilization Review (DUR) Board to review Partnership's DUR program and activities and make recommendations where necessary to improve Partnership's drug utilization. The P&T meets quarterly, providing regular activity reports and recommendations to the PAC, the approval authority for P&T related activities. A quorum, defined by one-third of the practicing members from the community, must be present in order to conduct the P&T Committee meeting. A consensus recommendation is made on drug coverage changes and drug/benefit policies. If no consensus is established, the issue is voted on with the decision determined by majority vote of the voting membership. Voting

membership includes the practicing members from the community, Partnership CMO, Partnership Medical Directors, Partnership Director of Pharmacy, Partnership Manager of Clinical Pharmacy and Partnership Clinical Pharmacists.

2025	January	April	July	October
Total # of Practicing Members in Attendance	3	4	2	2
Total # of Practicing Members	6	5	5	6
Quorum	Yes	Yes	Yes	Yes

A total of four P&T meetings were held in 2025. Quorum requirements were met for all four meetings. Review of the committee's activities confirms it executed the responsibilities of its functions. No further action or change to this aspect of the program was deemed necessary.

B. PROGRAM SCOPE

1. POLICY REVIEW

The UM and Pharmacy Departments review each policy at least annually in order to remain compliant with Partnership policy and regulatory requirements. Although six policies fell outside of this review schedule as a result of prolonged review for regulatory or contracting changes (5) and (1) administrative transfer of a policy from another department, no additional actions are needed at this time.

For 2025, the UM Department had 78 policies which encompass both behavioral and non-behavioral healthcare. Of those 78 policies, 53 policies did not have substantive revisions and were approved as consent. 25 policies had substantive revisions that were reviewed and approved by the respective external advisory committee.

For 2025, the Pharmacy Department had seven policies. Of those seven policies, four policies did not have substantive revisions and were approved as consent. Three policies had substantive revisions that were reviewed and approved by the respective external advisory committee.

Department	Policies	Policies reviewed for consent	Policy revisions approved
UM	78	53	25
Rx	7	4	3

C. PROGRAM PROCESS

1. UM RATES

(Reference*: NCQA Utilization Management Standard 1 Element F report*)**

UM and Pharmacy monitored approval and denial rates, as well as timeliness compliance, on a quarterly basis to evaluate performance and identify opportunities for operational and reporting improvements. The 2025 results, along with the interventions and ongoing activities by UM and Pharmacy to address identified gaps and opportunities are detailed in the UM 1F Evaluation of Utilization Management Rates Report (**Appendix A**).

2. CONSISTENCY OF APPLYING UM CRITERIA

(Reference*: NCQA Utilization Management Standard 2 Element C Report*)

The organization uses a methodology of 5% or 50 TARS, whichever is less, for each staff member to test inter-rater reliability (IRR). For 2025, 50 TARs per reviewer pursuant to Partnership policy MPUP3026 (including appeal cases where indicated on Partnership's P&P) were reviewed by each nurse coordinator, pharmacy technician, pharmacist, and physician for IRR.
The IRR concurrence rate by reviewer type is as follows:

- Nurse Reviewers: 4893 TAR cases were reviewed with a total concurrence rate of 95%
- Physician Reviewers: 865 TAR cases were reviewed with a total concurrence rate of 98%
- Pharmacist Reviewers: 280 TAR cases were reviewed with a total concurrence rate of 99%
- Pharmacy Technician Reviewers: 405 TAR cases were reviewed with a total concurrence rate of 100%

2025 Results:
The IRR aggregated annual concurrence rate for each reviewer type met the organization's established goal of 90%. For Inpatient Nurse Reviewers, the concurrence rate for Q2-Q4 fell below the 90% threshold, and several actions are being taken by UM Leadership in addressing this area for improvement as described in the UM 2C Report on Consistency in Applying Criteria.

3. APPROPRIATE CARE: MONITORING FOR OVER/UNDERUTILIZATION

Summary of Over/Underutilization Workgroup Activities from 2025
Prepared March 13, 2025
Summarized by Robert Moore, CMO

Distribution:
This report is included in the annual UM Program Evaluation and also presented to the Compliance Committee

Overview:

Partnership has systematic processes for monitoring for over-utilization and under-utilization of services (see Appropriate Service and Coverage Policy MPUP3006 and UM Program Description MPUD3001 for details). Evaluation and analysis of the availability of primary care and specialty care providers and accessibility of primary care and specialty care services are evaluated as part of the network adequacy and availability section of the QI evaluation, following DHCS and NCQA standards. The Over/Under-utilization Workgroup evaluates available data on PCP utilization to determine if any apparent under-utilization is associated with capitation of providers (versus due to data incompleteness). Specialty utilization patterns are addressed in the Access and Availability Grand Analysis (part of the annual QI evaluation), and as a separate report on follow ups for specialty referral, presented to IQI and Q/UAC each January.

The under-utilization of preventive care is initially identified in two ways: results of annual quality data reporting (HEDIS® measures and some others); and medical record reviews conducted periodically at each PCP and prenatal care sites. HEDIS results are reviewed by the quality committees (IQI and Q/UAC) and governance committees (PAC and Board). The HEDIS Measure Improvement Workgroup prioritizes interventions to improve HEDIS measures and monitors these interventions, and the NCQA Steering Committee oversees these efforts. Preventive healthcare deficiencies identified through the site review process are addressed with corrective action plans, or other actions as detailed in the Site Review Requirements and Guidelines Policy MPQP1022. Additional analysis of selected preventive care measures that are under-utilized is also presented at each Over/Under-utilization Workgroup meeting.

Over-utilization of clinical activities/procedures may be prevented through the overall prior authorization process for pharmacy, inpatient hospital, long-term care, skilled nursing, durable medical equipment, etc. The potential and propensity of health care providers to over-utilize a service is a factor for deciding which services/medications, etc. are subject to prior authorization; cost is the other major factor that is considered. The policies and standards which define prior authorization criteria are designed to assure medically necessary use without overuse. Surveillance for over-utilization of medications/services/equipment that do **not** require prior authorization is conducted by the Medical Directors, Nurses, and Pharmacists when reviewing clinical records for other purposes (in the UM/Pharmacy prior authorization, peer review, HEDIS® data abstraction, medical record review, fraud/waste/abuse reporting and grievance processes). Individual instances of potential over-utilization are noted and potentially addressed with the individual clinician (depending on the certainty of over-utilization by the reviewer and the implications of the over-utilization). If a systematic or more global over-utilization is suspected, the CMO or designee is consulted. Based on the review of the CMO or designee, data analysis related to the potential over-utilization will be conducted and the results presented at the Over/Under-utilization Workgroup. In addition, systematic review of hospital-based care metrics is reviewed for patterns of potential overuse. Actions based on the over-utilization depend on the circumstances but may include referral to FWA, Peer Review, Credentialing, and/or quality committees.

Summary of Over-Under Utilization Workgroup Analyses for January through December 2025

Meeting dates in 2025: January 29, April 30, July 30 and October 29.

The Over/Under-Utilization Workgroup continued to monitor, evaluate, and address both under-utilization and over-utilization across the Partnership network throughout 2024–2025. Analysis focused on primary and specialty care access, preventive service utilization, behavioral health trends, diagnostic testing, transportation use, genetic testing, and high-cost authorization patterns. Across these domains, the Workgroup identified persistent variation by county, language, and provider group, and guided targeted interventions to improve both access and appropriate use of services.

Primary Care Utilization

PCP visit rates remained a core monitoring area. Counties such as Del Norte, Colusa, and Sonoma demonstrated higher visit rates, while Solano, Placer, Nevada, Sierra, and Lassen counties remained consistently low. Data lags, clinic restructuring, and access barriers contributed to under-performance at specific sites.

Preventive Services

Several preventive care measures remain under-utilized despite targeted efforts:

- **Developmental screening** increased overall but remains highly variable, with lowest performance in Lassen, Trinity, and Plumas.
- **Childhood immunizations (CIS-10)** showed notable regional disparities, with three subregions below the national 25th percentile.
- **Maternal vaccinations** (Flu, Tdap, COVID, RSV) continue to show declining or low uptake, with significant disparities across language groups.
- **Tobacco screening and referral (TSR)** demonstrated strong year-over-year gains, becoming a relative success story.
- **ACEs screening** rose substantially in both claim volume and provider participation.
- **Well-Child (W30–6)** performance continues to be affected by access challenges and data capture gaps.

Specialty Services

Specialty visit volume continues to rise, exceeding 500,000 visits in 2025. Under-utilization persists in several high-need specialties, driven by capacity constraints and stagnant reimbursement rates. Telemedicine continues to play an expanding role.

Emergency Department Utilization

ED utilization increased by 28%, with the highest rates observed in the Eureka region and rural northern counties. ED use among unhoused Members rose 85%, driven by high-acuity presentations such as chest pain, suicidal ideation, and abdominal pain.

ED CT Scan Use

CT utilization varied widely, with increases noted at Oroville, Sierra Nevada Memorial, St. Helena, and Kaiser Vacaville, while other systems demonstrated declines. Monitoring and provider feedback activities remain ongoing.

Behavioral Health

Follow-up after ED visits for mental illness remains below national benchmarks. Utilization patterns show divergent trends: increases in County Mental Health and Carelon services coupled with reduced MH care delivered in PCP settings.

Foster Youth

Child Welfare–Involved Youth utilization remained stable, with well-child care and ED visits comprising the largest service categories. ED utilization was highest for Native/Pacific Islander youth and in rural northern counties.

Transportation

Non-Emergency Medical Transportation (NEMT)/ Non-Medical Transportation (NMT) utilization exceeded 88,000 monthly trips, with heavy reliance in rural areas. Demographic variation in usage patterns remains significant.

Genetic Testing

Genetic testing referrals increased, particularly for children aged 0–5. Denial rates remain high for several commonly billed codes, and a substantial portion of referrals originate from out-of-network providers.

Treatment Authorization Requests (TARs)

Authorization volume increased dramatically in 2024 (56.7% growth) with total expenditures exceeding $2.47B. High-cost categories included inpatient hospital care, SNF, and medical supplies.

Hospital OB Quality

Hospital performance on maternity measures varied substantially. Enloe and Marin Health performed well; Sutter Roseville and Dignity Sierra Nevada continued to show elevated C-section rates.

Improvement Activities

Partnership advanced multiple systemwide improvement efforts, including expanded eReports, new training initiatives (e.g., IMO (Improving Measure Outcomes) training series), Vax Facts campaigns, and incentive programs such as Growing Together (CIS-10). Additional analytic and operational follow-up was assigned for low-performing clinics and high-variability measures.

Overall Conclusion

The 2025 Workgroup findings reflect ongoing variability in utilization across regions and service types. While certain areas, such as tobacco screening and specialty access, demonstrated progress, other indicators, particularly childhood immunizations, maternal vaccinations, PCP access in specific counties, and follow-up after MH-related ED visits, require continued focus. The Workgroup’s ongoing monitoring and targeted interventions remain essential components of Partnership’s strategy to ensure appropriate, equitable, and effective service utilization across the network.

D. INFORMATION SOURCE USED TO DETERMINE BENEFIT COVERAGE AND MEDICAL NECESSITY

Partnership uses the most currently available InterQual® Criteria sets as the primary review guidelines for UM medical necessity decisions. For the calendar year 2025, UM used the 2024 InterQual decision criteria until the 2025 version became electronically available.

InterQual® criteria and other approved UM criteria outside of InterQual®, are reviewed, discussed, and evaluated at Partnership's Q/UAC and PAC as described in policy MPUP3139 Criteria and Guidelines for Utilization Management. Criteria utilized include, but are not limited to, Medi-Cal (State of California) guidelines, Medicare criteria, State policy letters, national treatment guidelines, and clinical practice recommendations from UpToDate®. UM criteria are also reviewed at the monthly internal CMO/MD meeting attended by the CMO and Medical Directors, leadership from UM, Behavioral Health, Population Health, Care Coordination, Quality, Pharmacy, and Grievances & Appeals, as well as ad hoc specialists in the appropriate field of the policies being developed.

In addition, Partnership's medication decision criteria and pharmacological drug classes are reviewed in collaboration with external and internal providers on an on-going and annual basis. Criteria are selected, reviewed, updated or modified using feedback from the Partnership staff, the P&T Committee, the PAC, the Community Advisory Committee (CAC), external providers, State policy letters, or medical literature among other sources.

Summary: UM and Pharmacy criteria were timely and comprehensively reviewed to ensure they remained current and appropriate. If revisions were needed, criteria was updated to align with current evidence. No change to this aspect of the program was deemed necessary.

E. PRIOR AUTHORIZATION REQUIREMENTS

Partnership's decision-making process and the criteria used to determine which pharmaceuticals require a TAR (including when a TAR is no longer required) were reviewed. Partnership's Pharmacy & Therapeutics (P&T) Committee determines whether or not a particular drug or pharmaceutical class shall be absent of TAR requirements based on therapeutic advantages in safety and efficacy, standards of care, and generally accepted place in therapy. Cost, utilization, and approval rates are also considered. In 2025, two drug codes had a TAR requirement added, and 12 had a TAR requirement removed. Among new drug codes, 82 had a TAR requirement added and 41 were designated as no TAR required. Meeting minutes and feedback from the P&T committee regarding this process were reviewed and found effective in determining pharmaceuticals that require a TAR. No opportunities were identified.

F. INVOLVEMENT OF SENIOR LEVEL PHYSICIANS IN THE UM PROCESS

Partnership's CMO, supported by multiple Medical Directors, is actively involved in the monthly review, discussion, and approval of policies and procedures in Partnership's IQI, P&T, and Q/UAC Committees. Policies approved in IQI, P&T, and Q/UAC are presented at PAC where attending network practitioners and Partnership's CMO and Medical Directors discuss and approve the

presented policies. The CMO also actively participates in clinical rounds and performs UM review and decisions to fulfill his assigned responsibilities based on scope of work as detailed in the UM Program Description. The CMO is integral to Partnership committees and UM processes. The CMO's level of involvement meets the needs of the UM Program.

Partnership has a designated Behavioral Health Clinical Director (MD) who actively participates in Partnership's UM Program. In Q1-Q3 2025, Partnership delegated behavioral health services to an NCQA Accredited organization. In Q4, Partnership managed behavioral health services in-house. Partnership Members do not need a referral or prior authorization to receive mental health services. [Partnership covers Non-Specialty Mental Health Services (aka Mild to Moderate Mental Health Services), while Specialty Mental Health Services (aka Serious and Persistent Mental Health Services) are carved out to the State and Counties.] The Behavioral Health Clinical Director actively participates in various Partnership Quality committees (i.e. IQI, Q/UAC, Over-/Under-utilization) and oversees BH policy development and updates. Partnership's committees also include network behavioral health practitioners who actively participate and contribute to Partnership's UM Program. The level of involvement of the BH Clinical Director meets the needs of Partnerships' UM Program.

G. ASSESSING EXPERIENCE WITH THE UM PROCESS

1. IMPROVING PRACTITIONER EXPERIENCE WITH THE UM PROCESS

Partnership contracts with an external entity, Press Ganey (PG), to administer the Physician Satisfaction Survey annually. All contracted Primary Care Provider (PCP) sites and Specialists across Partnership's 24 counties were surveyed according to Northern, Southern, and Eastern network regions. The 2025 survey was the first to incorporate Partnership's expansion counties, with 10 newly added counties comprising the Eastern Region. A total of 499 physician/specialist surveys were completed from March through June 2025. The response rates for the two types of providers are as follows: PCPs 72.4%, Specialists 70.9%.

Partnership establishes a minimum threshold of 90% satisfaction and tracks and trends variations greater than 5% from the preceding year.

Please refer to **Appendix B** for Physician Satisfaction Survey Data.

Summary of PCP Outcomes:

- All UM department questions among PCPs met their respective goal of 90% for strongly agree or agree. For the Pharmacy department, the following question did not meet threshold in the Southern Region:
  1. "I am satisfied with my interactions with PHC Pharmacy Staff." (84%)

Interventions:

The Partnership Pharmacy Department has implemented the following interventions to address the PCP Outcome listed above that did not meet threshold:

1. Collaborate with the Provider Relation (PR) team to participate in clinic site visits to share information about the Partnership Pharmacy program and the services available to providers.
2. Collaborate with the PR team to educate PCPs on the differences between the Partnership Pharmacy program and Medi-Cal Rx.

Summary of Specialist Outcomes:

- Six UM questions among Specialists did not meet the 90% goal for strongly agree or agree:
  1. "When I receive a referral, it contains sufficient clinical information for me to know how to proceed with treatment." (88%)
  2. "My TARs are approved in a timely manner." (87%)
  3. "When a TAR for medical service is denied by the plan, the basis for denial is clearly specified." (87%)
  4. "When one of my TARs is returned/deferred for more information, I know what additional documentation I need to submit." (88%)
  5. "I am satisfied with my interactions with UM Staff." (89%)
  6. "I am satisfied with the PHC e-RAF system." (89%)

Interventions:

The Partnership UM Department has implemented the following interventions to address the Specialist Outcomes listed above that did not meet threshold:

1. A potential gap in provider education for Eastern and Southern Region specialists was identified as a potential root cause and driver of multiple results throughout this survey period. Over the past year, UM has engaged with the Provider Relations team in educating network providers about Partnership's online resources available on our website, including UM policies and TAR requirements. UM will continue to work with the Provider Relations team in identifying opportunities to educate this provider group on Partnership processes and resources.
2. Partnership UM experienced a high turnover of experienced staff, which resulted in an influx of newer, untrained staff during 2024-2025. This resulted in periodic challenges for the UM team in meeting timeliness requirements for UM decisions, as well as ensuring required information was included in delay and denial notifications. UM Leadership has taken the following actions in addressing overall timeliness and quality control concerns:
   a. Creation of a UM Training & Education team to address training opportunities in real time.
   b. Daily file reviews conducted by UM Regulations staff to monitor and address opportunities to align processes with NCQA requirements.
   c. Adjustments to UM workflows to remove barriers created by nurses working only in specific review categories and provide cross-training across the review continuum. This will allow nursing staff to effectively respond to fluctuations in TAR volume and staffing levels on a daily basis.
3. Partnership UM will be migrating from our legacy TAR platform (Essette) to a new enterprise application (Jiva). This migration has allowed Partnership UM an opportunity to address areas of process inefficiencies identified in the legacy platform that may be contributing to underperformance in areas of focus in this survey.

Conclusion:

The results from the 2025 Physician Satisfaction Survey revealed opportunities to improve provider satisfaction with Partnership's UM process. UM and Pharmacy departments will continue to monitor survey results annually and provide interventions as needed.

2. MEMBER EXPERIENCE WITH THE UM AND PHARMACY PROCESS

This portion of the program evaluation was provided by the Grievance and Appeals (G&A) department through the G&A PULSE Report. The report contains an analysis of Member-reported Grievance concerns about any dissatisfactory experience related to Utilization Management (UM). If the number of grievances per 1,000 members in the current period (2025) increases by more than 10% from the previous period (2024), then the threshold is triggered. An unmet NCQA Threshold identifies growing areas of Member dissatisfaction, and intervention(s) may be required.

While Partnership's membership decreased slightly in 2025, the total number of cases received increased, including the number of grievances related to the UM process overall. In 2025, a total of 426 concerns were reported regarding the UM process, compared to 270 concerns in the previous year. Because of this increase, Partnership did exceed the 10% threshold in three categories in 2025.

The primary issue reported concerning the UM process was access-related issues. Notably, 57.3% of these access-related issues were associated with Partnership's Referral Authorization Form (RAF) process, while the remaining 42.7% were linked to the Treatment Authorization Request (TAR) process.

Among the reported issues within the referral process, delays by providers (162) was the most reported concern. Members alleged that their primary care providers were delaying submission of RAFs, consequently causing delays in obtaining appointments with specialists.

The most prominent driver behind Member dissatisfaction with the TAR process was related to Members alleging that their providers delayed submission of TARs to Partnership (87 reported concerns).

Conclusion:

Partnership's evaluation of the Member Experience with the UM Program in 2025 revealed opportunities to improve Member satisfaction through focused and sustained engagement with our Provider Relations team in pursuing educational opportunities with our provider network on Partnership processes and resources.

Please refer to **Appendix C** for further details of Member satisfaction data for 2025.

II. CONCLUSION:

The UM Program Evaluation report assesses the program's effectiveness, capacity, and integrity in managing the utilization of healthcare resources delivered to our members and ensures our members receive the appropriate quality and quantity of care at the appropriate time and setting. In addition, the evaluation report identifies gaps and improvement opportunities for which interventions are developed.

In this evaluation, the results demonstrated strengths in the areas of consistency in applying criteria, comprehensive review of information sources, program structure and appropriate workload management. Opportunities were identified in sustaining Physician to Nurse staffing oversight ratios

and IRR concurrence rate for inpatient nurse reviewers. TAR timeliness will also be an area of focus in the upcoming year due to a planned software update.

Physician to Nurse ratios did not meet the threshold goal from July through December 2025. In 2025, Partnership's senior-level physicians and Utilization Management (UM) leadership collaborated to evaluate opportunities to improve authorization efficiency in anticipation of fiscal challenges at the state and federal levels. Through a review of TAR requirements, opportunities were identified, leading to a decision to relax certain requirements. This approach was intended to reduce physician workload, enhance provider and member satisfaction, decrease administrative friction with network providers, and improve timely access to care for members. For 2026, Partnership plans to re-assess and monitor our staffing ratios and recommends updating the established threshold from 1:5 (0.20) to 1:6 (0.167). This updated ratio accurately reflects Partnership's current staffing/hiring methodology while continuing to reflect a responsible clinical oversight model that allows for continued responsible utilization decision making. This recommendation will bring the Physician to Nurse ratio back within an appropriate threshold.

Based on the results from the 2025 UM program evaluation, Partnership's UM Leadership concludes there are no significant changes required for the UM program. Partnership's UM program functions effectively and efficiently through a solid program structure, comprehensive set of policies, and robust support, guidance, and engagement from senior level physicians and advisory committee members. Activities addressing the improvement opportunities will continue to be monitored, measured, and reported in future evaluations.

OPPORTUNITIES/INTERVENTIONS

Priority	Opportunities Identified	Barriers	UM Program Evaluation Component	Interventions
1	**IRR concurrence rate for inpatient nurse reviewers**	Lack of consistency in applying inpatient criteria by UM Nurses	UM Program Processes	• Tracking and trending for repeated deficiencies to be observed and acted upon by UM Leadership on a quarter-by-quarter basis. • Conduct team-wide discussions on consistency in applying medical necessity criteria during internal Inpatient Rounds • Conduct annual training on InterQual for UM Nurses. • UM Nurse Scorecard template updated to include IRR components. The scorecard is used to score IRR and other competencies for each nurse on a monthly basis. Transition quarterly IRR monitoring process to the UM Training & Education team to focus and standardize the application of inter-rater reviews and ensure that secondary reviews are consistent.
2	**Physician**	Uncertain fiscal	UM Program	• Continuing to assess and monitor staffing ratios

Priority	Opportunities Identified	Barriers	UM Program Evaluation Component	Interventions
	to Nurse staffing ratios	climate at State and Federal levels	Structure	• Continuing to assess opportunities for increased efficiency in evaluating TAR requirements. • Increase staff ratio threshold from 1:5 (0.20) to 1:6 (0.167) based on 2025 process improvement and operational assessment
3	**Provider Experience with the UM Process**	Negative provider perceptions of Medi-Cal Rx may be conflated with Partnership's Pharmacy processes.	UM Program Scope	• Collaborate with the Provider Relations (PR) team to participate in clinic site visits to share information about the Partnership Pharmacy program and the services available to providers. • Collaborate with the PR team to educate PCPs on the differences between the Partnership Pharmacy program and Medi-Cal Rx
4	**Member Experience with the UM Process**	Absence of year-over-year comparative data for recent Eastern Region expansion counties con-strains analysis of factors contributing to lower Member satisfaction scores.	UM Program Processes	• Collaborate with the G&A team to include additional data points in the PULSE report for "Member Experience with the UM Program" — adding data for Member "County" and "Provider Substantiation" (Yes or No). This additional information will allow UM to further stratify the data and gain insights into trends in Member concerns. • Collaborate with the PR team in pursuing educational opportunities with our provider network on Partnership processes and resources to improve Member satisfaction with the authorization process.

Although it is not an identified opportunity based on the 2025 UM program evaluation, TAR timeliness will be an area of focus for 2026. UM will be transitioning to a new TAR processing platform in Q4 2026 and will be increasing the cadence of monitoring timeliness reporting from weekly to daily for the first 30-60 days of the go-live period.

Appendix A: Evaluation of Utilization Management Rates

NCQA Utilization Management Standard 1 Element F
(Calendar Year 2025)

Production Date: March 23, 2026
Prepared by: Tony Hightower, CPhT, Associate Director of UM Regulations
Kory Watkins, Director of Grievance & Appeals
Latrice Innes, Manager of Grievance & Appeals Compliance
Baylie Allegro, Compliance Analyst, Grievance & Appeals
Andrea Ocampo, Pharm.D., Clinical Pharmacist
Lady Lyn Carlos, CPhT, Pharmacy Technician II
Anna Campbell, MPH, Policy Analyst, UM Regulations
Kandice Dixon, Program Manager II, UM Regulations
Emmanuel Gabriel, Health Services Analyst, UM Regulations

I. Objective
The purpose of this evaluation is to assess key Utilization Management (UM) rates to ensure approval and denial rates are appropriate and authorizations are reviewed timely. This evaluation also reviews overall appeal rates and appeal overturn rates to assess the accuracy of initial determinations.

The organization monitors the timeliness of notification of all UM Adverse Benefit Determinations (ABDs) resulting from medical necessity review and calculates the percentage of decision notifications that adhere to timeframes specified in UM 5 Elements A and C using at least 12 months of data. At a minimum, the timeliness report calculates rates of adherence to timeframes for each category of request (i.e., urgent concurrent, urgent pre-service, non-urgent pre-service and post-service). Definition and timeliness parameters for each category of request is provided in the organization's Treatment Authorization Request (TAR) Review Process policy (MCUP3041) and Medical Benefit Medication TAR policy (MCRP4068). As of the production date of this report, the organization manages a Medicaid line of business.

II. Methodology
The following rates were analyzed for non-behavioral UM decisions and Pharmacy UM decisions:
- Overall approval rate
- Overall denial rate
- Overall timeliness of notification rate for denials
- Timeliness of notification rate for urgent concurrent denials
- Timeliness of notification rate for urgent preservice denials
- Timeliness of notification rate for non-urgent preservice denials
- Timeliness of notification rate for post-service denials
- Overall appeal rate
- Appeal overturn rate

Overall approval rate is the percentage of UM decisions that resulted in an approval. Overall denial rate is the percentage of UM decisions that resulted in a denial. Partial approvals/denials are included in both approval and denial rates. Rates exclude post-service requests, withdrawn requests, pending decisions, duplicate and dismissed requests.
Timeliness is reported by timeliness of decision notification. Timeliness of notification is measured from

the date and time the organization initially receives the request from the member or member's authorized representative, even if the organization does not have all the information necessary to make the decision. Notification is defined as the time when the electronic or written notification letter to the member and practitioner is generated and time-stamped in the UM platform by UM staff once a determination has been made. Data inclusion timeframe for this report is from January 1, 2025 through December 31, 2025 and includes only ABDs resulting from medical necessity review and benefit determinations, whether they are modification approvals or denials.

Appeal rates incorporate both UM and Pharmacy appeals and include member appeals and appeals submitted by providers on behalf of members.

Goal: A 95% compliance rate for timeliness of notification against the NCQA standards for all categories of requests (urgent concurrent, urgent pre-service, non-urgent, and post-service) for each product line. Approval and denial rate trends are evaluated for appropriateness. Significant deviations in denial rates are analyzed for root causes. Sample results are validated at least annually to ensure accuracy of the report. Results are reviewed on a quarterly basis with department leadership and analyzed on an annual basis under the UM 1 Element G, UM Program Evaluation report.

III. Results

UM 1 Element F, Factor 1: Non-Behavioral UM Rates

The following section includes two service lines for UM non-behavioral medical services – outpatient and inpatient.

Outpatient TARs consist of services including, but not limited to, DME and BHT. SNF/LTC TARs are also measured in this service line for timeliness.

Inpatient TARs consist of services including, but not limited to, medical and surgical hospitalization.

In accordance with NCQA Standard UM 5 Element A, timeliness for non-behavioral UM notification is based on the following time frame standards:

1. Urgent concurrent decisions and notification will be made within 72 hours of receipt of the request.
2. Urgent pre-service decisions and notification will be made within 72 hours of receipt of the request.
3. Non-urgent pre-service decisions and notification will be made within 14 calendar days of receipt of the request.
4. Post-service decisions and notification will be made within 30 calendar days of receipt of the request.

OVERALL RATES (January 1, 2025 through December 31, 2025)[1]:
Timeliness data presented includes only Adverse Benefit Determinations (ABD) resulting from medical necessity and benefit coverage reviews.

[1]UM approval and denial rates include initial medical necessity determinations, benefit determinations, and administrative determinations

Overall Approval Rate	Q1	Q2	Q3	Q4	Total
Numerator	62,201	65,265	64,972	58,199	250,637
Denominator	80,665	83,097	82,402	76,904	323,068
Rate	**77.11%**	**78.54%**	**78.85%**	**75.68%**	**77.58%**

Overall Denial Rate	Q1	Q2	Q3	Q4	Total
Numerator	18,464	17,832	17,430	18,705	72,431
Denominator	80,665	83,097	82,402	76,904	323,068
Rate	**22.89%**	**21.46%**	**21.15%**	**24.32%**	**22.42%**

Overall Timeliness of Denials Notification	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total	Goal (Goal Met)
Total # of requests compliant with notification timeframe (numerator)	18,616	17,981	17,704	18,976	73,277	
Total # requests (denominator)	18,716	18,144	17,848	19,057	73,765	
% compliant	**99.47%**	**99.10%**	**99.19%**	**99.57%**	**99.34%**	95% **(Yes)**

UM – Urgent Concurrent: *notification within 72 hours of the request (NCQA standard)*	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total	Goal (Goal Met)
Total # of requests compliant with notification timeframe (numerator)	1,690	2,164	2,047	2,053	7,954	
Total # requests (denominator)	1,746	2,278	2,162	2,111	8,297	
% compliant	**96.79%**	**95.00%**	**94.68%**	**97.25%**	**95.87%**	95% **(Yes)**

UM – Urgent Pre-service: *notification within 72 hours of the request (NCQA standard)*	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total	Goal (Goal Met)
Total # of requests compliant with notification timeframe (numerator)	1,315	1,236	1,217	1,261	5,029	
Total # requests (denominator)	1,356	1,281	1,240	1,279	5,156	
% compliant	**96.98%**	**96.49%**	**98.15%**	**98.59**	**97.54%**	95% **(Yes)**

UM – Non-urgent Pre-service: *notification within 14* calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Total**	**Goal (Goal Met)**
Total # of requests compliant with notification timeframe (numerator)	15,359	14,270	14,023	15,311	58,963	
Total # requests (denominator)	15,362	14,273	14,028	15,315	58,978	
% compliant	**99.98%**	**99.98%**	**99.96%**	**99.97%**	**99.97%**	95% **(Yes)**

**According to DHCS requirements, Partnership makes determinations and notifications of non-urgent pre-service TARs within business 5 days. Figures represent compliance with 5 business day standard*

UM – Post-service: *notification within 30 calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Total**	**Goal (Goal Met)**
Total # of requests compliant with notification timeframe (numerator)	252	311	417	351	1,331	
Total # requests (denominator)	252	312	418	352	1,334	
% compliant	**100%**	**99.68%**	**99.76%**	**99.72%**	**99.78%**	95% **(Yes)**

UM 1 Element F, Factor 2: Behavioral UM Rates

As described in MPUD3001 *Utilization Management Program Description*, Partnership does not require TARs for Non-Specialty Mental Health Services (*aka* mild to moderate mental health services), and Specialty Mental Health Services (*aka* serious and persistent mental health services) are carved out to the state. Data collection was completed based on NCQA requirements to confirm there were no authorization requests specific to behavioral health. The results indicated zero (0) authorization requests for BH services during the measurement period. The decision timeliness tables are provided below to demonstrate findings.

In accordance with NCQA Standard UM 5 Element B, timeliness for behavioral UM notification is based on the following timeframe standards:

1. Urgent concurrent decisions and notification will be made within 72 hours of receipt of the request.
2. Urgent pre-service decisions and notification will be made within 72 hours of receipt of the request.
3. Non-urgent pre-service decisions and notification will be made within 14 calendar days of receipt of the request.
4. Post-service decisions and notification will be made within 30 calendar days of receipt of the request.

OVERALL RATES (January 1, 2025 through December 31, 2025):
Timeliness data presented includes only Adverse Benefit Determinations (ABD) resulting from medical

necessity and benefit coverage reviews.

UM – Urgent Concurrent: *notification within 72 hours of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Total**	**Goal (Goal Met)**
Total # of requests compliant with notification timeframe (numerator)	0	0	0	0	0	
Total # requests (denominator)	0	0	0	0	0	
% compliant	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	95% (N/A)

UM – Urgent Pre-service: *notification within 72 hours of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Total**	**Goal (Goal Met)**
Total # of requests compliant with notification timeframe (numerator)	0	0	0	0	0	
Total # requests (denominator)	0	0	0	0	0	
% compliant	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	95% (N/A)

UM –Non-urgent Pre-service: *notification within 14* calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Total**	**Goal (Goal Met)**
Total # of requests compliant with notification timeframe (numerator)	0	0	0	0	0	
Total # requests (denominator)	0	0	0	0	0	
% compliant	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	95% (N/A)

**According to DHCS requirements, PHC makes determinations and notifications of non-urgent pre-service TARs within business 5 days. Figures represent compliance with 5 business day standard .*

UM – Post-service: *notification within 30 calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Total**	**Goal (Goal Met)**
Total # of requests compliant with notification timeframe (numerator)	0	0	0	0	0	
Total # requests (denominator)	0	0	0	0	0	
% compliant	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	95% (N/A)

UM 1 Element F, Factor 3: Pharmacy UM Rates

The following section includes Physician Administered Drug (PAD) TARs. PADs are excluded from the federal definition of "covered outpatient drugs," as stated in SSA 1927(k)(3). The definition of covered outpatient drugs is outlined in MCRP4068 Medical Benefit Medication TAR policy. Thus, timeliness for pharmacy notification is based on the following timeframe standards in accordance with NCQA Standard UM 5 Element C:

1. Urgent concurrent decisions and notification will be made within 72 hours of receipt of the request.
2. Urgent pre-service decisions and notification will be made within 72 hours of receipt of the request.
3. Non-urgent pre-service decisions and notification will be made within 14 calendar days of receipt of the request.
4. Post-service decisions and notification will be made within 30 calendar days of receipt of the request.

OVERALL RATES (January 1, 2025 through December 31, 2025)[2]:
Data presented includes only medical necessity and benefit determinations for Physician Administered Drugs (PADs)

[2] partial approvals/denials are included in both approval and denial rates

(PAD) requests covered under Partnership's medical benefit. Timeliness data presented includes only Adverse Benefit Determinations (ABD) resulting from medical necessity and benefit coverage reviews.

Overall Approval Rate	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Numerator	1,677	1,814	2,013	1,808	7,312
Denominator	1,967	2,122	2,282	2,098	8,469
Rate	**85.17%**	**85.49%**	**88.21%**	**86.18%**	**86.34%**

Overall Denial Rate	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Numerator	397	403	421	427	1,648
Denominator	1,967	2,122	2,282	2,098	8,469
Rate	**20.18%**	**18.99%**	**18.45%**	**20.35%**	**19.46%**

Overall Timeliness of Denials Notification	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total	Goal (Goal Met)
Total # of requests compliant with notification timeframe (numerator)	415	428	443	451	1,737	
Total # requests (denominator)	420	430	449	454	1,753	
% compliant	**98.81%**	**99.53%**	**98.66%**	**99.34%**	**99.09%**	95% (Yes)

Pharmacy - Urgent Pre-service: *notification within 72 hours of the request (NCQA standard)*	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total	Goal (Goal Met)
Total # of requests compliant with	126	154	154	143	577	

notification timeframe (numerator)						
Total # requests (denominator)	130	156	160	146	592	
% compliant	**96.92%**	**98.72%**	**96.25%**	**97.95%**	**97.47%**	95% (Yes)

Pharmacy - Urgent Concurrent: *notification within 72 hours of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Total**	**Goal (Goal Met)**
Total # of requests compliant with notification timeframe (numerator)	0	0	0	0	0	
Total # requests (denominator)	0	0	0	0	0	
% compliant	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	95% (**N/A**)

Pharmacy-Non-urgent Pre-service: *notification within 14* calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Total**	**Goal (Goal Met)**
Total # of requests compliant with notification timeframe (numerator)	266	247	261	281	1,055	
Total # requests (denominator)	267	247	261	281	1,056	
% compliant	**99.63%**	**100.00%**	**100.00%**	**100.00%**	**99.91%**	95% (Yes)

**According to DHCS requirements, Partnership makes determinations and notifications of non-urgent pre-service TARs within 5 days.*

Pharmacy – Post-service: *notification within 30 calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Total**	**Goal (Goal Met)**
Total # of requests compliant with notification timeframe (numerator)	23	27	28	27	105	
Total # requests (denominator)	23	27	28	27	105	
% compliant	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	95% (Yes)

UM 1 Element F, Factor 4: Appeal Rates

	Overall Appeal Rate	**Appeal Overturn Rate**
Numerator	2,186	643
Denominator	75,005	2,186
Rate	**2.91%**	**29.41%**

IV. Quantitative Analysis:

UM:
In 2025, for non-behavioral healthcare decisions, UM had an overall 77.58% and a 22.42% denial rate. When analyzing rates by quarter, both approval rates (Q1: 77.11%, Q2: 78.54%, Q3: 78.85%, Q4:

75.68%) and denial rates (Q1: 22.89%, Q2: 21.46%, Q3: 21.15%, Q4: 24.32%) remained consistent throughout the year. 2.25% of denials were appealed, with 14.75% of those appeals request resulting in an overturn of the original decision.

Timeliness goals were met for urgent concurrent, urgent pre-service, non-urgent pre-service, and post-service decisions. For all TAR categories combined, UM achieved a 99.34% timeliness rate, which exceeded the 95% threshold goal for UM non-behavioral healthcare decisions for 2025.

Pharmacy:
In 2025, Pharmacy had an overall 86.34% approval rate and 19.46% denial rate. Quarterly reports show TAR approval rates remained stable throughout the year (Q1: 85.17%; Q2: 85.49%; Q3: 88.21%, Q4: 86.18%). TAR denial rates also remained stable throughout the year (Q1: 20.18%; Q2: 18.99%; Q3: 18.45%; Q4: 20.35%). The Pharmacy department processes appeals submitted by providers on behalf of members. In 2025, less than 1% of denials (0.36%) were appealed. The Pharmacy department processed 6 provider appeals, with 50% of the appeals overturned/overturned with modifications.

Timeliness goals were met for urgent preservice, nonurgent preservice, and post-service requests. The pharmacy department did not review any urgent concurrent requests in 2025. Overall results for all TAR categories combined (99.09%) show pharmacy has met the 95% timeliness goal for notification of pharmacy decisions in 2025.

Appeal Rates:
In 2025, the combined appeal rate for Grievance & Appeals (G&A), UM, and Pharmacy was 2.91%. This is comprised of 75,005 combined denials from Pharmacy and UM, and 2,186 combined appeals from G&A, UM, and Pharmacy. Of those 2,186 appeals, 643 were overturned. This made the overturn rate 29.41%. The upheld rate was 70.59%.

V. Qualitative Analysis:

UM:

Quarter-over-quarter analysis of denial rates reveal consistent trending for 2025. Medical Necessity, Benefit, and Administrative decisions are made in accordance with a well-established hierarchy of clinical criteria. Relatively low appeal and decision overturned rates suggest that UM's initial decision-making process is robust and produces accurate results.

UM met the 95% timeliness goal for all review categories in 2025. This suggests that a continued adherence to UM's action plan for timeliness compliance will continue to yield positive results

Pharmacy:

Quarter-over-quarter trend analysis did not reveal any significant deviations or irregularities in approval or denial rates throughout 2025. Quarterly reports show an increase in denial rate from 18.45% in Q3 to 20.35% in Q4. The ~2% increase in denials in Q4 was partly due to the introduction of a new preferred product requirement to Partnership's Eylea drug criteria. No other discernable trends were identified. Denials were aligned with established clinical criteria. Appeal rates for pharmacy remained low at 0.36%

for 2025, suggesting appropriate initial decision-making. The appeal overturn rate is 50%, with most overturns resulting from additional clinical information provided by the provider at the time of appeal.

In 2025, TAR volume for the Pharmacy department increased by 9.43% year over year from 2024. The Pharmacy department continued to meet the 95% timeliness goal for all review categories in 2025.

Appeal Rates:
A driver of appeals trends for UM in 2025 has been the practice of two contracted hospital providers submitting an increasing amount of appeal requests associated with denied or partially approved acute inpatient stays where the member had already discharged and did not experience a delay or denial in care. Although UM has historically processed such requests as Provider Appeals on behalf of members, our re-evaluation of our appeals process has led us to determine that these scenarios more appropriately belong to a Provider Dispute Resolution process and workflow. G&A experienced a steady increase in appeals each quarter in 2025. There were 284 appeals closed in Q4 of 2025, compared to 198 closed in Q1. This is primarily attributed to an increase in Community Supports-related appeals, specifically the Medically Tailored Meals benefit. Partnership released a new Community Supports policy in August 2025, outlining the eligibility criteria for each of the benefits available, including Medically Tailored Meals. G&A's overturned appeals mainly consisted of specialist referrals and durable medical equipment. This was often caused by missing documents during the original denial, or additional proof of medical necessity being received during the appeal process. Many TARs and RAFs were denied administratively for various reasons but were overturned during the appeal process when the missing documents were received or medical necessity was proven.

VI. Actions Taken / Opportunities for Improvement:

UM:
In 2025, UM pursued, and continues to pursue the following remedies in order to mitigate risk to overall timeliness:

- Adjustments to UM workflows to decrease training timeframes and allow for new hires to enter into production more quickly
- Adjustments to the entire UM review workflow continuum to address inefficiencies
- Evaluating TAR denial rates to create opportunities for auto-approval for requests with low denial rates

Pharmacy:
In 2025, approval and denial rates have remained consistent throughout the year. Timeliness goals were met for all types of requests. No opportunities for improvement were identified.

Grievance and Appeals:
G&A did not identify any concerns requiring mitigation based on the review of our appeals and overturned decisions. The increase in appeals was caused by the Community Supports policy clarification. Members had previously been approved for two or more rounds of medically tailored meals when eligibility criteria were less clearly defined.

VII. Summary

Approval, denial and timeliness rates for 2025 support timely access to medically necessary Physician Administered Drugs and Non-Behavioral Healthcare services.

The UM and Pharmacy departments plan to continue to closely monitor and evaluate timeliness performance and data integrity and will provide quarterly reports to leadership for update and review. G&A will continue to monitor trends in both appeals filed and overturned decisions to look for opportunities for improvement.

Appendix B: Physician Satisfaction Survey

Improving Practitioner Experience with the UM process

Northern Region Counties: Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, Trinity
Southern Region Counties: Lake, Marin, Mendocino, Napa, Solano, Sonoma, Yolo
Eastern Region (Expansion) Counties: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba

Key:

- ≥5% Improvement relative to prior year
- ≥5% Decline relative to prior year
- n= total respondents

Trended PCP Regional and Plan-wide Performance on the Physician Satisfaction Survey

PCP (% Strongly Agree or Agree)	2024			2025				% Difference			Goal	
	North (n=46)	South (n=97)	2024 Total	North (n=56)	South (n=156)	East (n=53)	2025 Total 265	North	South	East	2025 Goal	Goal Met?
I am satisfied with my interactions with UM Staff.	92%	92%	92%	96%	99%	96%	98%	4%	7%	N/A	90%	Yes
I am satisfied with the PHC e-RAF system.	95%	99%	97%	100%	99%	92%	98%	5%	0%	N/A	90%	Yes
I am satisfied with my interactions with PHC Pharmacy Staff	94%	94%	94%	96%	75%	96%	84%	2%	-19%	N/A	90%	No

Trended Specialist Regional and Plan-wide Performance on the Provider Satisfaction Survey

Specialist (% Strongly Agree or Agree)	2024			2025				% Difference			Goal	
	North (n=53)	South (n=107)	2024 Total	North (n=59)	South (n=114)	East (n=61)	2025 Total 234	North	South	East	2025 Goal	Goal Met?
I get all the information I need from a referring physician to determine if my services are needed	77%	99%	92%	91%	94%	86%	91%	+14%	-5%	N/A	90%	Yes
When I receive a referral, it contains sufficient clinical information for me to know how to proceed with treatment.	82%	98%	93%	91%	88%	85%	88%	+9%	-10%	N/A	90%	No

Specialist (% Strongly Agree or Agree)	2024			2025				% Difference			Goal	
	North (n=53)	South (n=107)	2024 Total	North (n=59)	South (n=114)	East (n=61)	2025 Total 234	North	South	East	2025 Goal	Goal Met?
I know how to determine whether or not a service requires that a TAR (Auth) be submitted to PHC	86%	96%	92%	96%	93%	91%	93%	**10%**	-3%	N/A	90%	Yes
My TARs are approved in a timely manner.	94%	97%	96%	98%	90%	69%	87%	4%	**-7%**	N/A	90%	**No**
When a TAR for medical service is denied by the plan, the basis for denial is clearly specified.	87%	91%	90%	98%	91%	69%	87%	**7%**	0%	N/A	90%	**No**
When one of my TARs is returned/deferred for more information, I know what additional documentation I need to submit.	98%	92%	94%	96%	94%	68%	88%	-2%	2%	N/A	90%	**No**
I am satisfied with my interactions with UM Staff.	100%	98%	99%	100%	92%	74%	89%	0%	**-6%**	N/A	90%	**No**
I am satisfied with the PHC e-RAF system.	90%	96%	94%	93%	98%	69%	89%	3%	2%	N/A	90%	**No**
I am satisfied with the PHC e-TAR system.	96%	97%	96%	98%	89%	88%	91%	-3%	**-8%**	N/A	90%	Yes
I am satisfied with my interactions with PHC Pharmacy Staff	100%	98%	98%	94%	100%	88%	95%	**-6%**	2%	N/A	90%	Yes

Appendix C: Member Experience with the UM Program

THE UM EXPERIENCE

REPORTING PERIOD

As required by NCQA, this section reports G&A findings about members who encountered problems with the Utilization Management (UM) processes involving authorizations or referrals in 2025 compared to 2024. For more details, please reference the attached NCQA UM 1B: Member Experience-UM Threshold Report.

OVERVIEW

There were 426 reported concerns regarding the UM process in 2025 compared to 270 in 2024. The Grievance rate per 1,000 members for 2025 increased to 0.47, compared to 0.30 in 2024. This does not meet the overall threshold of 0.30. We have met the threshold in the Quality of Provider Office and Billing/Financial categories. We did not meet the threshold in the Access, Attitude/Service, or Quality of Care categories. There continues to be communication issues between members and their providers regarding referrals. This resulted in providers delaying or refusing to submit Treatment Authorization Requests (TARs) or Referral Authorization Forms (RAFs).

DISSATISFACTION WITH RAF PROCESS

Of the 426 UM concerns, 244 of them were related to the RAF process. Of those, 162 of the concerns were related to a member's primary care provider allegedly delaying their RAF request, which caused delays in getting appointments with specialists. There were 39 cases referred to Quality Improvement for further research.

RAF Process	
# of Reported Concerns	
Delayed by Provider	162
Refused by Provider	36
Member dislikes overall	19
Other	14
Delayed by PHC	8
Refused by PHC	5
Total	244

DISSATISFACTION WITH TAR PROCESS

Member's concerns related to the TAR process account for 182 of the 426 cases reported. The most significant driver was members alleging their provider delayed submission of their TAR to Partnership, which was reported in 87 of the concerns. There were 12 cases referred to Quality Improvement for further research.

TAR Process	
# of Reported Concerns	
Delayed Provider	87
Delayed by PHC	36
Member dislikes overall	21
Refused by Provider	17
Other	16
Med nec unmet by med recs	5
Total	182

1Q26 Grievance and Appeals PULSE Report: Supplemental Data
NCQA UM 1B: Member Experience-UM Threshold Report
REPORTING PERIOD: 2024 and 2025
Year-to-Year Report

Grievances Only Reporting Period: Annual 2024 vs. Annual 2025								
	Previous Period: 2024			Current Period: 2025				
NCQA Category	Grievances	Avg Partnership Mship	Grievances p/1,000	Grievances	Avg Partnership Mship	Grievances p/1,000	Threshold	Threshold Met?
Access	185	905,570	0.20	297	901,645	0.33	0.22	No
Attitude/Service	59		0.07	78		0.09	0.07	No
Billing/Financial	0		0.00	0		0.00	0.00	Yes
Quality of Care	26		0.03	51		0.06	0.03	No
Quality of Provider Office	0		0.00	0		0.00	0.00	Yes
TOTAL	270		0.30	426		0.47	0.33	No

Purpose of report: It reflects a subset of data from the ME.7 Member Experience Report. Data reflects Member-reported dissatisfaction related to experiences with the TAR and RAF process. If the number of cases per 1,000 members in the current period increases by more than 10% from the previous period, then the Threshold is triggered. An unmet NCQA Threshold(s) identifies growing areas of member dissatisfaction and an intervention(s) may be required. This report is published bi-annually. The March report provides an annual depiction of the two years under evaluation. The September report provides a mid- year update. All data is reported with a 95% confidence level.

Published March 2026

this page left blank

SUPPLEMENTAL TAR REPORT
to the
2025 UM PROGRAM EVALUATION

Prepared March 27, 2026

Utilization Management and Pharmacy Reports

The tables below present data for all UM and Pharmacy TARs according to the following categories and statuses:

I. **UM TARs:**

A. A total of **329,727** UM TARs completed in 2025 are presented in comparison to the 2024 UM TARs completed in four tables below according to these categories:

1. Inpatient
2. Outpatient (includes TAR types a.- d.)
   a. Durable Medical Equipment (DME)
   b. Medical
   c. Ancillary
   d. Transportation
3. Long term care (LTC)
4. Wellness and Recovery (TARS for Residential SUD Treatment) ***Note**: In 2025, the NCQA UM 1G report for the Annual UM Program evaluation did not include W&R TARs because that is a limited scope program. The total number of TARs in 2025 less the W&R TARs was 327,639*

B. For each category of UM TAR, the following TAR status types are summarized:

1. Approved TARs
   a. Approved
   b. EB Approved
   c. IB Approved
   d. CTC (capped to capped)
   e. Correction Received
   f. Modified per Correction Request

2. Approved as Modified TARs

3. Admin Modification TARs

4. Denied TARs
   a. Medical Necessity Denials[1]
      1) Med Nec Not Justified
      2) Denied by Cap Hosp
      3) Member Not Eligible
      4) Other Insurance
      5) Not timely (new category since 2023 for TARs received more than 1 year from date of service)
   b. Administrative Denials
      1) Admin Denial Duplicate AR
      2) Admin Denial No Auth Required
      3) Admin Denial Void

[1] For NCQA purposes, only TARs with an Adverse Benefit Determination for medical necessity in which clinical criteria are applied for review are considered for timeliness reporting and file review.

5. **Appeals and Grievance TARs**
   a. Grievance Overturned
   b. Overturned by Appeal
   c. Appeal Partially Overturned
   d. Appeal Upheld

Data Summary for UM TARs (2024 and 2025)

Year	Total TARs	Total Approved	% App-roved	Total App. as Mod.	% App. as Mod.	Total Admin Mod.	% Admin Mod.	Total Med. Nec. Denials	% Med. Nec. Denials	Total Admin Denials	% Admin Denials
2024	344,695	274,099	79.5%	2,093	0.61%	2,733	0.8%	14,118	4.1%	51,385	14.9%
2025	329,727	246,639	74.8%	4,638	1.41 %	5,010	1.5%	19,808	6.0%	51,876	15.7%

Data Summary for UM Grievances and Appeals (2024 and 2025)

Year	Total Grievances Overturned	Total Appeals	Total Appeals Overturned	% Appeals Overturned	Total Appeals Partially Overturned	% Appeals Partially Overturned	Total Appeals Upheld	% Appeals Upheld
2024	38	226	53	23.5%	2	0.9%	171	75.66%
2025	95	1,661	245	14.8%	0	0.0%	1,416	85.25%

INPATIENT

INPATIENT TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEPT		OCT		NOV		DEC		TOTAL	
	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025
Approved	4,912	4,974	4,649	4,560	4,481	4,497	4,814	4,414	4,841	4,657	4,591	4,598	5,177	4,614	4,661	4,548	4,631	4,603	4,997	4,448	4,300	3,907	4,208	4,665	56,262	54,485
EB Approved	20	3	6	1	17	2	14	2	8	5	6	4	9	10	14	13	2	4	2	12	1	10	1	10	100	76
IB Approved	12	0	35	0	61	0	10	0	19	1	70	0	15	0	29	0	91	1	18	4	46	4	524	8	930	18
CTC / Capped Review	3	1	9	0	31	0	0	1	0	0	15	1	5	1	5	0	20	0	7	0	6	0	69	4	170	8
Correction Received	0	0	1	0	3	0	1	0	2	0	1	0	2	0	1	0	4	0	1	0	4	0	9	0	29	0
Modified per Correction Request	3	3	0	1	3	3	3	1	4	2	4	2	1	0	0	1	0	2	0	0	1	0	1	0	20	15
TOTAL (APPROVED)	**4,950**	**4,981**	**4,700**	**4,562**	**4,596**	**4,502**	**4,842**	**4,418**	**4,874**	**4,665**	**4,687**	**4,605**	**5,209**	**4,625**	**4,710**	**4,562**	**4,748**	**4,610**	**5,025**	**4,464**	**4,358**	**3,921**	**4,812**	**4,687**	**57,511**	**54,602**
Approve as Modified	**34**	**99**	**39**	**106**	**45**	**117**	**40**	**92**	**49**	**127**	**52**	**143**	**69**	**126**	**71**	**156**	**63**	**137**	**67**	**137**	**81**	**128**	**48**	**168**	**658**	**1,536**
Admin Modification	**0**	**1**	**0**	**0**	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**1**	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**3**	**0**	**9**	**0**	**18**
Med Nec Not Justified	64	88	66	85	73	99	75	136	80	166	94	199	82	183	90	208	106	179	103	170	127	179	128	201	**1,088**	**1,893**
Denied by Cap Hospital	3	3	3	6	5	8	6	4	5	0	8	5	7	5	9	3	11	4	9	8	3	4	6	5	**75**	**55**
Member not Eligible	17	15	10	11	12	9	8	12	10	9	8	13	18	17	19	9	10	12	8	10	15	8	11	8	**146**	**133**
Not Timely	0	1	0	0	0	0	0	0	0	1	1	0	0	0	1	0	0	0	0	0	0	0	0	0	**2**	**2**
Other Insurance	190	170	110	109	129	161	126	133	119	141	118	153	171	153	191	158	191	160	137	149	148	176	172	247	**1,802**	**1,910**
TOTAL (MED NEC DENIALS)	**274**	**277**	**189**	**211**	**219**	**277**	**215**	**285**	**214**	**317**	**229**	**370**	**278**	**358**	**310**	**378**	**318**	**355**	**257**	**337**	**293**	**367**	**317**	**461**	**3,113**	**3,993**
Admin Denial (Duplicate TAR)	110	95	63	100	63	84	69	93	72	186	63	176	84	152	104	143	124	113	109	170	83	72	92	87	**1,036**	**1,471**
Admin Denial (No Auth Required)	96	105	144	94	108	107	86	115	88	143	79	120	88	134	103	134	109	114	90	127	77	87	84	100	**1,152**	**1,380**
Admin Denial (Void)	512	110	161	135	222	116	114	117	114	126	109	107	166	91	181	118	157	104	118	93	96	67	106	73	**2,056**	**1,257**
TOTAL (ADMIN DENIALS)	718	310	368	329	393	307	269	325	274	455	251	403	338	377	388	395	390	331	317	390	256	226	282	260	4,244	4,108
TOTAL (DENIALS)	**992**	**587**	**557**	**540**	**612**	**584**	**484**	**610**	**488**	**772**	**480**	**773**	**616**	**735**	**698**	**773**	**708**	**686**	**574**	**727**	**549**	**593**	**599**	**721**	**7,357**	**8,101**
Grievance Overturned	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Overturned by Appeal	1	5	1	2	0	1	2	6	1	7	0	12	4	15	1	11	1	8	2	19	1	20	0	9	14	115
Appeal Partially Overturned	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeal Upheld	17	64	5	56	2	61	19	113	17	128	6	86	14	90	10	66	1	85	6	123	5	111	0	23	102	1,006
TOTAL TARs	**5,994**	**5,737**	**5,302**	**5,266**	**5,255**	**5,266**	**5,387**	**5,240**	**5,429**	**5,699**	**5,225**	**5,620**	**5,912**	**5,592**	**5,490**	**5,569**	**5,521**	**5,526**	**5,674**	**5,470**	**4,994**	**4,776**	**5,459**	**5,617**	**65,642**	**65,378**
IP Nurse FTE	**11**	**22**	**13**	**22**	**15**	**22**	**15**	**24**	**14**	**25**	**16**	**25**	**17**	**26**	**17**	**26**	**18**	**28**	**20**	**26**	**20**	**26**	**20**	**26**		
Working Days	**21**	**21**	**20**	**19**	**21**	**21**	**22**	**22**	**22**	**21**	**20**	**21**	**22**	**22**	**22**	**21**	**20**	**21**	**23**	**23**	**19**	**18**	**19**	**20**		
TARs per Nurse per Day	25.95	12.42	20.39	12.60	16.68	11.40	16.32	9.92	17.63	10.86	16.33	10.70	15.81	9.78	14.68	10.20	15.34	9.40	12.33	9.15	13.14	10.21	14.37	10.80		

OUTPATIENT

OUTPATIENT TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEPT		OCT		NOV		DEC		PY	CURRENT
	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025
Approved	20,105	11,166	17,394	11,009	17,474	12,444	17,182	13,237	17,000	12,473	15,412	12,014	15,055	12,577	14,964	12,003	10,380	12,439	11,222	13,145	9,497	9,681	9,558	10,824	175,243	143,012
EB Approved	921	832	788	776	756	849	651	938	651	939	845	1,015	1,023	1,182	1,145	1,060	998	1,113	942	935	738	675	849	845	10,307	11,159
CTC / Capped Review	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	1	2
Correction Received	70	3	74	3	103	6	62	4	96	11	78	6	45	10	49	16	54	8	26	11	38	23	62	22	757	123
Modified per Correction Request	1,427	1,752	898	1,586	579	1,888	1,252	1,653	920	1,640	556	1,476	1,056	1,574	799	1,301	358	1,187	773	1,167	457	789	229	642	9,304	16,655
TOTAL (APPROVED)	**22,523**	**13,753**	**19,155**	**13,374**	**18,912**	**15,187**	**19,147**	**15,832**	**18,667**	**15,063**	**16,891**	**14,511**	**17,179**	**15,344**	**16,957**	**14,380**	**11,790**	**14,748**	**12,963**	**15,258**	**10,730**	**11,168**	**10,698**	**12,333**	**195,612**	**170,951**
Approve as Modified	**71**	**262**	**70**	**203**	**74**	**203**	**94**	**190**	**74**	**217**	**70**	**223**	**177**	**260**	**101**	**226**	**110**	**212**	**181**	**219**	**167**	**192**	**167**	**211**	**1,356**	**2,618**
Admin Modification	**149**	**254**	**158**	**251**	**179**	**263**	**177**	**382**	**133**	**452**	**156**	**507**	**275**	**534**	**289**	**404**	**245**	**461**	**324**	**520**	**308**	**363**	**334**	**490**	**2,727**	**4,881**
Med Nec Not Justified	258	1,119	226	937	313	845	426	907	255	880	239	878	715	858	358	899	470	898	902	1,039	982	968	633	965	**5,777**	**11,193**
Denied by Cap Hospital	1	3	0	1	2	0	0	0	2	1	2	1	0	0	0	1	1	0	0	1	0	0	1	0	**9**	**8**
Member not Eligible	27	22	13	20	23	24	29	22	23	27	26	21	30	20	40	19	20	21	20	21	15	14	24	25	**290**	**256**
Not Timely	1	3	3	0	2	3	1	8	0	20	1	1	1	3	2	3	0	3	17	2	1	2	1	21	**30**	**69**
Other Insurance	418	423	369	347	371	42	351	400	379	385	366	413	422	449	415	327	346	39	423	334	325	306	293	343	**4,478**	**3,808**
TOTAL (MED NEC DENIALS)	**705**	**1,570**	**611**	**1,305**	**711**	**914**	**807**	**1,337**	**659**	**1,313**	**634**	**1,314**	**1,168**	**1,330**	**815**	**1,249**	**837**	**961**	**1,362**	**1,397**	**1,323**	**1,290**	**952**	**1,354**	**10,584**	**15,334**
Admin Denial (Duplicate TAR)	801	966	627	900	739	1,055	792	1,078	863	1,004	848	1,050	983	1,013	920	946	706	948	776	1,010	745	840	849	918	**9,649**	**11,728**
Admin Denial (No Auth Required)	2,255	2,739	1,994	2,218	2,230	2,471	2,251	2,151	1,988	2,208	2,666	2,058	2,257	2,200	2,102	2,090	3,301	2,233	3,696	2,534	2,545	2,499	2,433	2,760	**29,718**	**28,161**
Admin Denial (Void)	605	507	435	422	388	466	478	490	351	439	412	391	589	439	466	405	423	384	598	451	399	401	369	382	**5,513**	**5,177**
TOTAL (ADMIN DENIALS)	3,661	4,212	3,056	3,540	3,357	3,992	3,521	3,719	3,202	3,651	3,926	3,499	3,829	3,652	3,488	3,441	4,430	3,565	5,070	3,995	3,689	3,740	3,651	4,060	44,880	45,066
TOTAL (DENIALS)	**4,366**	**5,782**	**3,667**	**4,845**	**4,068**	**4,906**	**4,328**	**5,056**	**3,861**	**4,964**	**4,560**	**4,813**	**4,997**	**4,982**	**4,303**	**4,690**	**5,267**	**4,526**	**6,432**	**5,392**	**5,012**	**5,030**	**4,603**	**5,414**	**55,464**	**60,400**
Grievance Overturned	4	8	3	7	1	9	2	4	1	14	0	3	6	7	7	7	3	7	4	4	3	12	3	6	37	88
Overturned by Appeal	0	18	2	10	4	10	8	8	3	10	1	8	8	9	2	11	1	7	8	8	2	12	0	10	39	121
Appeal Partially Overturned	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	2	0
Appeal Upheld	4	57	6	34	2	28	20	35	5	33	1	37	10	25	6	18	0	21	12	29	0	35	0	39	66	391
TOTAL TARs	**27,117**	**20,134**	**23,062**	**18,724**	**23,240**	**20,606**	**23,776**	**21,507**	**22,744**	**20,753**	**21,679**	**20,102**	**22,652**	**21,161**	**21,665**	**19,736**	**17,416**	**19,982**	**19,925**	**21,430**	**16,222**	**16,812**	**15,805**	**18,503**	**255,303**	**239,450**
OP Nurse FTE	**23**	**38**	**23**	**40**	**24**	**42**	**24**	**42**	**27**	**43**	**30**	**43**	**28**	**44**	**29**	**44**	**29**	**44**	**32**	**44**	**36**	**46**	**38**	**46**		
Working Days	**21**	**21**	**20**	**19**	**21**	**21**	**22**	**22**	**22**	**21**	**20**	**21**	**22**	**22**	**22**	**21**	**20**	**21**	**23**	**23**	**19**	**18**	**19**	**20**		
TARs per Nurse per Day	56.14	25.23	50.13	24.64	46.11	23.36	45.03	23.28	38.29	22.98	36.13	22.26	36.77	21.86	33.96	21.36	30.03	21.63	27.07	21.18	23.72	20.30	21.89	20.11		

LTSS

LTC TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEPT		OCT		NOV		DEC		PY	CURRENT
	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025
Approved	2,098	1,486	1,321	1,213	1,210	1,208	1,133	1,073	1,083	1,127	1,765	1,294	1,545	1,305	1,217	1,086	1,192	1,218	1,239	1,227	1,221	967	1,376	1,356	16,400	14,560
EB / IB Approved	239	54	187	77	209	78	190	64	219	66	195	89	243	133	205	178	192	167	192	180	85	141	122	137	2,278	1,364
Correction Received	25	0	18	0	66	0	3	0	16	0	28	0	12	0	13	0	38	1	22	5	22	5	51	3	314	14
Modified per Correction Request	13	289	9	264	12	277	22	265	19	269	7	331	27	338	17	257	9	288	19	241	13	169	4	175	171	3,163
TOTAL (APPROVED)	**2,375**	**1,829**	**1,535**	**1,554**	**1,497**	**1,563**	**1,348**	**1,402**	**1,337**	**1,462**	**1,995**	**1,714**	**1,827**	**1,776**	**1,452**	**1,521**	**1,431**	**1,674**	**1,472**	**1,653**	**1,341**	**1,282**	**1,553**	**1,671**	**19,163**	**19,101**
Approve as Modified	**4**	**25**	**2**	**29**	**9**	**20**	**5**	**30**	**7**	**47**	**7**	**41**	**6**	**47**	**2**	**42**	**3**	**43**	**12**	**68**	**16**	**44**	**6**	**48**	**79**	**484**
Admin Modification	**0**	**4**	**0**	**1**	**0**	**2**	**1**	**5**	**0**	**7**	**1**	**2**	**0**	**3**	**0**	**4**	**0**	**9**	**3**	**20**	**1**	**9**	**0**	**45**	**6**	**111**
Med Nec Not Justified	10	32	6	28	24	26	20	27	31	41	29	35	29	28	33	29	18	24	25	32	15	17	21	50	**261**	**369**
Member not Eligible	7	2	3	2	4	2	3	3	3	6	4	3	7	4	0	1	2	4	3	5	4	0	6	6	**46**	**38**
Not Timely	0	1	1	2	0	3	3	3	1	0	1	2	1	1	0	1	4	0	1	0	0	0	2	0	**14**	**13**
Other Insurance	7	8	9	7	17	4	25	3	5	4	6	3	8	5	6	3	7	3	4	4	3	5	3	6	**100**	**55**
TOTAL (MED NEC DENIALS)	**24**	**43**	**19**	**39**	**45**	**35**	**51**	**36**	**40**	**51**	**40**	**43**	**45**	**38**	**39**	**34**	**31**	**31**	**33**	**41**	**22**	**22**	**32**	**62**	**421**	**475**
Admin Denial (Duplicate TAR)	79	100	95	64	105	70	94	64	81	72	75	97	82	71	80	72	111	88	67	71	63	82	63	64	**995**	**915**
Admin Denial (No Auth Required)	1	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**3**	**0**
Admin Denial (Void)	294	210	112	126	82	146	67	127	55	130	84	123	90	171	88	138	84	139	97	140	69	130	93	110	**1,215**	**1,690**
TOTAL (ADMIN DENIALS)	374	310	207	190	188	216	161	191	137	202	159	220	172	242	168	210	195	227	164	211	132	212	156	174	**2,213**	2,605
TOTAL (DENIALS)	**398**	**353**	**226**	**229**	**233**	**251**	**212**	**227**	**177**	**253**	**199**	**263**	**217**	**280**	**207**	**244**	**226**	**258**	**197**	**252**	**154**	**234**	**188**	**236**	**2,634**	**3,080**
Grievance Overturned	1	0	0	1	0	1	0	1	0	0	0	1	0	1	0	0	0	0	0	1	0	1	0	0	1	7
Overturned by Appeal	0	0	2	0	0	0	1	1	0	1	0	1	0	1	0	1	0	0	0	1	0	2	0	1	3	9
Appeal Partially Overturned	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeal Upheld	1	0	1	1	0	2	1	0	0	1	0	3	0	0	0	2	0	3	0	4	0	2	0	1	3	19
TOTAL TARs	**2,779**	**2,211**	**1,766**	**1,815**	**1,739**	**1,839**	**1,568**	**1,666**	**1,521**	**1,771**	**2,202**	**2,025**	**2,050**	**2,108**	**1,661**	**1,814**	**1,660**	**1,987**	**1,684**	**1,999**	**1,512**	**1,574**	**1,747**	**2,002**	**21,889**	**22,811**
LTSS Nurse FTE	**4**	**10**	**3**	**10**	**4**	**9**	**5**	**9**	**6**	**9**	**9**	**10**	**10**	**11**	**10**	**13**	**9**	**11**	**9**	**11**	**9**	**11**	**10**	**11**		
Working Days	**21**	**21**	**20**	**19**	**21**	**21**	**22**	**22**	**22**	**21**	**20**	**21**	**22**	**22**	**22**	**21**	**20**	**21**	**23**	**23**	**19**	**18**	**19**	**20**		
TARs per Nurse per Day	33.08	10.53	29.43	9.55	20.70	9.73	14.25	8.41	11.52	9.37	12.23	9.64	9.32	8.71	7.55	6.64	9.22	8.60	8.14	7.90	8.84	7.95	9.19	9.10		

SUD

Wellness & Recovery (BH) TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEPT		OCT		NOV		DEC		PY	CURRENT
	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025
Approved	125	123	91	78	73	53	137	110	90	97	44	44	107	121	73	71	44	47	94	113	61	52	27	69	966	978
EB Approved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IB Approved	20	36	22	51	84	92	20	34	60	61	78	97	32	42	61	67	89	97	47	62	80	60	103	118	696	817
Correction Received	5	19	11	19	17	34	8	6	8	12	19	13	7	2	11	11	13	32	6	8	19	14	27	20	151	190
Modified per Correction Request	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL (APPROVED)	**150**	**178**	**124**	**148**	**174**	**179**	**165**	**150**	**158**	**170**	**141**	**154**	**146**	**165**	**145**	**149**	**146**	**176**	**147**	**183**	**160**	**126**	**157**	**207**	**1,813**	**1,985**
Approve as Modified	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Admin Modification	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL (MED NEC DENIALS)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**2**	**0**	**1**	**0**	**6**
Admin Denial (Duplicate TAR)	3	4	5	7	4	6	4	2	1	12	4	3	1	5	1	1	2	5	4	6	0	4	0	11	29	66
Admin Denial (No Auth Required)	0	0	0	1	0	0	0	0	0	0	0	0	2	2	0	0	0	1	0	2	0	0	0	0	2	6
Admin Denial (Void)	1	0	1	1	2	2	2	1	2	1	0	0	4	3	1	1	1	5	0	5	1	1	2	5	17	25
TOTAL (ADMIN DENIALS)	4	4	6	9	6	8	6	3	3	13	4	3	7	10	2	2	3	11	4	13	1	5	2	16	48	97
TOTAL (DENIALS)	**4**	**4**	**6**	**9**	**6**	**8**	**6**	**4**	**3**	**14**	**4**	**3**	**7**	**10**	**2**	**2**	**3**	**12**	**4**	**13**	**1**	**7**	**2**	**17**	**48**	**103**
Grievance Overturned	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Overturned by Appeal	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeal Partially Overturned	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeal Upheld	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL TARs	**154**	**182**	**130**	**157**	**180**	**187**	**171**	**154**	**161**	**184**	**145**	**157**	**153**	**175**	**147**	**151**	**149**	**188**	**151**	**196**	**161**	**133**	**159**	**224**	**1,861**	**2,088**
SUD Nurse FTE	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**1**	**2**	**1**	**2**	**1**	**2**	**2**	**2**	**2**	**2**	**2**	**2**		
Working Days	**21**	**21**	**20**	**19**	**21**	**21**	**22**	**22**	**22**	**21**	**20**	**21**	**22**	**22**	**22**	**21**	**20**	**21**	**23**	**23**	**19**	**18**	**19**	**20**		
TARs per Nurse per Day	3.67	4.33	3.25	4.13	4.29	4.45	3.89	3.50	3.66	4.38	3.63	3.74	6.95	3.98	6.68	3.60	7.45	4.48	3.28	4.26	4.24	3.69	4.18	5.60		

Total All TAR Types	**344,695**	**329,727** *
	2024	**2025**

* In 2025, the NCQA UM 1G report for the Annual UM Program evaluation did not include W&R TARs because that is a limited scope program. The total number of TARs in 2025 less the W&R TARs was 327,639.

DATA SUMMARY FOR ALL TAR TYPES (including W&R)

Year	Total Griev. Over-turned	Total Appeals Rcvd in UM	Total Appeals Over-turned	% Appeals Over-Turned	Total Appeals Partially Over-turned	% Appeals Partially Over-Turned	Total Appeals Upheld	% Appeals Upheld
2024	38	**229**	56	24.5%	2	0.9%	171	74.67%
2025	95	**1,661**	245	14.8%	0	0.0%	1,416	85.25%

Year	Total	Total TARs App-roved	% App-roved	Total App. as Mod.	% App. as Mod.	Total Admin. Mod.	% Admin. Mod.	Total Med. Nec. Denials	% Med. Nec. Denials	Total Admin Denials	% Admin Denials
2024	**344,695**	274,099	79.5%	2,093	0.61%	2,733	0.8%	14,118	4.1%	51,385	14.9%
2025	**329,727**	246,639	74.8%	4,638	1.41%	5,010	1.5%	19,808	6.0%	51,876	15.7%

II. **Pharmacy TARs:**

A. A total of **11,772** Pharmacy TARs were completed in 2025 and are presented in comparison to the 2024 Pharmacy TARs completed in the table below. Table includes all requests for Physician Administered Drugs (PADs).

B. The final determination statuses are Approved, Approved as Modified, Denied, and Void.

1. **Approved -** Full quantity requested is approved
2. **Approved as Modified** - TAR approved with quantity less than requested amount
3. **Denied**
    a. Medical Necessity Not Justified
    b. Member Not Eligible
    c. Other Health Insurance
    d. Carve-out to Fee-For-Service (FFS)
    e. Not Timely
    f. Administrative Denials
        1) Duplicate TAR
        2) No Auth Required
4. **VOID**

Pharmacy data continued on next page

Pharmacy TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEP		OCT		NOV		DEC		TOTAL	
	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025
Approved	625	633	600	531	544	578	562	567	516	696	512	639	514	764	553	671	490	677	632	673	545	567	538	628	6,631	7,624
Approved as Modified	68	41	51	37	47	34	24	33	37	36	32	30	32	51	33	58	29	49	34	54	28	41	28	49	443	513
Medical Necessity Not Justified	118	125	110	101	86	81	95	101	96	109	82	118	108	116	102	82	84	92	139	123	118	93	102	94	1,240	1,235
Member Not Eligible	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Other Health Insurance	23	36	29	29	39	32	18	21	30	20	29	20	17	19	19	23	26	22	22	25	20	24	16	22	288	293
Carve-out to FFS	1	1	2	0	0	0	0	1	1	2	1	0	0	0	0	0	0	3	1	5	0	0	0	0	6	12
Not Timely	0	2	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	2	0	1	0	0	0	0	0	6
Admin Denial	206	174	165	142	123	161	147	164	157	174	162	151	190	126	144	142	141	148	144	143	121	110	100	142	1,800	1,777
Void	24	35	37	32	38	31	33	19	28	23	30	28	20	23	32	32	27	18	29	25	26	18	26	27	350	311
Total TARs	**1,065**	**1,047**	**994**	**872**	**877**	**917**	**879**	**906**	**865**	**1,060**	**848**	**987**	**881**	**1,099**	**883**	**1,008**	**797**	**1,011**	**1,001**	**1,049**	**858**	**853**	**810**	**963**	**10,758**	**11,772**
Working Days	21	21	20	19	21	21	22	22	22	21	20	21	22	22	22	21	20	21	23	23	19	18	20	21		
Tech FTE	4	7	5	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	8	7	8	7	8		
TARs/tech per day	12.7	7.1	9.9	6.6	6.0	6.2	5.7	5.9	5.6	7.2	6.1	6.7	5.7	7.1	5.7	6.9	5.7	6.9	6.2	5.7	6.5	5.9	5.8	5.7		
RPh FTE	5	5	5	5	5	5	5	5	5	6	5	6	5	5	5	5	5	5	5	6	5	6	5	6		
TARs/RPh per day	10.1	10	9.9	9.2	8.4	8.7	8.0	8.2	7.9	8.4	8.5	7.8	8.0	10	8.0	9.6	8.0	9.6	8.7	7.6	9.0	7.9	8.1	7.6		

Data Summary for Pharmacy TARs

Year	Total	% Approved	% Approved as Modified	% Med Necessity Denials	% Admin Denials	% Void	% Operational Denials (OHI, Carve-out to FFS, etc)
2025	11,772	64.76%	4.36%	10.49%	15.1%	2.64%	2.65%
2024	10,758	61.64%	4.12%	11.53%	16.73%	3.25%	2.73%

Data Summary for Pharmacy Appeals

Year	Total Provider Appeals	Total Appeals Overturned	% Appeals Overturned	Total Appeals Overturned with Modifications	% Appeals Overturned with Modifications	Total Appeals Upheld	% Appeals Upheld
2025	6	2	33.33%	1	16.67%	3	50%
2024	11	5	45.45%	1	9.1%	5	45.45%

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS & SYSTEMS (CAHPS®) PROGRAM

2024-2025

MEMBER EXPERIENCE GRAND ANALYSIS (NCQA ME 7C/7D REPORT)

PERIOD

(JULY 1, 2024 – JUNE 30, 2025)

PRODUCTION DATE

SEPTEMBER 2025

PARTNERSHIP HEALTHPLAN of CALIFORNIA

A Public Agency

TABLE OF CONTENT

QUALITATIVE ANALYSIS & STRATEGIC PRIORITIES	
MEMBER EXPERIENCE OVERVIEW	4
ANALYSIS OF MEMBER EXPERIENCE BARRIERS AND STRATEGIC RESPONSE	4
QUALITY IMPROVEMENT	4
2024 ANNUAL ASSESSMENT OF NONBEHAVIORAL HEALTHCARE COMPLAINTS AND APPEALS	5
GRIEVANCES	5
APPEALS & SECOND LEVEL GRIEVANCES	5
2024 CAHPS® SURVEY PLAN PERFORMANCE	6
ADULT SURVEY	7
CHILD SURVEY	7
IDENTIFICATION OF OPPORTUNITIES AND PRIORITY	8
MEMBER EXPERIENCE	8
RATING MEASURES	9
ACCESS TO CARE MEASURES	10
WHAT ARE NEW COUNTY MEMBERS REPORTING -COUNTY EXPANSION	11
HEALTH EQUITY AND MEMBER EXPERIENCE ANALYSIS	11
QUALITATIVE ANALYSIS	11
SUMMARY OF ACTIVITIES AND INTERVENTIONS	13
ORGANIZATIONAL GOAL #5 | FY 2025-2026	13
MEMBER EXPERIENCE & QUANTITATIVE ANALYSIS	
OBJECTIVE	16
DEPARTMENT OVERVIEW	16
METHODOLOGY	17
2024 ASSESSMENT OF NONBEHAVIORAL HEALTHCARE GRIEVANCES AND APPEALS	20
GRIEVANCES	21
APPEALS & SECOND LEVEL GRIEVANCES	21
ANALYSIS OF NCQA CATEGORIES NOT MEETING THRESHOLDS	22
SUMMARY HIGHLIGHTS	23
2024 CAHPS® SURVEY PLAN PERFORMANCE | QUANTITATIVE ANALYSIS	23
ADULT SURVEY	24
CHILD SURVEY	25
COVID IMPACT ANALYSIS	26
NCQA HEALTH PLAN RATING | PATIENT EXPERIENCE PERFORMANCE QUANTITATIVE ANALYSIS	27
ADULT NOTABLE FINDINGS	28
CHILD NOTABLE FINDINGS	29
ANALYSIS OF CAHPS® MEMBER EXPERIENCE BARRIERS	30
HEALTH EQUITY AND MEMBER EXPERIENCE QUANTITATIVE ANALYSIS	30
2024 SURVEY RESPONSE ANALYSIS	31
APPENDIX	
A: 2025-2026 ORGANIZATIONAL GOAL #5	34
B: 2024-2025 IMPROVEMENT ACTIONS TAKEN	37

QUALITATIVE ANALYSIS & STRATEGIC PRIORITIES

CAHPS® PROGRAM

MEMBER EXPERIENCE OVERVIEW

In FY 2024–2025, Partnership HealthPlan of California ("Partnership") achieved two (2) transformative milestones in its mission to help our members live healthy lives. These achievements reflect not only organizational growth, but a deepened commitment to access, culturally responsive care.

In January 2024, Partnership expanded its service area from 14 to 24 counties, significantly enhancing healthcare access across Northern California. This expansion introduced new opportunities and challenges in member experience, as assessed in our Member Experience Grand Analysis (ME 7). Building on this momentum, in August 2025, Partnership earned NCQA Health Equity Accreditation, affirming our dedication to delivering culturally responsive, equitable care across our expanded service region.

This narrative sets the stage for a deeper exploration of the qualitative outcomes that underpin our ME 7 performance and inform the data-driven insights that follow. From operational alignment to member-centered innovation, the following outcomes illustrate how strategic intent translated into measurable impact shaping both the experience and expectations of the communities we serve.

ANALYSIS OF MEMBER EXPERIENCE BARRIERS AND STRATEGIC RESPONSE

Our analysis of member experience, drawn from both Grievance & Appeals (G&A) reporting and CAHPS survey results, aligns with NCQA's required assessment categories while revealing opportunities to enhance overall member experience across 24 counties, serving nearly one-million-members:

1. **NCQA CATEGORY: ACCESS**
   - G&A Data: Access complaints (2.83 per 1,000 members, exceeding threshold)
     - **Key Focus:** Access and Transportation related issues, collectively representing the highest volume of access-related grievances
   - CAHPS® Data: Getting Needed Care (5th percentile) and Getting Care Quickly (11th percentile)

   BARRIERS:
   - **Regional Growth Impact**
     - Expansion into 10 new counties resulting in 33% membership growth
   - Limited PCP and specialty provider availability within our rural counties
   - Members reported PCP scheduling challenges and timely appointment availability
   - **Operational Systems Integration**
     - Lack of systematic real-time tracking between transportation complaints and specific drivers
     - Manual complaint management process limiting timely response
     - High volume of trips versus complaints creates challenge in pattern identification and transportation provider management

2. **NCQA Category: Quality of Practitioner Office Site**
   - G&A Data: Quality of Provider's Office concerns (Threshold Status: Increased from 0.003 to 0.006 per 1,000 members, exceeding threshold range)
     - **Key Focus:** PCP provider office cleanliness

Barriers:

- **No barriers identified**
  - 40% of reported cases (2 of 5) could not be validated due to absence of appointment verification
  - Limited sample size (5 cases) affects statistical significance of rate increase
  - Complaint categorization may not accurately reflect actual facility quality issues, as verified cases demonstrated appropriate cleaning protocols

3. **NCQA Category: Attitude and Service**
   - G&A Data: attitude and service complaints (2.84 per 1,000 members, threshold met)
     - **Key Focus:** Transportation service delivery barriers, and health plan customer service
   - CAHPS® Data: Customer Service performance at 12th percentile for Adult and 74th percentile for Child populations, highlighting significant variation in service experience

Barriers:

- **Regional Growth Impact**
  - Expansion into 10 new counties resulting in 33% membership growth
  - Transportation drivers providing unsatisfactory service
  - Extended hold times while seeking support from the plan
  - Members not satisfied with phone/call tree system
  - Transportation coordination and lack of benefit awareness and reimbursement processes
- **Operational Systems Integration**
  - Lack of systematic real-time tracking between transportation complaints and specific drivers
  - Manual complaint management process limiting timely response
  - High volume of trips versus complaints creates challenge in pattern identification and transportation provider management
  - Plan main phone number / auto attendant not providing ease of access to route members directly to the transportation department

Impact on Member Experience:

Our data demonstrates that focused improvements in Access and Attitude/Service categories directly influence broader member experience measures, including:

- Health Plan ratings
- Health Care satisfaction
- Overall service delivery perception

This analysis informs our prioritized improvement strategies detailed in Table III, while recognizing these efforts are part of Partnership's comprehensive approach to quality enhancement. While this report focuses on specific member experience measures, it complements other organizational initiatives detailed in separate analyses (such as Network Adequacy Assessment Report (NET 3) and Population Health Management reports).

Our prioritized improvement strategies (Table III) align interventions across these categories:

High Priority Areas

- Access and Transportation
- Attitude and Service
- Member Experience Enhancement

Supporting Priorities

- Health Equity integration
- Dental benefit awareness and data collection
- Customer service enhancement

These priorities directly align with our data findings: High Priority areas address our most significant challenges shown in both G&A data (Access at 2.83 per 1,000 members) and CAHPS® results (Getting Needed Care at 5th percentile), while Supporting Priorities target additional improvement opportunities identified in our analysis. This prioritization framework acknowledges that sustainable improvement requires coordinated effort across multiple organizational workstreams and reports.

With these identified barriers and priorities established, the following sections provide a deeper exploration of the qualitative and quantitative analyses that underpin our ME 7 performance. This comprehensive assessment demonstrates how our strategic focus on Access and Service/Attitude improvements influences measurable impact across member experience initiatives, while shaping both the experience and expectations of the communities we serve.

QUALITY IMPROVEMENT

The Quality Improvement Department's Consumer Assessment of Healthcare Providers & Systems (CAHPS®) program provides programmatic structure and resource commitment to effectively administer National Committee for Quality Assurance (NCQA) requirements and influence organizational change to improve member experience and the health plan rating.

Our approach and discipline in leveraging team strengths equip us with the necessary skills to implement a mixed methodology, including quality improvement tools and program management principles such as plan-do-study-act (PDSA), lean, root-cause analysis, data analytics, and both qualitative and quantitative analysis. As the team identifies new opportunities or lessons learned, we continuously explore and develop pathways for improvement. The established program is designed to be flexible, allowing us to adapt and pivot, each fiscal year.

2024 Annual Assessment of Nonbehavioral healthcare Grievances and Appeals

Grievances

Grievance and Appeals reporting evaluates member experience year-over-year to assess member dissatisfaction across five (5) NCQA-defined categories, including: Access, Attitude/Service, Billing/Financial, Quality of Care, and Quality of Provider's Office. The reporting triggers a threshold alert when case numbers per 1,000 members increase by more than 10% compared to the previous period.

Partnership's expanded county coverage drove membership to a record high of 905,570 members by the end of 2024, a 33.5% increase from 678,546 members in 2023. Despite this substantial membership growth, Grievances showed only a modest increase (from 5.79 to 6.05 per 1,000 members, Table VI), while both Appeals and Second Level Grievances demonstrated favorable decreases. Most notably, Second Level Grievances declined from 1.02 to 0.74 per 1,000 members (Table VII).

Further analysis of the 6,149 total cases closed in 2024 (compared to 4,261 in 2023) reveals specific patterns in member concerns. Of these cases, 5,477 were Grievances and 672 were Appeals and Second Level Grievances (Tables VI and VII). Access and Attitude/Service remain the most frequently reported concerns, accounting for 2,567 and 2,569 cases, respectively.

The number of Grievances filed per 1,000 members increased from 2.25 to 2.83 for access-related issues. More missed rides were reported, resulting in access issues to appointments. In 2023, there were two (2) cases related to the Quality of a Provider's Office, while in 2024, this number increased to five (5) cases. When adjusted for membership growth, this represents an increase from 0.003 to 0.006 cases per 1,000 members, exceeding the threshold range of 0.00 to 0.01.

Appeals & Second Level Grievances

Appeals and Second Level Grievances showed a year-over-year decrease from 689 to 672 cases. All five (5) categories (Access, Attitude/Service, Billing/Financial, Quality of Care, and Quality of Provider's Office) remained within the 10% threshold target. However, notable changes occurred in two (2) categories: Access increased by 26.3% (from 350 to 442 cases), while Quality of Care decreased by 88.9% (from 9 to 1 case), as shown in Table VII.

CAHPS® Measure Year 2024 | Reporting Year 2025 Plan Performance

Patient experience measures substantially influence NCQA Health Plan Ratings through key rating and composite scores. The MY 2024 CAHPS® survey performance analysis evaluates these measures across Adult and Child populations, examining current performance, identified barriers, and planned interventions for Fiscal Year (FY) 2025-2026.

The CAHPS® survey measures member experience performance through the HEDIS (Healthcare Effectiveness Data and Information Set) QC (Quality Compass) national percentile rankings, comparing performance against other Medicaid plans. Performance targets include Partnership’s internal benchmark

(≥33rd percentile ranking) and Department of Health Care Services (DHCS) Minimum Performance Level requirement (≥50th percentile ranking).

ADULT SURVEY

Analysis of MY 2024 Adult CAHPS® measures reveals seven (7) of nine (9) measures performing below the plan's 33rd percentile benchmark target. Comparative year-over-year assessment demonstrates ranking decreases in five (5) measures, with detailed performance measures presented in Table I.

Table: I

HEDIS Quality Compass (QC) Benchmarks

Measure Domain	Plan Performance		
	MY 2024 HEDIS QC Ranking	Plan Benchmark Target ≥33rd Percentile Ranking	MY 2024 Ranking Compared to MY 2023
Rating of Health Plan (% 8, 9, 10)	19th	Not Met	Improvement
Rating of Health Care (% 8, 9, 10)	35th	Met	Improvement
Rating of Personal Doctor (% 8, 9, 10)	30th	Not Met	Decline
Rating of Specialist Seen Most Often (% 8, 9, 10)	96th	Met	Improvement
Getting Needed Care (% Always or Usually)	5th	Not Met	Decline
Getting Care Quickly (% Always or Usually)	11th	Not Met	Improvement
Care Coordination (% Always or Usually)	9th	Not Met	Decline
How Well Doctors Communicate (% Always or Usually)	8th	Not Met	Decline
Customer Service (% Always or Usually)	12th	Not Met	Decline

CHILD SURVEY

For the Child population, MY 2024 CAHPS® measures indicate four (4) of nine (9) measures performing below the plan's 33rd percentile benchmark target. Year-over-year analysis shows ranking decreases in five (5) measures, with comprehensive performance measures outlined in Table II.

Table: II

HEDIS Quality Compass (QC) Benchmarks

Measure Domain	Plan Performance		
	MY 2024 HEDIS QC Ranking	Plan Benchmark Target ≥33rd Percentile Ranking	MY 2024 Ranking Compared to MY 2023
Rating of Health Plan (% 8, 9, 10)	44th	Met	Decline
Rating of Health Care (% 8, 9, 10)	21st	Not Met	Improvement

Measure Domain	Plan Performance		
	MY 2024 HEDIS QC Ranking	Plan Benchmark Target ≥33rd Percentile Ranking	MY 2024 Ranking Compared to MY 2023
Rating of Personal Doctor (% 8, 9, 10)	73rd	Met	Decline
Rating of Specialist Seen Most Often (% 8, 9, 10)	31st	Not Met	Improvement
Getting Needed Care (% Always or Usually)	13th	Not Met	Decline
Getting Care Quickly (% Always or Usually)	13th	Not Met	Improvement
Care Coordination (% Always or Usually)	52nd	Met	Improvement
How Well Doctors Communicate (% Always or Usually)	36th	Met	Decline
Customer Service (% Always or Usually)	74th	Met	Decline

IDENTIFICATION OF OPPORTUNITIES AND PRIORITY

The QI CAHPS® framework continues to drive a coordinated, multi-disciplinary approach to enhance member experience through targeted initiatives and health equity integration. As part of a recent strategic realignment, Access initiatives have been separated from Member Experience and placed under the HR Workforce Development team to lead the FY 24-25 Access Strategic and Tactical plans in alignment with Organizational Goal #2: Network Optimization. Concurrently, the QI Department remains focused on advancing Member Experience improvements through the Strike-Team Pilot - an initiative designed to identify, prioritize, and eliminate service delivery barriers in real time.

Building on these structural improvements and our FY 2024-25 progress, (detailed in Appendix B), the Member Experience teams will advance our continuous improvement efforts through FY 2025-26. This includes enhancing member education, strengthening dental coverage initiatives, and integrating health equity perspective into service delivery. These strategic initiatives, as outlined in Appendix A, address evolving challenges while ensuring our interventions reflect our diverse member population's needs.

MEMBER EXPERIENCE – PRIORITY

Building on the organizational changes detailed earlier, this analysis examines Partnership's member experience measures within the context of our expanded service area and increased membership base. The data reflects our transition from a 14-county to 24-county service area, with MY2024 results capturing feedback from our broader membership population.

MEMBER EXPERIENCE MEASURES (NOT INCLUDED IN NCQA SCORING)

These supplementary measures evaluate three (3) key drivers of member satisfaction: *How Well Doctors Communicate* (doctor communication) quality, *Care Coordination* effectiveness, and *Customer Service* performance. These measures provide critical insights into how well our healthcare delivery system serves our members' needs.

WHAT CHANGED LAST YEAR (MY2023-MY2024)

NOTABLE IMPROVEMENTS:

- Care Coordination showed positive gains in both populations (Adult: **+2.5** points, Child: **+4.3** points).
- Doctor Communication maintained strong performance above 90% for both populations.
- Customer Service sustained high member satisfaction levels, particularly in Child population (90.5%).

ADULT POPULATION PERFORMANCE:

- Doctor Communication: 92.6% to 90.6% (↓ **-2.0** points)
- Care Coordination: 78.8% to 81.3% (↑ **+2.5** points)
- Customer Service: 96.4% to 86.5% (↓ **-9.9** points)

CHILD POPULATION PERFORMANCE:

- Doctor Communication: 93.0% to 93.3% (↑ **+0.3** points)
- Care Coordination: 80.4% to 84.7% (↑ **+4.3** points)
- Customer Service: 91.2% to 90.5% (↓ **-0.7** points)

RATING MEASURES

These rating measures reflect members' overall satisfaction with their healthcare experience, focusing on ratings of 9 or 10 on a 10-point scale. High scores indicate strong satisfaction with healthcare delivery systems.

WHAT CHANGED LAST YEAR (MY2023-MY2024)

NOTABLE IMPROVEMENTS:

- Both populations showed improved Health Plan ratings (Adult: **+1.3** points, Child: **+4.8** points).
- Health Care ratings increased significantly (Adult: **+9.1** points, Child: **+7.5** points).
- Child population demonstrated improvements across all rating measures.

ADULT POPULATION PERFORMANCE:

- Health Plan: 54.5% to 55.8% (↑ **+1.3** points)
- Health Care: 46.3% to 55.4% (↑ **+9.1** points)
- Personal Doctor: 70.0% to 65.7%

CHILD POPULATION PERFORMANCE:

- Health Plan: 68.1% to 72.9% (↑ **+4.8** points)
- Health Care: 58.9% to 66.4% (↑ **+7.5** points)
- Personal Doctor: 75.5% to 78.6%

(↓ **-4.3** points)
- Specialist: 69.5% to 70.3% (↑ **+0.8** points)

(↑ **+3.1** points)
- Specialist: 63.8% to 73.8% (↑ **+10.0** points)

ACCESS TO CARE MEASURES - PRIORITY

These measures evaluate members' ability to receive timely care and necessary services, providing crucial indicators of healthcare accessibility.

❖ GETTING NEEDED CARE (GNC)

This measure assesses members' ability to obtain necessary treatments and specialist appointments.

WHAT CHANGED LAST YEAR (MY2023-MY2024)

NOTABLE IMPROVEMENTS:

- Both populations showed improved composite scores (Adult: **+0.5** points, Child: **+0.8** points).
- Care/Tests/Treatment access improved for both populations.
- Child population maintained stable specialist appointment access.

ADULT POPULATION PERFORMANCE:

- GNC Composite Score: 74.0% to 74.5% (↑ **+0.5** points)
  - *Care/Tests/Treatment: 76.1% to 78.6% (↑ **+2.5** points)*
  - *Specialist Appointments: 71.9% to 70.5% (↓ **-1.4** points)*

CHILD POPULATION PERFORMANCE:

- GNC Composite Score: 77.1% to 77.9% (↑ **+0.8** points)
  - *Care/Tests/Treatment: 81.3% to 82.7% (↑ **+1.4** points)*
  - *Specialist Appointments: 72.8% to 73.1% (↑ **+0.3** points)*

❖ GETTING CARE QUICKLY (GCQ)

This measure evaluates timely access to urgent and routine care.

WHAT CHANGED LAST YEAR (MY2023-MY2024)

NOTABLE IMPROVEMENTS:

- Both populations showed improved composite scores.
- Adult urgent care access showed significant improvement (**+9.1** points).
- Both populations maintained strong urgent care performance above 78%.

ADULT POPULATION PERFORMANCE:

- GCQ Composite Score: 68.1% to 74.0% (↑ **+5.9** points)
  - *Urgent Care: 69.8% to 78.9% (↑ **+9.1** points)*

CHILD POPULATION PERFORMANCE:

- GCQ Composite Score: 78.9% to 80.0% (↑ **+1.1** points)
  - *Urgent Care: 83.7% to 84.2% (↑ **+0.5** points)*

- *Routine Care: 66.3% to 69.2% (↑ +2.9 points)*
- *Routine Care: 74.2% to 75.9% (↑ +1.7 points)*

What Are New County Members Reporting - County Expansion

The 2025 CAHPS survey results for Partnership's expanding service regions show notable variations between child and adult populations. Child survey respondents (29.8% of 783 total) consistently reported higher satisfaction rates compared to adult respondents (30.7% of 511 total), particularly in Health Plan Ratings and Access Measures.

Tehama County demonstrated the widest performance variance between populations, while the Chico Region maintained the most consistent performance. Detailed analysis of regional performance and specific measures available for review here, *2024 CAHPS® Survey Plan Performance.*

Health Equity and Member Experience Analysis

Our analysis of CAHPS® MY 2024 Survey results reveal compelling insights into member experience across diverse populations, highlighting critical areas where health equity initiatives can make a meaningful impact. The data presents a nuanced picture of how different demographic groups experience healthcare services, from plan satisfaction to access barriers.

Key Findings

- **Health Status Correlation:** MY 2024 members reporting poor or fair physical or mental health consistently showed lower satisfaction scores across multiple domains, including health plan ratings, customer service, and provider communication. This correlation suggests these vulnerable populations may require enhanced support services.
- **Age-Based Disparities:** Notable variations emerged in access satisfaction among age groups, with members aged 18-34 expressing greater challenges. This younger demographic's preferences for digital engagement and remote services contrast sharply with older members who prefer in-person care, highlighting the need for multi-channel access strategies.

Cultural and Ethnic Variations:

American Indian/Native American populations reported significant challenges with form completion
Hispanic members showed notably higher satisfaction levels across both adult and child services compared to other demographic groups. These variations underscore the importance of culturally tailored approaches to healthcare delivery

For additional insights into these findings, please refer to the detailed *CAHPS® MY 2024 Survey Results* section that follows.

QUALITATIVE ANALYSIS

During this period of organizational change, member experience data revealed distinct differences across populations and service regions. Our CAHPS® survey and member feedback show how service delivery evolved during these transitions.

The intent of this report is to meet the requirements of NCQA Standard ME 7 Elements C and D. Its objectives are to assess member experience through Grievance & Appeals data and CAHPS® survey results. Qualitative analyses are conducted by the QI Department and opportunities for improvement are identified and prioritized.

The primary ME 7 report contributors include:

1. Isaac Brown, Director of Quality and Performance Improvement
2. Barbara Selig, Manager of Quality Improvement Programs
3. Anthony Sackett, Program Manager II, Quality Improvement Programs
4. Andrea Thomas, Project Manager I, Quality Improvement Programs
5. Kory Watkins, Director of Grievance & Appeals
6. Latrice Innes, Manager of Grievance & Appeals Compliance
7. Bonnie Thompson, Certified NCQA Survey Vendor, VP, Strategic Consulting

MEMBER FEEDBACK OVERVIEW

Survey results across our service areas show varying experiences between adult and child members:

- Child services maintained strong performance, with 90.5% satisfaction with customer service.
- Adult services saw improvements in Health Care ratings (**+9.1** points).
- Getting care quickly improved for both adults (**+5.9** points) and children (**+1.1** points).

WHAT MEMBERS TOLD US

Member feedback through grievances and appeals provided key insights:

- Total feedback increased proportionally with growth (5,477 cases in 2024, up from 3,572).
  Main concerns focused on:
  - Getting rides to appointments (49% of cases)
  - Access to care (42% of cases)
  - Provider services (24% of cases)
  - Partnership services (10% of cases)

SERVICE DELIVERY IMPACT

Key factors influencing member experience included:

- Network adjustments, including Dignity Health contract changes (April 2024)
- Ongoing regional healthcare workforce constraints
- Adapting service delivery systems for scale

Regional Understanding

Our expanded service area revealed important insights about how healthcare needs and experiences vary across Northern California communities. CAHPS® survey results highlighted differences in how adult and child populations experience care across regions, with Tehama County demonstrating the most significant variations. These regional differences deepen our understanding of how service delivery and member satisfaction interact across diverse geographic areas.

These service delivery challenges reflect broader healthcare system constraints, as California continues to experience workforce shortages across clinical and non-clinical positions. This staffing environment, combined with Partnership's significant growth, likely will continue ongoing pressure on appointment availability and service delivery.

Looking ahead, additional external factors may significantly influence member experience. The implementation of H.R.1, the One Big Beautiful Bill Act (HR1) changes are expected to impact Medi-Cal eligibility and coverage transitions, in particular Adults 19 years of age or older. These mandates, coupled with ongoing redetermination processes, could affect how adult members perceive and access healthcare services. As communities navigate these changes, member satisfaction scores may reflect both system-wide adjustments and individual challenges in maintaining continuous care.

For comprehensive analysis of 2024 network capacity and access standards during this expansion period, reference the *NCQA Network Adequacy Assessment Report (NET 3)* or the *2024 Grievance And Appeals Annual Report.*

Summary of FY 2024-2025 Activities and Interventions

The detailed activities for the FY 2024-2025 Organizational Goal 4: Access to Care and Member Experience Improvement is available in Appendix B, while Tables III and XV demonstrate cross-department action focused on interventions.

Organizational Goal #5 | FY 2025-2026

Member Experience

Building on our FY 2024-25 progress, the Member Experience teams will advance our continuous improvement efforts through FY 2025-26, implementing strategic initiatives to address evolving challenges and achieve the key milestones outlined below.

It is important to note that Access to Care interventions will now align under FY 25-26 Organizational Goal 2*: Network Optimization, sponsored by Wendi Davis, Chief Operating Officer. This strategic realignment fosters enhanced collaboration among key operational departments, strengthening our ability to address Access barriers that impact both clinical outcomes and member experience. While Access continues to be measured through CAHPS® performance, this realignment will support improved member experience outcomes through focused organizational goal achievements.

The summary table below includes improvement focus based on the outcome of MY 2024-2025 quantitative, qualitative, causal analysis, and highlights organization priority of member barriers identified through the mentioned Table III.

Table: III

Intervention & Improvement Status	Improvement Focus	Goal Milestone #	Interdepartmental Collaboration		Definitions
			Yes / No	# of Depts.	
Continue	*Access	--	--	4	• **Adjust:** a lean approach or pivot. A continued focus and intent. • **Continue:** a continuation of intervention or improvement activity and focus. • **Maintain:** score or intervention met. • **Monitor:** intervention or improvement assessment period. • **New:** a new action or intervention.
Continue	Member Experience	All	Yes		
New	Health Equity	5			
Continue	Customer Service	All			
Continue	Attitude/Service	1			
Continue	Health Care Rating	All	Yes		
Continue	Health Plan Rating	All			

- **Milestone 1: MX Strike Team | Transportation Services:** The Transportation Department will continue its FY 2024-2025 pilot program, which connects member Grievance and Appeal cases with driver performance to enhance service quality and member satisfaction while developing data-driven improvement targets.
- **Milestone 2: MX Strike Team | Quality Improvement (QI):** The QI Consumer Assessment of Healthcare Providers and Systems (CAHPS®) team will lead the MX Strike Team pilot by leveraging real-time internal influence drivers to identify and address sources of member dissatisfaction (e.g., line staff engagement, causal factors), to enhance service delivery and effectiveness.
- **Milestone 3: Enhancement & Member Education | Member Services (MS):** The MS Department will lead activities to initiate one new initiative to improve member experience (MX) through operational and/or service delivery enhancements.
- **Milestone 4: Enhancement & Member Education | QI CAHPS® Team:**
  The QI CAHPS® team will advance dental coverage initiatives to improve MX through enhanced education, access, and service delivery.
- **Milestone 5: Integration of Health Equity into MX Initiatives** The Population Health Management (PHM) Department, in partnership with the Health Equity (HE) team, will lead collaborative workgroup activities aimed at advancing equitable member engagement and integrating diverse perspectives into the design and delivery of member experience (MX) initiatives. These efforts will reflect our diverse member population's cultural, linguistic, and social needs.

The comprehensive activities and implementation strategy for FY 2024-2025 Organizational Goal 5: Member Experience Goal Statement can be found in Appendix A, which outlines milestone outcomes and deliverables.

MEMBER EXPERIENCE & QUANTITATIVE ANALYSIS

2024-2025 GRAND ANALYSIS

OBJECTIVE

The intent of this report is to meet the requirements of NCQA Standard ME 7 Elements C and D. Its objectives are to assess member experience through Grievance & Appeals data and CAHPS® survey results. Quantitative analyses is conducted by the QI Department and opportunities for improvement are identified and prioritized.

The primary ME 7 report contributors include:

1. Isaac Brown, Director of Quality and Performance Improvement
2. Barbara Selig, Manager of Quality Improvement Programs
3. Anthony Sackett, Program Manager II, Quality Improvement Programs
4. Andrea Thomas, Project Manager I, Quality Improvement Programs
5. Kory Watkins, Director of Grievance & Appeals
6. Latrice Innes, Manager of Grievance & Appeals Compliance
7. Bonnie Thompson, Certified NCQA Survey Vendor, VP, Strategic Consulting

DEPARTMENT OVERVIEW:

GRIEVANCE AND APPEALS

The Grievance and Appeals (G&A) Department is responsible for the execution of Department of Healthcare Services (DHCS) APL 21-011, also known as the "Final Rule," which mandates that members have a right to report any problem(s) while using their Partnership Medi-Cal plan and Partnership has an obligation to investigate objectively.

The G&A analysts are responsible for investigating, monitoring, and reporting on members' dissatisfaction experiences related to Partnership, health plan delivery, and services provided within a clinical and non-clinical setting. The role G&A serves on behalf of our members is to advocate, mediate, educate, and ensure each member receives high-quality healthcare services across the healthcare continuum. The G&A Department performs quarterly and annual reporting, and, through their analyses, they provide insight into service dissatisfaction. Through continuous monitoring and reporting, the G&A Team makes data-driven decisions to address, improve, and transform member dissatisfaction into innovative system-wide changes with the purpose to improve the overall member experience.

QUALITY IMPROVEMENT | CAHPS® PROGRAM

The Quality Improvement Department - CAHPS® Program manages the contract administration of conducting an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) regulated survey, designed and governed by the Agency of Healthcare Research and Quality (AHRQ). The team is also responsible for:

- Leading the ME 7 report production, performing quantitative and qualitative analyses on survey results and other plan delivery data aligned with NCQA Standard ME 7 Elements C and D intended to drive continuous improvement activities and interventions.

- CAHPS® programmatic alignment with two (2) of the five (5) FY 24-25 Organizational Metrics, 1) Achieve a 4.0 Star NCQA Health Plan Rating (HPR), 2) Achieve a 2.5 Star NCQA, Patient Experience (CAHPS®) HPR.
- Presenting annual survey results, HEDIS Quality Compass benchmarks, and NCQA reportable measures.
- Leading goal activities, discussion, and collaboration with program charter members.

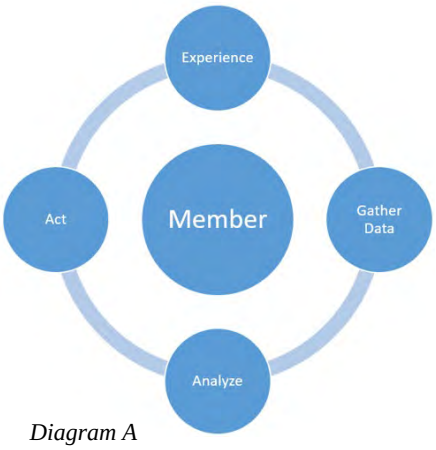


Diagram A

PROGRAM FRAMEWORK

The CAHPS® programmatic framework is rooted in the principles of continuous quality improvement (CQI) and is designed to be member-centered as shown in *Diagram A*, the framework emphasizes listening to member feedback, collecting and analyzing data, and implementing data-driven improvements. These efforts target key drivers of member experience, health outcomes, perceptions of the health plan, and performance scores. The outcomes of this continuous improvement process directly support Partnership's mission and vision.

METHODOLOGY

ANALYSIS WORKGROUP

As noted in the NCQA Standard ME 7 Elements C and D, the health plan is required to conduct a side-by-side annual quantitative and qualitative analysis of our data sources and make recommendations for interventions to ultimately improve our healthcare delivery system and most importantly, overall member experience. Partnership established internal thresholds and benchmarks as a strategy to set realistic goals for underperforming measures.

The QI CAHPS® Team leads ongoing activities and organizational efforts focused on improving CAHPS® score. Partnership relies on various internal and external data sources, including Grievance & Appeals (G&A) reports and CAHPS® results, to elevate member satisfaction and measure the effectiveness of improvement initiatives. The CAHPS® programmatic framework is guided by two (2) key documents: 1) the CAHPS® Program Charter and 2) the Organizational Goal #4 Charter. These documents are used to drive stakeholder commitment, outline specific actions to improve service delivery and member experience, and serve as core communication and strategic guidance tools.

DATA SOURCES

GRIEVANCE AND APPEALS: Partnership utilized NCQA's required data sources, which include G&A reporting and CAHPS® scores. The G&A analysts provided reporting for the period of January 1, 2024, through December 31, 2024, with 2023 data included for trending comparison. It's important to note that multiple reporting categories may apply to a single grievance, appeal, or second-level grievance. Therefore, the metrics presented here reflect the number of concerns expressed by our members during

the reporting periods, rather than unique case counts. In addition, please note that internally, Partnership refers to a member's dispute of a denied grievance as a "Second Level Grievance." For clarity, throughout this document, we will reference appeals as "Appeals" and "Second Level Grievances."

CAHPS® SURVEY: Partnership contracts with NCQA-certified vendor, Press Ganey, to administer the annual regulated survey and provide results of our CAHPS® survey on an annual basis. The CAHPS® regulated survey results are one of several sources used to complete the ME 7 analysis for MY 2024-2025 and include findings from the last two survey cycles (MY 2024 and MY 2023).

DATA MAPPING

GRIEVANCE AND APPEALS: NCQA Standard ME 7 Elements C and D requires organizations to aggregate G&A data into five (5) specific categories; Quality of Care, Quality of Practitioner Office Site, Attitude and Service, Billing/Financial Issues, and Access. Because Partnership's internal categorization is structured to meet DHCS requirements, a cross-departmental team (with representatives from Member Services, Health Services, G&A, Quality Improvement, and Communications) mapped Partnership's reporting categories to align with the five (5) NCQA-required categories.

CAHPS® SURVEY: Partnership reports on the eight (8) CAHPS® NCQA rating and composites measures including: Rating of Health Plan, Rating of Health Care, Rating of Personal Doctor, Rating of Specialist, Getting Needed Care, Getting Care Quickly, Care Coordination, and Customer Service.

THRESHOLDS & BENCHMARKS

As part of the NCQA process and to better evaluate member experience, thresholds and benchmarks have been set to measure our performance.

- GRIEVANCES AND APPEALS
  For each category, a ratio of the number of grievances per 1,000 members is used as a performance metric. Our numerator will be the total amount of Grievances or Appeals/Second Level Grievances for the reporting period, and our denominator will be the monthly average member base of each reporting period. If we see a 10% increase in any of the five (5) categories, it is flagged for discussion based on the number of grievances per 1,000 members.

- CAHPS® SURVEY
  The CAHPS® Team, in collaboration with program charter stakeholders, established methods to measure member satisfaction through continuous monitoring, analysis and targeted improvement activities and interventions. Each year, Partnership evaluates the effectiveness of these improvements using both quantitative and qualitative analysis. To guide this work, Partnership relies on the Healthcare Effectiveness Data and Information Set (HEDIS) Quality Compass benchmarks and internal performance targets.

In addition to the eight (8) NCQA rating and composite summary measures, see Table IV, the CAHPS® program also includes, *How Well Doctors Communicate* as an additional monitoring and performance

measure. The CAHPS® program evaluates measure set performance at or above the 33rd percentile target or better, see Table IV. Summary measures performing below the 33rd percentile target are flagged for review and discussion.

Table: IV

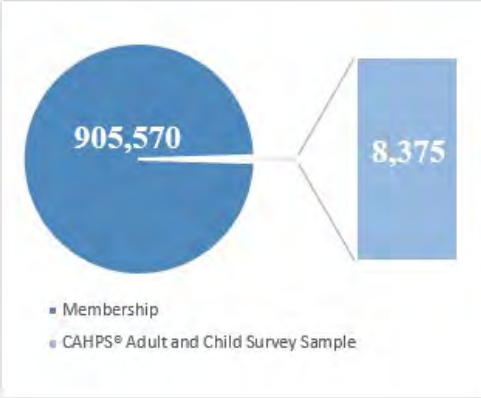
CAHPS® Composite Measures	CAHPS® Program Target
Getting Needed Care	Rating and composite measures ≥ 33rd percentile
Getting Care Quickly	
Getting Care Coordination	
Customer Service	
CAHPS® Rating Measures	
Rating of Health Plan	
Rating of All Health Care	
Rating of Specialist Seen Most Often	
Rating of Personal Doctor	

Survey Methodology

The CAHPS® survey is administered to capture accurate and complete information about HealthPlan member-reported experiences and specifically aims to measure how well plans are meeting member expectations. It also determines which areas of service have the greatest influence on overall member satisfaction and identifies areas of opportunity to improve the quality of care and service delivery.

Survey Sample Size

Survey sample size includes Adult and Children populations based on NCQA member sample frame eligibility requirements. The annual survey results provide a retrospective performance on key NCQA ratings and composite measures. Typically, the regulated survey is conducted in February of each calendar year, and members are asked to share their experiences over the past six (6) months that consists of dates-of-service between the months of July 1st and December 31st of the prior year. Survey questions target member experiences and engagement with a physician, non-emergent clinical setting, health plan, and health plan delivery of covered benefits within Partnership's twenty-four (24) county service area.



Oversample Strategy

In alignment with our county expansion, the QI CAHPS® Team implemented an enhanced oversampling strategy to exceed minimum requirements. For the Adult population, we maintained a 150% oversampling rate, while increasing the Child population rate from 150% to 200%. This strategy helps mitigate the risk of falling below the minimum threshold of 100 survey responses required for core CAHPS®/NCQA scoring measurements. The QI CAHPS® Team has successfully sustained this strategy across multiple survey cycles. As of December 2024, the combined Adult and Child sample size reached 8,375 participants, representing 0.92% of

DHCS-eligible members (905,570). Table V provides a detailed comparison of minimum sample requirements, oversampling percentages, and total sample sizes for each measurement year.

Table: V

Measure Year	Minimum Sample Size	Oversample %	Survey Sample Size		Minimum Sample Size	Oversample %	Survey Sample Size
	Adult				Child		
2024-2025	1,350	150%	3,375		1,650	200%	5,000
2023-2024		150%	2,700			150%	4,125

2024 Annual Assessment of Non-behavioral Healthcare Grievances and Appeals

Grievances | Appeals & Second Level Grievances

The G&A data and quantitative analysis encompass two (2) main components: 1) Grievances and 2) Appeals & Second Level Grievances (SLG). This analysis tracks total cases filed for both current and prior reporting periods, with data stratified across five defined NCQA service categories. Threshold calculations (category/average monthly member base) determine whether each category meets established targets.

The Member Experience Report monitors case volumes across these NCQA categories: Access, Attitude/Service, Billing/Financial, Quality of Care, and Quality of Provider's Office. A 10% increase in any category signals significant change, helping identify trends related to membership growth and case filing patterns.

Performance thresholds for 2024, based on prior year's data, are established for each NCQA category of grievances and appeals. Tables VI and VII provide comprehensive summaries of these annual performance metrics for all member filings throughout the calendar year.

In 2024, a total of 6,149 Grievances and Appeals were closed, as compared to 4,261 in 2023. Of these, Grievances represented 5,477 cases, while Appeals and Second Level Grievances accounted for 672 cases. During this period, membership grew by approximately 33.5%, from 678,546 to 905,570 members.

Table: VI

Grievances Only Reporting Period: Annual 2023 vs. Annual 2024								
	Previous Period: 2023			Current Period: 2024				
NCQA Category	Grievances	Avg PHC Mship	Grievances p/1,000	Grievances	Avg PHC Mship	Grievances p/1,000	Threshold	Threshold Met?
Access	1,526	678,546	2.25	2,567	905,570	2.83	2.47	No
Attitude/Service	1,752		2.58	2,569		2.84	2.84	Yes
Billing/Financial	106		0.16	140		0.15	0.17	Yes
Quality of Care	186		0.27	196		0.22	0.30	Yes
Quality of Provider Office	2		0.00	5		0.01	0.00	No
TOTAL	3,572		5.26	5,477		6.05	5.79	No

RESULTS & THRESHOLDS – GRIEVANCES ONLY

The trending data in Table VI above covers annual reporting periods between January 1, 2023, through December 31, 2023, as compared to January 1, 2024, through December 31, 2024.

In 2024, Partnership closed a total of 5,477 grievances, compared to 3,572 in 2023. When adjusted for the membership growth (from 678,546 in 2023 to 905,570 in 2024), the overall grievance rate rose from 5.26 to 6.05 per 1,000 members, exceeding the established threshold of 5.79.

Among the categories, Access and Attitude/Service were the most frequently reported concerns, accounting for 2,567 and 2,569 cases respectively, which together accounted for over 90% of all grievances filed in 2024.

Access and Quality of Provider Office did not meet the established thresholds in 2024. Access-related grievances increased from 2.25 to 2.83 per 1,000 members, while Quality of Provider Office grievances rose slightly from 0.00 to 0.01 per 1,000 members. In contrast, Attitude/Service, Billing/Financial and Quality or Care remained within thresholds.

Transportation-related concerns fall under NCQA Category Attitude/Service. In 2024, member-reported grievances related to transportation, including missed rides, driver arrival times, driver behavior, scheduling issues, and vehicle conditions represented 49% of total cases. In the context of transportation services, Partnership provided 1,166,701 rides in 2024, with transportation-related concerns representing just 0.4% of total rides, down from 0.6% in 2023.

Table: VII

Appeals & Second Level Grievances Reporting Period: Annual 2023 vs. Annual 2024								
	Previous Period: 2023			Current Period: 2024				
NCQA Category	Appeals & SLG	Avg PHC Mship	Appeals & SLGs p/1,000	Appeals & SLG	Avg PHC Mship	Appeals & SLGs p/1,000	Threshold	Threshold Met?
Access	350	678,546	0.52	442	905,570	0.49	0.57	Yes
Attitude/Service	33		0.05	18		0.02	0.05	Yes
Billing/Financial	297		0.44	211		0.23	0.48	Yes
Quality of Care	9		0.01	1		0.00	0.01	Yes
Quality of Provider Office	0		0.00	0		0.00	0.00	Yes
TOTAL	689		1.02	672		0.74	1.12	Yes

RESULTS & THRESHOLDS – APPEALS & SECOND LEVEL GRIEVANCES

Note: Following 2023 DHCS Audit findings, this analysis represents the final annual reporting period including Second Level Grievances. Effective January 1, 2025, this process will transition to a streamlined appeal system with enhanced member notification and documentation requirements.

The trending data in Table VII above compares annual reporting periods from January 1, 2023, to December 31, 2023, to January 1, 2024, through December 31, 2024.

In 2024, total Appeals and Second Level Grievances decreased from 689 in 2023 to 672 in 2024. Despite the significant membership growth (678,546 to 905,570), the overall rate of cases per 1,000 members decreased from 1.02 to 0.74 in 2024, indicated positive performance.

All categories met their thresholds in 2024. Access and Billing/Financial remained the primary reporting categories, with 442 and 211 cases respectively. Other categories showed lower volumes: Attitude/Service (18 cases), Quality of Care (1 case), and Quality of Provider's Office (0 cases). G&A met all threshold requirements across categories for 2024.

Future reporting periods will likely reflect several changes under APL 21-011, including simplified categorization with the removal of Second Level Grievances, new compliance metrics for notification timelines, potential shifts in case volumes due to the streamlined process, and enhanced monitoring of member communication requirements.

ANALYSIS OF NCQA CATEGORIES NOT MEETING THRESHOLDS

Based on the quantitative data presented in Tables VI and VII, the analysis of MY 2024 grievance data identified two categories exceeding established thresholds, requiring focused barrier analysis:

1. **NCQA CATEGORY: ACCESS**
   - G&A Data: Access complaints (2.83 per 1,000 members, exceeding threshold)
     - **Key Focus:** Access and Transportation related issues, collectively representing the highest volume of access-related grievances
   - CAHPS® Data: Getting Needed Care (5th percentile) and Getting Care Quickly (11th percentile)

   BARRIERS:
   - **Regional Growth Impact**
     - Expansion into 10 new counties resulting in 33% membership growth
   - Limited PCP and specialty provider availability within our rural counties
   - Members reported PCP scheduling challenges and timely appointment availability
   - **Operational Systems Integration**
     - Lack of systematic real-time tracking between transportation complaints and specific drivers
     - Manual complaint management process limiting timely response
     - High volume of trips versus complaints creates challenge in pattern identification and transportation provider management

2. **NCQA CATEGORY: QUALITY OF PRACTITIONER OFFICE SITE**

- G&A Data: Quality of Provider's Office concerns (Threshold Status: Increased from 0.003 to 0.006 per 1,000 members, exceeding threshold range
    - **Key Focus:** PCP provider office cleanliness

BARRIERS:

- **No barriers identified**
    - 40% of reported cases (2 of 5) could not be validated due to absence of appointment verification
    - Limited sample size (5 cases) affects statistical significance of rate increase
    - Complaint categorization may not accurately reflect actual facility quality issues, as verified cases demonstrated appropriate cleaning protocols

These identified barriers inform our improvement priorities discussed in the Member Experience Overview section and intervention strategies detailed in Appendix A: 2025-2026 Organizational Goal #5.

SUMMARY HIGHLIGHTS

GRIEVANCES AND APPEALS & SECOND LEVEL GRIEVANCES

GRIEVANCES

In 2024, grievances increased in volume with membership growth, reaching 6.05 per 1,000 members and exceeding the 5.79 threshold. Access and Quality of Provider Office did not meet thresholds, while Attitude/Service, Billing/Financial and Quality of Care remained within acceptable limits. Access and Attitude/Service together accounted for the vast majority of grievance cases.

APPEALS & SECOND LEVEL GRIEVANCES

Despite significant membership growth, Appeals and Second Level Grievances decreased slightly to 672 cases, with the overall rate improving from 1.02 in 2023 to 0.74 in 2024 (per thousand members). All categories met threshold requirements.

IDENTIFICATION OF OPPORTUNITIES

- Transportation remains a primary concern, representing 49% of total cases, though the rate of this concern decreased from 0.6% to 0.4% of total rides provided.

GRIEVANCES AND APPEALS BY NCQA CATEGORY

- Access and Attitude/Service continued to account for the majority of grievances.
- Quality of Provider Office cases remain relatively low but did exceed threshold in 2024.
- All other categories met thresholds.

EXPANSION/PLAN CHANGES

- Membership: 33.5% growth from prior year (678,546 to 905,570 members)
- Future Changes: Following DHCS Audit findings, Second Level Grievances will transition to a streamlined appeal process effective January 1, 2025 (APL 21-011).

PLAN PERFORMANCE

The CAHPS® Program evaluates health plan performance using HEDIS® MY 2024 Quality Compass benchmark targets set at the 33rd percentile for both rating and composite measures. The plan benchmark targets differ from NCQA-ratable measures in two key aspects:

1. CAHPS® Rating Measures: The program includes both summary rates (percentage of 9 or 10 responses) and supplemental ratings (percentage of 8, 9, or 10 responses) for team goal-setting activities.
2. NCQA Star Rating Measures: These exclusively use summary rates, consisting of:
   - Percentage of 9 or 10 responses for rating measures
   - Percentage of "Always" or "Usually" responses for composite measures

The CAHPS® survey plan performance for MY 2023-2024 / MY 2024-2025, and comparable analyses are included in each section by population and illustrated within Table VIII and Table IX.

ADULT CAHPS® PLAN PERFORMANCE

The comparison table illustrates Adult CAHPS® survey scores by MY 2023 and MY 2024.

Table: VIII

	ADULT CAHPS Composite	2023-2024 (15.3.% Response Rate) Sample Size 3,375 Total Returns 510	2023 HEDIS Percentile Ranking	Partnership Benchmark Target	Benchmark Target Met?	2024-2025 (15.3.% Response Rate) Sample Size 3,375 Total Returns 511	2024 HEDIS Percentile Ranking	Partnership Benchmark Target	Benchmark Target Met?
Rating Measure	Rating of Health Plan (% 8, 9, 10)	68.4%	<5th	PHC ≥ 33rd	No	73.7%	19th	PHC ≥ 33rd	No
	Rating of Health Care (% 8, 9, 10)	66.9%	5th	PHC ≥ 33rd	No	73.9%	35th	PHC ≥ 33rd	Yes
	Rating of Personal Doctor (% 8, 9, 10)	82.8%	51st	PHC ≥ 33rd	Yes	81.3%	30th	PHC ≥ 33rd	No
	Rating of Specialist Seen Most Often (% 8, 9, 10)	81.0%	41st	PHC ≥ 33rd	Yes	88.0%	6th	PHC ≥ 33rd	No
Composite Measure	Getting Needed Care (% Always or Usually)	74.0%	7th	PHC ≥ 33rd	No	74.5%	5th	PHC ≥ 33rd	No
	Getting Care Quickly (% Always or Usually)	68.1%	<5th	PHC ≥ 33rd	No	74.0%	11th	PHC ≥ 33rd	No
	Care Coordination (% Always or Usually)	78.8%	11th	PHC ≥ 33rd	No	81.3%	9th	PHC ≥ 33rd	No
	How Well Doctors Communicate (% Always or Usually)	92.6%	48th	PHC ≥ 33rd	Yes	90.6%	8th	PHC ≥ 33rd	No
	Customer Service (% Always or Usually)	87.0%	18th	PHC ≥ 33rd	No	86.5%	12th	PHC ≥ 33rd	No

WHAT CHANGED LAST YEAR (MY2023-MY2024): The CAHPS® survey results reflect changes in member experience across rating and composite measures.

RATING MEASURES

Overall Performance:

- Rating of Health Plan: Increased by 5.3 percentage points (68.4% to 73.7%), below benchmark
- Rating of Health Care: Increased by 7.0 percentage points (66.9% to 73.9%), exceeded benchmark

- Rating of Personal Doctor: Decreased by 1.5 percentage points (82.8% to 81.3%), below benchmark
- Rating of Specialist Seen Most Often: Increased by 7.0 percentage points (81.0% to 88.0%), below benchmark

Benchmark Analysis:

- Health Care ratings exceed the target benchmark.
- The remaining three (3) rating measures remained below benchmark.

COMPOSITE MEASURES

Overall Performance:

- Getting Needed Care increased by 0.5 percentage points (74.0% to 74.5%)
- Getting Care Quickly increased by 5.9 percentage points (68.1% to 74.0%)
- Care Coordination increased by 2.5 percentage points (78.8% to 81.3%)
- Doctor Communication decreased by 2.0 percentage points (92.6% to 90.6%)
- Customer Service decreased by 0.5 percentage points (87.0% to 86.5%)

Benchmark Analysis:

- No composite measures reached benchmark targets

CHILD CAHPS® PLAN PERFORMANCE

The comparison table illustrates Child CAHPS® survey scores by measure years; MY 2023, and MY 2024.

Table: IX

	CHILD CAHPS Composite	2023-2024 (16.1% Response Rate) Sample Size 4,125 Total Returns 659	2023 HEDIS Percentile Ranking	Partnership Benchmark Target	Benchmark Target Met?	2024-2025 (15.8% Response Rate) Sample Size 5,000 Total Returns 783	2024 HEDIS Percentile Ranking	Partnership Benchmark Target	Benchmark Target Met?
Rating Measure	Rating of Health Plan (% 8, 9, 10)	86.5%	45th	PHC ≥ 33rd	Yes	86.0%	44th	PHC ≥ 33rd	Yes
	Rating of Health Care (% 8, 9, 10)	76.9%	<5th	PHC ≥ 33rd	No	84.5%	21st	PHC ≥ 33rd	No
	Rating of Personal Doctor (% 8, 9, 10)	89.9%	55th	PHC ≥ 33rd	Yes	91.4%	73rd	PHC ≥ 33rd	Yes
	Rating of Specialist Seen Most Often (% 8, 9, 10)	81.5%	21st	PHC ≥ 33rd	No	85.6%	31st	PHC ≥ 33rd	No
Composite Measure	Getting Needed Care (% Always or Usually)	77.1%	14th	PHC ≥ 33rd	No	77.9%	13th	PHC ≥ 33rd	No
	Getting Care Quickly (% Always or Usually)	78.9%	9th	PHC ≥ 33rd	No	80.0%	13th	PHC ≥ 33rd	No
	How Well Doctors Communicate (% Always or Usually)	93.0%	40th	PHC ≥ 33rd	Yes	93.3%	36th	PHC ≥ 33rd	Yes
	Care Coordination (% Always or Usually)	80.4%	22nd	PHC ≥ 33rd	No	84.7%	52nd	PHC ≥ 33rd	Yes
	Customer Service (% Always or Usually)	91.2%	89th	PHC ≥ 33rd	Yes	90.5%	74th	PHC ≥ 33rd	Yes

WHAT CHANGED LAST YEAR (MY2023-MY2024): The Child CAHPS® survey results demonstrate changes in member experience across rating and composite measures.

RATING MEASURES

Overall Performance:

- Health Plan ratings remained stable with slight decrease of 0.5 percentage points (86.5% to 86.0%), maintaining above benchmark performance.
- Health Care ratings increased by 7.6 percentage points (76.9% to 84.5%).
- Personal Doctor ratings increased by 1.5 percentage points (89.9% to 91.4%), exceeding benchmark target.
- Specialist ratings increased by 4.1 percentage points (81.5% to 85.6%).

Benchmark Analysis:

- Personal Doctor ratings exceeded target at the 73rd percentile.
- Health Plan ratings maintained above benchmark at the 44th percentile.
- Two (2) rating measures remained below benchmark.

COMPOSITE MEASURES

Overall Performance:

- Getting Needed Care increased by 0.8 percentage points (77.1% to 77.9%).
- Getting Care Quickly increased by 1.1 percentage points (78.9% to 80.0%).
- How Well Doctors Communicate increased by 0.3 percentage points (93.0% to 93.3%), maintaining above benchmark.
- Care Coordination increased by 4.3 percentage points (80.4% to 84.7%), achieving benchmark target.
- Customer Service decreased slightly by 0.7 percentage points (91.2% to 90.5%), maintaining strong performance.

Benchmark Analysis:

- Three (3) measures exceeded benchmark: Customer Service (74th percentile), Care Coordination (52nd percentile), and How Well Doctors Communicate (36th percentile).
- Two (2) measures remained below benchmark targets.

COVID IMPACT ANALYSIS MY2020-MY2024

The COVID era triggered sharply divergent trends in CAHPS® Health Plan and Health Care performance. While Child measures show marked improvements in key ratings, Adult measures reveal substantial declines, particularly in access to care. This stark contrast, observed during the expansion beyond our original 14-county service area, illuminates the varying impact of COVID-era changes across populations.

KEY FINDINGS:

ADULT POPULATION

Most significant declines in access measures:

- Specialist appointments (**-10.6** points)
- Routine care access (**-9.4** points)
- Care coordination (**-7.3** points)

Areas of stability/improvement:

- Health Plan ratings (**+0.9** points)
- Doctor Communication (**+0.1** points)
- Customer Service (**+0.9** points)

CHILD POPULATION

Areas of significant improvement:

- Specialist ratings (**+10.2** points)
- Personal Doctor ratings (**+7.4** points)
- Health Plan ratings (**+5.8** points)

Persistent challenges:

- Routine care access (**-6.3** points)
- Getting needed care (**-2.8** points)

NCQA HEALTH PLAN RATING:
CAHPS® PATIENT EXPERIENCE PERFORMANCE QUANTITATIVE ANALYSIS

The NCQA Health Plan Rating (HPR) methodology evaluates plan performance through a comprehensive scoring system that combines CAHPS® patient experience measures (weighted at 25%) and HEDIS® clinical quality measures (weighted at 75%).

This analysis focuses on the CAHPS® component, examining summary rates that reflect members' experiences with their health plan and healthcare services, as detailed in Tables X and XI for Adult and Child populations, respectively.

Summary rates, as defined by NCQA's HEDIS 2024 CAHPS® 5.1H guidelines, represent the percentage of most favorable responses:

- Rating Measures: Percentage of members rating 9 or 10 on a 0-10 scale
- Composite Measures: Percentage of members responding "Always" or "Usually"

Star ratings are assigned based on percentile distributions of plan performance:

- 5 Stars: ≥90th percentile
- 4 Stars: 75th to 89th percentile
- 3 Stars: 50th to 74th percentile
- 2 Stars: 25th to 49th percentile
- 1 Star: <25th percentile

Composite measure star ratings (such as Getting Care) represent weighted averages of their component questions, with statistical significance of year-over-year changes factored into trend analysis. Final Patient Experience ratings are calculated by averaging the star ratings across all CAHPS® measures, with results rounded to the nearest half-star.

The following analysis examines three-year trends across key domains using MY 2024 data and percentiles for commercial, Medicaid HEDIS/CAHPS®, and Medicare HEDIS measures. Table X presents Adult HEDIS/CAHPS® measures, while Table XI details Child HEDIS/CAHPS® measures, both evaluated against national benchmarks. These tables provide comprehensive trending of summary rates from RY 2023 through RY 2025, along with year-over-year comparisons and estimated star ratings.

Table: X

ADULT HEDIS/CAHPS® Measures Required for Health Plan Accreditation Quality Compass Reporting Year Summary Rate Trend					
Patient Experience	RY 2023	RY 2024	RY 2025	RY 24 | RY 25 Comparison	MY 2024 Estimated Star Rating
	Summary Rate Performance				
Getting Care					**1.5**
Getting Needed Care (% Always or Usually)	76.4%	74.0%	74.5%	**0.5%**	1
Getting Care Quickly (% Always or Usually)	69.5%	68.1%	74.0%	**5.9%**	2
Satisfaction with Plan Physicians					**2**
Rating of Personal Doctor (% 9 + 10)	66.9%	70.0%	65.7%	**-4.3%**	2
Satisfaction with Plan and Plan Services					**2.5**
Rating of Health Plan (% 9 + 10)	56.8%	54.4%	55.8%	**1.4%**	2
Rating of Health Care (% 9 + 10)	55.7%	46.3%	55.4%	**9.1%**	3

ADULT NOTABLE FINDINGS FOR RY 2025

- Adult oversampling strategy contributed to meeting the 100-survey response threshold for all NCQA Reportable measures.
- RY 2025 Patient Experience Star Rating Estimate: 2.0, ***showing improvement from prior year.***
- Getting Care (% Always or Usually): ***Mixed performance in Access measures with notable improvement in Getting Care Quickly***
    - Getting Needed Care - Slight improvement of +0.5% compared to RY 2024
    - Getting Care Quickly - Significant improvement of +5.9% compared to RY 2024
- Satisfaction with Plan Physicians (% 9+10):
    - Rating of Personal Doctor - Notable decline of -4.3% compared to RY 2024
- Satisfaction with Plan and Plan Services (% 9 + 10):
    - Rating of Health Plan - Modest improvement of +1.4% compared to RY 2024
    - Rating of Health Care - Significant improvement of +9.1% compared to RY 2024

Table: XI

CHILD HEDIS/CAHPS® Measures Required for Health Plan Accreditation Quality Compass Reporting Year Summary Rate Trend					
Patient Experience	**RY 2023**	**RY 2024**	**RY 2025**	**RY 24 | RY 25 Comparison**	**MY 2024 Estimated Star Rating**
	Summary Rate Performance				
Getting Care					**2**
Getting Needed Care (% Always or Usually)	76.7%	77.0%	77.9%	**0.9%**	2
Getting Care Quickly (% Always or Usually)	76.3%	78.9%	80.0%	**1.1%**	2
Satisfaction with Plan Physicians					**4**
Rating of Personal Doctor (% 9+10)	74.4%	75.5%	78.6%	**3.1%**	4
Satisfaction with Plan and Plan Services					**2.5**
Rating of Health Plan (% 9 + 10)	68.0%	68.1%	72.9%	**4.8%**	3
Rating of Health Care (% 9 + 10)	64.2%	58.8%	66.4%	**7.6%**	2

CHILD NOTABLE FINDINGS FOR RY 2025:

- Child oversampling strategy contributed to meeting the 100-survey response threshold for all NCQA reportable measures.
- RY 2025 Patient Experience Star Rating Estimate: 2.8, ***showing continued improvement from prior year.***
- Getting Care (% Always or Usually): ***Consistent improvement in Access measures continues to positively impact overall satisfaction***
    - Getting Needed Care - Modest improvement of +0.9% compared to RY 2024
    - Getting Care Quickly - Continued improvement of +1.1% compared to RY 2024
- Satisfaction with Plan Physicians (% 9+10):
    - Rating of Personal Doctor - Strong improvement of +3.1% compared to RY 2024, achieving 4-star performance
- Satisfaction with Plan and Plan Services (% 9 + 10):
    - Rating of Health Plan - Significant improvement of +4.8% compared to RY 2024
    - Rating of Health Care - Substantial improvement of +7.6% compared to RY 2024

ANALYSIS OF CAHPS® MEMBER EXPERIENCE BARRIERS

The analysis of barriers impacting CAHPS® performance below benchmark draws from comprehensive causal analysis detailed throughout this report. Key findings from our examination of root causes include:

Adult Population Measures

- **Getting Needed Care (5th percentile)**
  Root causes analyzed in Service Delivery Impact and Member Feedback sections include:
  - Network adequacy challenges during expansion period
  - Workforce constraints affecting appointment availability
  - Transportation coordination barriers (49% of member feedback)
  - Regional healthcare delivery system adaptations
- **Getting Care Quickly (11th percentile)**
  Primary barriers identified through member experience analysis include:
  - Clinical workforce shortages across service regions
  - System adaptation challenges in expanded counties
  - Service delivery constraints detailed in Network Assessment
- **Customer Service (12th percentile)**
  Causal factors examined in Service Delivery sections include:
  - Service system adaptation needs during expansion
  - Regional variation in service delivery
  - Resource allocation challenges across expanded territory

Child Population Measures

- **Getting Needed Care and Getting Care Quickly (13th percentile)**
  Root causes identified through Health Equity and Service Delivery analysis include:
  - Regional variations in pediatric service availability
  - Healthcare workforce distribution challenges
  - Service delivery adaptation needs in expansion areas
  - Cultural and linguistic service coordination requirements

For detailed discussion of these barriers and their impacts, refer to Service Delivery Impact, Member Feedback, and Health Equity analysis sections. These identified root causes inform improvement strategies detailed in Appendix A: 2025-2026 Organizational Goal #5.

HEALTH EQUITY AND MEMBER EXPERIENCE QUANTITATIVE ANALYSIS

Member Experience at Partnership integrates two (2) important frameworks that inform our approach to equitable healthcare delivery. Our Member Experience assessment incorporates HE CAHPS® survey data and Culturally and Linguistically Appropriate Services (CLAS) supplemental questions to assess plan and interpreter service experiences. The survey results provide insights into how members feel about our healthcare and service delivery.

The CAHPS® survey captures members' direct feedback on access, communication, and satisfaction, while our NCQA (HE 6) CLAS standards implementation ensures culturally responsive care delivery across provider and plan touchpoints.

Together, these measures support our successful NCQA Health Equity (HE 6) accreditation, demonstrating our systematic approach to reducing health disparities and improving care quality for all members.

MY 2024 Survey Response Analysis

Partnership's annual CAHPS® Adult and Child Surveys provide critical insights into member experiences and representation across our diverse populations. The data reveals significant variations in both demographic participation and satisfaction with services.

Demographic Representation

The surveys show marked differences in participation across populations. Hispanic/Latino representation is notably stronger in child surveys (68.6%) compared to adult surveys (42.7%). White respondents comprise the majority in both surveys (adult: 65.0%, child: 62.8%), highlighting persistent gaps in representation from other racial and ethnic groups.

Asian members represent 12.0% of adult responses and 10% of child responses, while Black/African American members show higher participation in child surveys (8.1%) compared to adult surveys (5.3%). American Indian/Alaska Native participation is similar across both populations (adult: 7.2%, child: 6.5%), and Native Hawaiian/Pacific Islander members maintain consistent but low representation (adult: 2.3%, child: 2.2%).

Language Services Experience

Members utilizing interpreter services reported varying experiences between provider interactions and health plan services. In adult surveys, 68.6% gave top ratings (9-10) to interpreter services during provider visits, while 58.1% gave similar high ratings to health plan interpreter services. This 10.5 percentage point difference suggests more effective communication through interpreters during direct provider interactions.

Families using interpreter services for their children's healthcare reported higher satisfaction overall. Top ratings for interpreter services reached 78.8% for provider visits and 74.7% for health plan interactions. While families still rated provider interpreter services more favorably, the gap between provider and plan services was smaller (4.1 percentage points) than in the adult population.

Notable Findings for RY 2025

1. Demographic Representation
    - Stronger Hispanic/Latino engagement in child surveys
    - Consistent underrepresentation of most communities of color in both surveys
    - Similar participation patterns across most racial groups between adult and child populations

2. Language Services
    - Consistently higher satisfaction with provider interpreter services compared to health plan services

- Notably higher satisfaction rates in pediatric settings
- Substantial gap between adult and child populations' experiences (16.6 percentage points higher for child survey respondents with health plan services)

These findings suggest opportunities for improving both member representation and language access services, particularly in adult services where satisfaction rates lag behind pediatric care. The data points to the need for targeted strategies to enhance engagement across all demographic groups while strengthening language support services, especially at the health plan level.

For detailed insights into our health equity achievements and opportunities, please refer to the NCQA Health Equity (HE 6) Grand Analysis Report. This integrated assessment framework allows us to identify gaps, implement targeted improvements, and measure the impact of our health equity initiatives across our expanded service area.

APPENDIX

MEMBER EXPERIENCE

APPENDIX A

APPENDIX OVERVIEW

This appendix outlines the FY 25/26 Member Experience organizational goals and their implementation framework. These goals are strategically designed to address identified member barriers through comprehensive data analysis, including CAHPS® Survey results and other member experience metrics. The status tracking system detailed in Table III demonstrates our systematic approach to monitoring interventions and improvements across departments.

Each milestone within Goal 5 directly corresponds to specific improvement focuses identified through member experience analysis, ensuring a coordinated approach to addressing member barriers through interdepartmental collaboration.

Table: III

INTERVENTION & IMPROVEMENT STATUS	IMPROVEMENT FOCUS	GOAL MILESTONE #	INTERDEPARTMENTAL COLLABORATION		DEFINITIONS
			YES / NO	# OF DEPTS.	
Continue	*Access	--	--	4	• **Adjust:** a lean approach or pivot. A continued focus and intent. • **Continue:** a continuation of intervention or improvement activity and focus. • **Maintain:** score or intervention met. • **Monitor:** intervention or improvement assessment period. • **New:** a new action or intervention.
Continue	Member Experience	All	Yes		
New	Health Equity	5			
Continue	Customer Service	All			
Continue	Attitude/Service	1			
Continue	Health Care Rating	All	Yes		
Continue	Health Plan Rating	All			

**Access priority aligns with Org. Goal #2: Network Optimization*

FY 25/26 ORGANIZATIONAL GOAL 5: MEMBER EXPERIENCE

Goal 5: Member Experience	
GOAL OWNER:	Isaac Brown, Director of Quality and Performance
GOAL SPONSOR:	Dr. Robert Moore, Chief Medical Officer
GOAL LEAD:	Anthony Sackett, Program Manager II

Goal Statement
The goal for Member Experience in FY 25-26 is to drive meaningful improvements in member satisfaction by fostering collaboration across departments, boosting CAHPS® scores, embedding Health Equity into member experience initiatives, and enhancing overall quality.

Milestones	
Milestone 1 – MX Strike Team | Transportation Services: The Transportation Department will continue its FY 2024-2025 pilot program, which connects member Grievance and Appeal cases with driver performance to enhance service quality and member satisfaction while developing data-driven improvement targets. **Outcome(s)/Deliverable(s):** • Design and implement one (1) operational pilot improvement initiative • Establish specific ridership improvement targets based on NCQA quality measures • Complete the full PDSA (Plan-Do-Study-Act) cycle with comprehensive analysis	**Target Completion Date:** June 30, 2026 **Required Milestone?** ☒ Yes ☐ No
Milestone 2 – MX Strike Team | Quality Improvement (QI): The QI Consumer Assessment of Healthcare Providers and Systems (CAHPS®) team will lead the MX Strike Team pilot by leveraging real-time internal influence drivers to identify and address sources of member dissatisfaction (e.g., line staff engagement, causal factors), to enhance service delivery and effectiveness. **Outcome(s)/Deliverable(s):** • Develop recommendations and implement proposed improvements based on the outcome of root cause analysis and PDSA results.	**Target Completion Date:** June 30, 2026 **Required Milestone?** ☐ Yes ☒ No
Milestone 3 – Enhancement & Member Education | Member Services (MS): The MS Department will lead activities to initiate one new initiative to improve member experience (MX) through operational and/or service delivery enhancements. **Outcome(s)/Deliverable(s):** • Implement and measure the impact of the new MX-focused initiative through defined metrics. (i.e. member satisfaction scores, reduced inquiries about covered benefits, or other indicators).	**Target Completion Date:** June 30, 2026 **Required Milestone?** ☒ Yes ☐ No
Milestone 4 – Enhancement & Member Education | QI CAHPS® Team: The QI CAHPS® team will advance dental coverage initiatives to improve MX through enhanced education, access, and service delivery. **Outcomes/Deliverables:**	**Target Completion Date:** June 30, 2026 **Required Milestone?** ☒ Yes ☐ No

• Measure and report on implementation progress using defined metrics for dental service utilization and member dental awareness	
Milestone 5 – Integration of Health Equity into MX Initiatives: The Population Health Management (PHM) Department, in partnership with the Health Equity (HE) team, will lead collaborative work group activities aimed at advancing equitable member engagement and integrating diverse perspectives into the design and delivery of member experience (MX) initiatives. These efforts will reflect our diverse member population's cultural, linguistic, and social needs. **Outcomes/Deliverables:** • Co-develop at least three (3) improvement strategies and actionable interventions/initiatives that incorporate member-informed health equity perspectives into the evaluation and enhancement of MX initiatives. • Implement at least two (2) developed strategies to improve visibility into barriers to care and service delivery.	**Target Completion Date:** June 30, 2026 **Required Milestone?** ☒ Yes ☐ No

APPENDIX B

APPENDIX OVERVIEW

This appendix documents FY 2024-2025's Goal 4 achievements and improvement tracking methodology. Through Table III's systematic status indicators and comprehensive milestone outcomes, it demonstrates Partnership's continuous improvement journey in member experience and access to care. The completed initiatives, strategic realignment, and ACAP CAHPS® Collaborative findings established the foundation for FY 2025-2026's Goal 5 initiatives, ensuring sustained progress in member experience enhancement.

Table: III

INTERVENTION & IMPROVEMENT STATUS	IMPROVEMENT FOCUS	GOAL MILESTONE #	INTERDEPARTMENTAL COLLABORATION		DEFINITIONS
			YES / NO	# OF DEPTS.	
Continue	Access	1,2	Yes	4	• **Adjust:** a lean approach or pivot. A continued focus and intent. • **Continue:** a continuation of intervention or improvement activity and focus. • **Maintain:** score or intervention met. • **Monitor:** intervention or improvement assessment period. • **New:** a new action or intervention.
Continue	Member Experience	2,3,4,5,6,7	Yes		
Continue	Customer Service	3,8			
Continue	Attitude/Service	3,5			
Continue	Health Care Rating	1,2,4,5,6,7	Yes		
Continue	Health Plan Rating	All	Yes		

2024-2025 ORGANIZATION GOAL #4

Goal 4: Access to Care and Member Experience Improvement. The Access to Care/Member Experience Improvement organizational goal will focus on three (3) main areas:

1. Understanding the landscape of our specialty provider network, identifying gaps, and developing targeted action plans
2. Understanding the landscape of our primary care provider network, identifying gaps, and developing targeted action plans
3. Expanding the "Your Partner in Health" branding campaign and implementing an action plan to improve and increase member awareness

CAHPS® SCORE IMPROVEMENT (CSI) PARTICIPANTS

The FY 2024-2025 QI Department CSI Goal cross-department workgroup participants illustrate organization-wide participants involved in a multi-disciplinary approach focused on improvement activities and strategic CSI planning during the reporting and evaluation period, Table: XII.

Table: XII

ORG. GOAL 4: ACCESS TO CARE AND MEMBER EXPERIENCE IMPROVEMENT	
WORKGROUP PARTICIPANTS	**DEPARTMENT | NAME**
GOAL CO-SPONSORS: DR. ROBERT MOORE *CHIEF MEDICAL OFFICER* WENDI DAVIS *CHIEF OPERATING OFFICER* **GOAL CO-OWNERS:** DAVID LAVINE *ASSOC. DIRECTOR OF WORKFORCE DEVELOPMENT* DUSTIN LYDA *DIRECTOR OF COMMUNICATIONS* **GOAL LEAD:** ANTHONY SACKETT *PROGRAM MANAGER II*	**COMMUNICATIONS:** Dustin Lyda, Amanda Bernal
	FINANCE HEALTH ANALYTICS: Liat Vaisenberg, Dejene Bikila, Shivani Sivasankar
	GRIEVANCE & APPEALS: Kory Watkins, Latrice Innes
	HEALTH EQUITY: Dr. Jalloh
	HR/WORKFORCE DEVELOPMENT: Cody Thompson, Arielle Tello
	IT WEB APPS TEAM: Shankar Reddy
	MEMBER SERVICES: Edna Villasenor, Maria Cabera, Melissa Shumann, Ryan Ciulla
	POPULATION HEALTH MANAGEMENT: Monika Brunkal, Nicole Curreri, Ruth Hood
	PROVIDER RELATIONS: Ledra Guillory, Garnet Booth, Stephanie Nakatani
	QI: Andrea Thomas, Amy McCune, Athena Beltran-Nampraseut, Barb Selig, Isaac Brown,
	TRANSPORTATION SERVICES: Melissa McCartney, Michelle Mootz, Brandi Walker

Goal Overview and Impact Summary

Improving access to care and enhancing member experience are pivotal for fostering a healthcare system that prioritizes both quality and member experience.

The CAHPS® regulated survey measures adult and child (member/patient) experience or perception of key aspects of their care. As an accredited health plan, we may designate which CAHPS® survey we want scored, either adult or child population. Last measure year, we chose child survey results that earned us 2.0 Patient Experience (CAHPS®) rating and an overall NCQA 3.5 Star Health Plan rating. This measure year, Partnership designated adult survey results to be included in the scoring.

This fiscal year Partnership aims to achieve or exceed a 2.5 Star NCQA Patient Experience (CAHPS®) rating and achieve or exceed a 4.0 Star NCQA Health Plan rating. The Goal #4 Team will continue to build on the prior year's interventions and improvement activities. The established FY 2024-2025 goals are intended to impact or influence positive change on the key focus areas:

Access to Care: Improving access to care serves as the gateway to improve patient/member experience and health outcomes. As an organization, Partnership must plan to navigate through access obstacles linked to ever-changing membership levels, clinical staffing shortages, and economic climate at state, county and federal levels. Over the next fiscal goal period, our plan is to broaden our approach with the

stewardship of Workforce Development leadership. In scope is to incorporate the past four (4) years of implemented access improvements and lessons learned through the 5-Star Quality Strategic and Tactical Plans, and, where applicable, adjust them as we develop a comprehensive Access Strategy and Tactical Plan fully dedicated to access moving forward.

Member Experience: Advancing the Quality Improvement (QI) CAHPS® programmatic framework will require implementing interventions rooted in present barriers and before eligible members participate in the regulated CAHPS® survey. Lessons learned through CSI activities over the past two (2) fiscal goal periods have paved the path forward. The plan is to leverage more real time data (i.e., Grievance & Appeals [G&A] and Population Health Management [PHM] community engagement responses) on a quarterly basis to examine and respond timelier to topical themes identified directly from our members, including complaints about the health plan and providers. This enhanced method will provide Goal #4 Team more real-time opportunities to measure intervention effectiveness against targeted barriers.

Positive Reputation and Brand Identity: Continue to distinguish Partnership as a Managed Care Plan leader that is committed to member-centered care, leading to a positive reputation and member awareness, "our story" within the communities we serve.

Effective Communication: Enhance member communication through texting, email, and Partnership mobile application designed to centralize and simplify all member-facing online websites/tools/platforms. This will help drive usability and value by engaging members through various communication modalities in delivering proactive resources that promote health education, covered benefits literacy, wellness, and preventative care resources.

Member Engagement and Adherence: Empower members with knowledge and resources intended to lead to greater engagement in their own care and increased adherence to treatment plans, resulting in better long-term health outcomes.

Enhanced Digital Experience: Develop a user-friendly mobile app and enhance member portal functionality and methods to empower members to self-serve and inform Partnership how they would prefer to engage with us. The plan is to build upon member demographic collection integration through existing C-Square enhancements.

ORGANIZATIONAL GOAL #4 | FY 2024-2025 OUTCOMES

Below are the milestone outcomes for the Access and Member Experience workgroups, organized sequentially and showing requirement status and goal completion.

Final Goal Status		
☒ **Goal Completed at Full Credit**	☐ Goal Completed at Partial Credit	☐ Goal Not Completed

Milestone 1: Access Strategy Development

The Access Workgroup successfully completed Milestone 1 of developing a comprehensive multi-year Access Strategy for specialty and primary care provider networks. Key accomplishments included creating a strategic framework with defined metrics, implementing advanced network visualization tools, and engaging 15 departments through 22 stakeholder interviews. The team delivered technical solutions including provider exit scoring, network gap analysis tools, and enhanced data reporting capabilities. The strategy incorporated critical elements such as workforce retention, telehealth integration, health equity, and transportation services, while establishing the foundation for tactical implementation in Milestone 2. This milestone met all requirements for framework development, stakeholder validation, and technical infrastructure establishment.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 2: Access Tactical Plan

The Access Workgroup successfully executed Milestone 2 by developing a comprehensive tactical plan for improving specialty and primary care network access. Through extensive stakeholder engagement across eight (8) key departments, the team produced a detailed multi-year implementation framework with defined timelines and success metrics. Key deliverables included a Provider Gap Analysis Tool, resource allocation framework, and integration strategies for existing services. The plan incorporated lessons from existing quality initiatives while addressing critical implementation factors such as staff capacity, technological infrastructure, and community partnerships. This milestone successfully established the operational blueprint for enhancing provider network accessibility.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 3: Member Experience Improvement Strike Team

The Member Experience Workgroup successfully implemented the CAHPS® Score Improvement (CSI) initiative through a Strike-Team approach, focusing on transportation services and benefit awareness enhancement. Key achievements included implementing Kinetik trip tracking, analyzing 154 grievances, and establishing NCQA-aligned incident thresholds for transportation services. The team strengthened benefit awareness through comprehensive staff training, enhanced communication channels, and strategic partnerships, particularly with DHCS's Smile, California program. Significant improvements were made in data analysis, G&A reporting, and cross-departmental collaboration, resulting in enhanced member service delivery and monitoring capabilities. The milestone exceeded original deliverables across stakeholder engagement, operational enhancement, data analysis, transportation provider accountability, and system-wide benefit awareness.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 4a: Digital Platform Enhancements

The Member Experience Workgroup completed preliminary planning for digital communication enhancements through the Member Portal platform. While the team successfully completed initial requirements gathering, system testing, and stakeholder engagement for sexual orientation and gender identity (SOGI) data collection and Community Advisory Committee (CAC), application integration, implementation has been strategically postponed to align with the upcoming HRP/JIVA platform launch.

Key preparatory work included C2 platform testing, SOGI module development, and CAC application framework design. This milestone established the technical groundwork and documentation necessary for future implementation while ensuring seamless integration with the new HRP system.

Required Milestone: ☑ No ☐ **Status:** Not Complete

Milestone 4b: Mobile Application Assessment

The Member Experience Workgroup completed a comprehensive assessment for Partnership's mobile application initiative through extensive stakeholder engagement and strategic analysis. The team gathered valuable insights from Family Advisory Committee (FAC), CAC, and Member Services, resulting in a detailed operational assessment framework and requirements inventory. Key deliverables included developing vendor evaluation criteria, establishing feature prioritization methodology, and creating implementation recommendations based on member feedback. This milestone successfully laid the groundwork for mobile application development by aligning stakeholder needs with operational feasibility and integration requirements.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 5: Member Informative Session (MIS) Program

The Member Experience Workgroup successfully established the Member Informative Session (MIS) program framework, securing both executive approval and resources for regional implementation. Key achievements included creating five (5) new positions (4 Member Engagement Specialists and 1 CAC Coordinator), developing partnerships across 24 counties, and implementing a comprehensive cross-departmental collaboration system. The team completed the initial phase by staffing four (4) regional offices (Fairfield, Redding, Auburn, and Chico) and establishing the infrastructure for 48 annual sessions. The milestone delivered a scalable framework for future expansion to Eureka and Santa Rosa offices, supported by robust event tracking systems and sustainable budget planning.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 6: Text Messaging Program Implementation

The Member Experience Workgroup successfully implemented Year 1 of the text messaging program, establishing comprehensive infrastructure, and launching multiple targeted campaigns. The team created a cross-departmental texting workgroup, developed operational parameters, and successfully executed campaigns reaching approximately 100,000 members with remarkably low opt-out rates (0.013%). Notable achievements included rapid emergency response deployment for the Park Fire, implementation of the Welcome Campaign, and execution of multiple health initiative campaigns across three (3) quarters. The program established robust KPI tracking mechanisms and demonstrated operational success through high delivery rates and engagement metrics. This milestone created a scalable foundation for future messaging campaigns while proving the effectiveness of text-based member communication.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 7: Partnership Awareness Communications Strategy

The Member Experience Workgroup launched the "Your Partner in Health" branding campaign, establishing a comprehensive grassroots communications strategy. Working with NKE Strategies, the

team developed and secured executive approval for a Strategic Communications Plan focused on community-centered messaging. Key achievements included creating targeted messaging for Congressional visits, advancing immigration-focused communications, and establishing a grassroots engagement framework. The milestone successfully delivered messaging architecture and presentation materials while laying the groundwork for Year One implementation. With strategic planning and executive approval phases completed, the initiative is positioned to move into active implementation.

Required Milestone: ☐ No **Status:** ☑ Completed

Milestone 8: CAHPS® Integration Strategy

The Member Experience Workgroup successfully established an integrated approach to patient experience measurement by connecting clinic-level CG-CAHPS® with health plan CAHPS® scoring. Working with the Quality Improvement Pay-for-Performance team, the group developed unified measurement standards and specific improvement targets, which were successfully incorporated into the 2025 PCP specifications. Key achievements included gaining Technical Work Group consensus on measure modifications, creating comprehensive resource documentation, and establishing clear connections between provider and health plan performance metrics. The milestone completed all planned implementation steps through July 2024, positioning the program for ongoing stakeholder education and support.

Required Milestone: ☑ Yes **Status:** ☑ Completed

LESSONS LEARNED

ACAP CAHPS® Collaborative: Year 2 Summary

The CAHPS® Team partnered with 10 sister plans through the Association for Community Affiliated Plans (ACAP) CAHPS® Collaborative to improve survey performance and member experience.

KEY INITIATIVES AND FINDINGS

1. Member Experience Projects: The cornerstone of our work was knowledge sharing between sister plans. Through collaboration, we developed solutions to optimize access to care, enhance needed care scores, and streamline durable medical equipment access.

2. Health Plan Operational Assessment: Our operational assessment uncovered key insights about structure and performance. Through systematic evaluation, we identified organizational strengths in quality metrics and cross-functional collaboration, while noting opportunities to enhance member contact systems, provider experience, and regional access consistency. Priority improvement areas emerged in pharmacy services, healthcare access, and transportation.

3. Enhanced Engagement: To facilitate ongoing learning and collaboration, the team implemented monthly "Office Hours" sessions. These forums proved value by offering real-time problem-solving and best practice sharing among peer organizations.

4. Benefit Literacy Initiative: Perhaps the most significant finding from our MY 2023/RY 2024 surveys was the widespread challenge in benefit comprehension. The most common areas of confusion included transportation, vision, behavioral health, and dental services. This discovery prompted a series of targeted interventions in FY 24/25, including.

- **Targeted Interventions:**
    - **Transportation:** Improved tracking tools, data analysis, and alignment with NCQA standards.
    - **Dental:** Formed a dedicated work group, expanded member education, and planned outreach events.
    - **Organizational Support:** Increased staff training, multilingual communication efforts, and digital engagement strategies.

LOOKING AHEAD

The initiatives implemented through this collaborative have laid a strong foundation for continued improvement in member experience. The combination of structural changes, enhanced communication channels, and targeted service improvements positions us to better serve our member population. Moving forward, we will continue to monitor these initiatives' effectiveness and adapt our strategies based on member feedback and performance measures.

FY 24-25 ORG. GOAL CONCLUSION

The FY 2024–2025 Quality Improvement Evaluation reflects Partnership's continued commitment to advancing member experience, access to care, and health outcomes through data-driven, cross-functional collaboration. This year's findings reaffirm the importance of listening to member voices—whether through survey results, grievances, or community engagement—and translating those insights into targeted, meaningful action.

Despite challenges such as workforce shortages, regional access disparities, and growing member needs, the organization has made measurable progress. Improvements in provider ratings and select CAHPS® measures, alongside successful interventions in benefit literacy, transportation, and dental access, underscore the impact of our collective efforts.

Looking ahead, Partnership remains focused on equity, responsiveness, and continuous learning. The insights gained from this evaluation will shape the next cycle of strategic priorities, with an emphasis on sustained improvement, community trust, and alignment with our organizational mission to help the members of our communities be healthy.

Health Equity Standards –
HE 6: Reducing Healthcare Disparities

September 2024

Table of Contents

Introduction 3
Objective 3
Methodology 5
Element A: Reporting Stratified Measures 6
Element B: Use of Data to Assess Disparities 13
Factor 1: Analyzing clinical performance measures by race/ethnicity 13
Factor 2: Analyzing clinical performance measures by preferred language 13
Factor 3: Analyzing clinical performance measures by gender identity and/or sexual orientation 15
Factor 4: Analyzing individual experience measures by race/ethnicity or preferred language 17
Element C: Use of Data to Monitor and Assess Services 20
Factors 1 & 3: Utilization of language services for organization functions and staff experience with language services for organization functions 20
Factors 2 & 4: Individual experience with language services for organization functions and during health care encounters 24
Element D: Use of Data to Measure CLAS and Inequities 32
Factor 1: Identifies and prioritizes opportunities to reduce health care inequities 32
Factor 2: Identifies and prioritizes opportunities to improve CLAS 36
Factor 3: Implements at least one intervention to address an inequity 39
Factor 4: Implements at least one intervention to improve CLAS 45
Factor 5: Evaluates the effectiveness of an intervention to reduce an inequity 47
Factor 6: Evaluates the effectiveness of an intervention to improve CLAS 49
References 50
Appendix 52

Introduction

The HE 6 report summarizes the work of Partnership HealthPlan of California (Partnership) to analyze potential disparities within the member population through an analysis of race and ethnicity, language, and gender data, as well as Partnership's effort to implement impactful interventions to reduce inequities and improve any culturally and linguistically appropriate services (CLAS) identified through the analysis.

For the purposes of this grand analysis, health inequities are significant differences in health between racial or ethnic groups, gender groups, sexual orientation, age, disability status, socioeconomic status, geographic location, etc. For most groups, health disparities result in significantly higher rates of chronic disease and/or premature death when compared to a historically dominant group, which is why positively impacting these inequities is important (National Academies Press, 2017). The current demographics of Partnership members are listed below:

Table I: Partnership Demographic Information per Race (as of August 2024)

Race/Ethnicity	Membership (n, %)
African American/Black	31,327 (3.50%)
American Indian/Alaska Native	15,947 (1.78%)
Asian Indian	14,072 (1.57%)
Asian or Pacific Islander	12,419 (1.39%)
Filipino	9,961 (1.11%)
Hispanic/Latino	300,739 (33.57%)
Other	36,713 (4.10%)
Unknown	122,361 (13.66%)
Vietnamese	3,707 (.41%)
White	348,514 (38.91%)

Objective

In 2024, Partnership convened a multidisciplinary team to collect and review the data, prioritize the findings, recommend interventions, and prioritize opportunities for improvement in specific groups.

The primary HE 6 team members include:

1. Robert Moore, MD MPH MBA, Chief Medical Officer
2. Mohamed Jalloh, Pharm.D. BCPS, Health Equity Officer
3. Nancy Steffen, Senior Director of Quality and Performance Improvement
4. Dorian Roberts, Senior Project Manager, Performance Improvement
5. Anthony Sackett, Program Manager II, Performance Improvement
6. Cyress Mendiola, Senior Manager of Member Services
7. Latrice Innes, Manager of Grievance and Appeals
8. Sue Quichocho, Manager of Quality Measurement
9. Margarita Garcia-Hernandez, Director of Health Analytics
10. Shivani Sivasankar Ph.D., M.S, Senior Health Data Analyst II

The measures of focus for this report are:

1. Controlling High Blood Pressure (CBP).
2. Hemoglobin A1c Control for Patients with Diabetes (HBD).
3. Prenatal and Postpartum Care (PPC).
4. Child and Adolescent Well Care Visits (WCV).

The stratifications of the quality measures include:

1. Race/Ethnicity
2. Language
3. Gender Identity

Methodology

Step 1: Sample Selection to Evaluate Disparities

Partnership initially utilized Measurement Year 2023 (MY 2023) Health Plan Accreditation final measure samples (n=186 to 167,450 members) to evaluate each of the clinical measures of focus. The rates for each measure are comprised of the members included in each measure's audit for Partnership's Health Plan Accreditation Plan-wide summary of performance report. The random member sample that was generated for each hybrid measure and full member denominator along with member race/ethnicity demographic information, was provided by Partnership's HEDIS vendor, Inovalon. Inovalon has been classified is a direct data source.

Through the initial analysis of MY 2023 Health Plan Accreditation sample, Partnership identified no statistically significant lower rates of performance for many of the race-stratified measures highlighted in Element A that aligned with our internal quality improvement data and state health managed care accountability final rate samples. These consistent insignificant findings were likely secondary due to the small sample sizes included in each hybrid measure sample when trying to evaluate and compare groups to the White, English-speaking, and Male populations, respectively.

As a result of the limited findings from the analysis of the NCQA Final rates and the limitations of the NCQA Final data, and to truly identify and evaluate other inequities, Partnership chose to evaluate the MY 2023 Managed Care Accountability Set (MCAS) final rate samples (n=812 to 167,450 members) for the measures included in the Grand Analysis report to provide a more meaningful analysis for the measures of focus for this report. The MCAS samples may be theoretically more consistent with current Partnership member demographics due to their included region stratifications. However, this is relative to the comparison to the Health Plan Accreditation sample. Finally, the MCAS rates have a greater denominator in the hybrid measure samples for the represented race and ethnicity groups and Partnership is able to evaluate rates per region—which provides a more comprehensive and tailored approach to prioritizing disparities.

Step 2: Statistical Analysis to Identify Key Disparities

After receiving the data from Inovalon, members from Partnership's Health Analytics team conducted various statistical analyses. The Chi-Square and Fisher's Exact statistical tests were utilized, based upon sample size, to determine if there were significant differences for the various categorical measure outcomes.

When analyzing disparities based upon race/ethnicity, Partnership conducted various statistical analyses using the White group as the key comparator group. When analyzing disparities based upon language, Partnership conducted various statistical analyses using the English language group as the key comparator group. Finally, when analyzing disparities based upon gender, Partnership conducted various statistical analyses using the Male gender identity group as the key comparator group. A statistically significant difference was classified as a p value less than 0.05 when comparing the categorical outcomes of one group versus the key comparator group, respectively (i.e. White, English-speaking, Male).

These comparators were identified based upon various literature suggesting that such groups, respectively, have had significantly more political, economic, and/or social advantages within the United States (Malat et al., 2018). Data, that were excluded from the evaluation, were findings from patients who reported "Unknown" in race, language, and gender identity.

Step 3: Analysis of Measures

Due to the low sample sizes for the hybrid measures included in the Health Plan Accreditation data (n=186 to 368), a lack of statistically significant inequities identified for all measures, and low number of disparities found through this analysis, Partnership again chose to also evaluate the MCAS final sample measures (at sub region level) to assess, identify, and prioritize any disparities identified through this additional analysis.

Partnership also reviewed the performance of each race/gender identity/linguistic group in comparison to the MCAS benchmarks to asses not only how each group performed statistically in comparison to the White/Male/English speaking group, but in comparison to the national Medicaid benchmarks. In MY 2023, DHCS is holding managed care plans (MCPs) accountable and imposing sanctions on selected Hybrid and Administrative measures performing below the minimum performance level (MPL) (50th national Medicaid percentile) by reporting region, and as a result, Partnership thought it valuable to assess how each group is performing in comparison to that benchmark to assess whether group performance could also have an impact on accountable measures.

As a result, Element A and the prioritization of activities to address and reduce disparities is based on the MCAS samples for the measures of focus. The HPA final rate stratifications can be found in the Appendix of the report, however it is not included in the classification table or the prioritization of activities to address and reduce disparities for the limitations mentioned above.

Step 4: Presentation of Data

After the first data analysis was completed, members of the primary HE 6 team placed the data points in graphs and included various percentile targets per various National benchmarks. To aid in the evaluation of outcomes, Partnership color coded the bar graphs with the color orange indicate a group percentile performance below the MPL; bars highlighted in green indicated groups performed above the 90th percentile.

Finally, Partnership created a table (Table XXXI) to classify and provide guidance to help prioritize inequities identified through this analysis. While these classifications are referenced in the measure descriptions below, this table can be found in Element D, Factors 1 & 3.

Element A: Reporting Stratified Measures

Element Summary: Partnership found statistically significant lower rates when comparing each race/ethnicity group to the white group while using the NCQA Health Plan Accreditation generated sample for WCV, CBP, and PPC - Prenatal, and HBD – Poor Control per the analysis that was produced on July 24th, 2024. PPC – Postpartum included statistically significant higher rates for the Hispanic or Latino group. When comparing each group to the Health Plan Accreditation National Medicaid Benchmarks, The Asian group had the lowest performance and was the only group below the 33.33rd percentile for CBP. Interestingly, the American Indian and

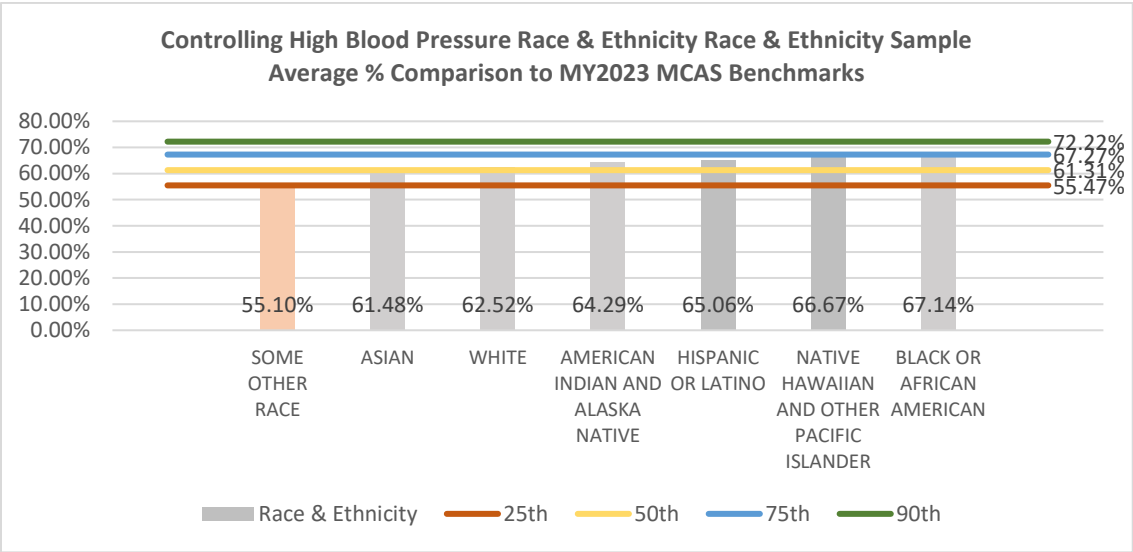
Alaska Native group had the lowest performance and was the only group below the 10th percentile for PPC – Prenatal, PPC Postpartum, and HBD – Poor Control. The Native Hawaiian and Pacific Islander group was the lowest performing and only group below the 10th percentile for WCV.

*Due to the low sample sizes for the hybrid measures included in the Health Plan Accreditation data (*n=186 to 368*), a lack of statistically significant inequities identified for all measures, and low number of disparities found through this analysis, Partnership chose to also evaluate the MCAS final sample measures (at sub region level) to assess, identify, and prioritize any disparities identified through this additional analysis.*

<u>Element Key Methodology:</u> The sections below highlight the results of the statistical significance testing done for each measure by race for the MCAS samples. "Unknown" and "some other race group" data were excluded from the evaluation. Additional analysis of the HPA samples can be found in the Appendix.

Controlling High Blood Pressure (CBP):

Partnership found that no group had a statistically significantly lower rate of CBP when compared to the White group while using the MCAS generated hybrid sample in all four reporting regions (n=1,395) (Table III). Overall, groups performed at average across respective regions, or above the Minimum Performance Level (MPL – 50th). However, when comparing each group's performance in comparison to the National Medicaid benchmarks in each of Partnership's regions (Graphs II – V), the American Indian/Alaska Native population had rates below the 25th percentile in 2 of 4 regions (Southeast and Southwest). The Asian group performed below the Minimum Performance Level (MPL – 50th) in 2 regions (Northeast and Southeast), and the 'Some Other Race' Group in 3 (Northeast, Northwest, and Southwest). The Native Hawaiian and Other Pacific Islander, Hispanic or Latino, and White groups only performed below the MPL in 1 region respectively (Northeast for Hispanic or Latino and Native Hawaiian and Other Pacific Islander, Northwest for White group). Interestingly, the Black/African American group performed better than the White group in 3 of the 4 regions (Northeast, Northwest, and Southeast).

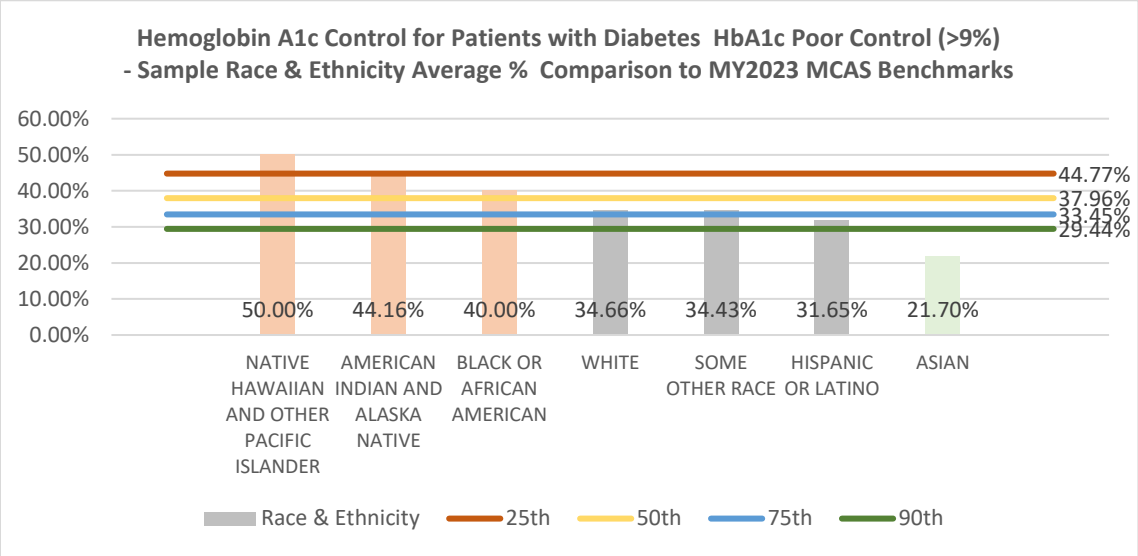


Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

When taking the average rate for each race/ethnicity group in comparison to the MCAS benchmarks, Partnership found that the 'Some Other Race' group was the only group that performed below the MPL – 50th, and no group performed above the 90th percentile.

Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%):

Partnership found that the American Indian and Alaska Native group in the Southwest region performed significantly worse than the White population and the Asian population performed significantly better in the Southeastern region (Table V) when reviewing the MCAS data. It was identified that although there was a small sample of Native Hawaiian and Other Pacific Islander members included in the sample, this group did not meet the MPL percentile in 2 regions (Northwest, Southeast) in which they were included. Also, the American Indian/Alaska Native did not meet the MPL in 3 regions (Northwest, Southeast, Southwest). The Black/African American population also did not meet the MPL in 2 regions (Northwest and Southeast). Finally, the White population in the Northeast region was the lowest performing group, and did not meet the MPL (1.54% away from MPL) in comparison to the benchmarks, with the Hispanic or Latino group performing only marginally better in the region (.22% away from MPL), the only region in which they did not meet the MPL for the measure (Graphs VII – X).

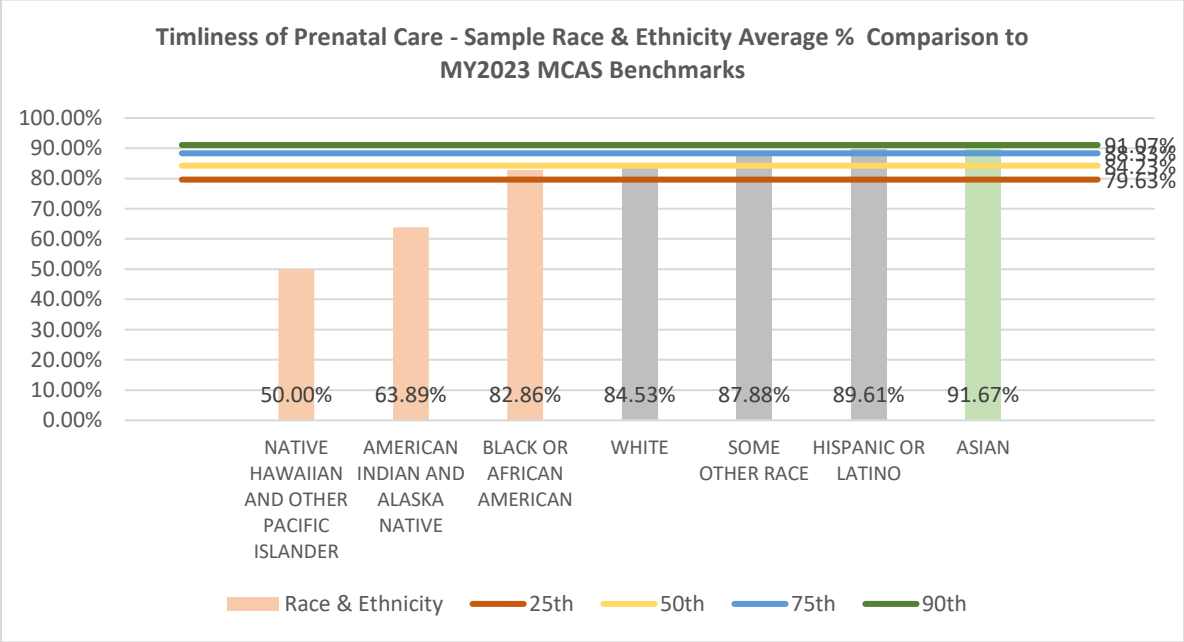


Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

When comparing the sample's average rate for each race/ethnicity group to the MCAS benchmarks, Partnership found that the Native Hawaiian and Other Pacific Islander, American Indian and Alaska Native, and Black or African American groups all performed below the MPL – 50th, and only the Asian group performed above the 90th percentile.

Timeliness of Prenatal Care (PPC – Pre):

Partnership found that only the American Indian and Alaska Native group in the Southwest region performed significantly worse than the White population (Table VII) per the MCAS sample. However, the Black/African American group was well below the 25th performing percentile in 2 of 4 regions (Northeast, Northwest). This is likely due to the very small sample size of Black/African American group members within these regions (n=7). In the Northeast region, 4 groups performed below the MPL (Black or African American, American Indian and Alaska Native, Asian, and 'Some Other Race'), and in the Northwest, 4 different groups performed below the MPL (Black or African American, American Indian and Alaska Native, 'Some Other Race', and White). Also, the American Indian and Alaska Native group performed numerically worse than the White population, and was below the MPL in 3 regions (Northeast, Northwest, Southwest). In the Southeast region, only the Native Hawaiian and Other Pacific Islander group performed below the 25th (n=1) (Graphs XII – XV).



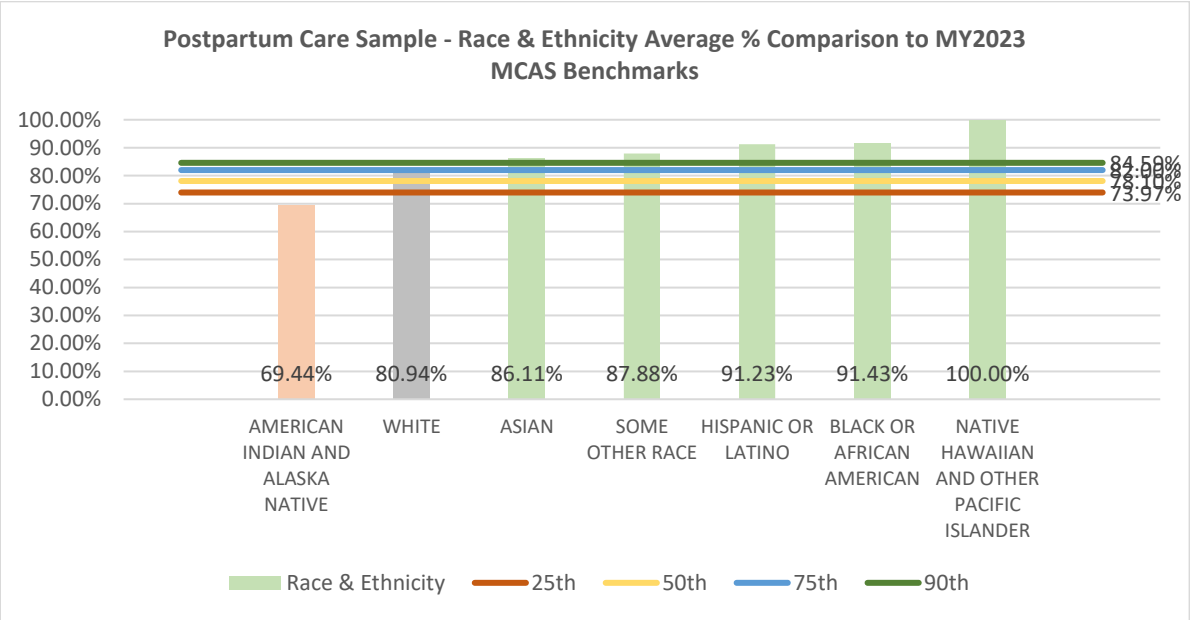
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

When comparing the sample's average rate for each race/ethnicity group to the MCAS benchmarks, Partnership found that the Native Hawaiian and Other Pacific Islander, American Indian and Alaska Native, and Black or African American groups all performed below the MPL – 50th, and only the Asian group performed above the 90th percentile.

Postpartum Care (PPC – Post):

Partnership found that only the American Indian and Alaska Native group in the Northeast region performed significantly worse than the White population (Table IX) per the MCAS sample. However, when comparing each group to the MCAS benchmarks, the American Indian and Alaska Native population performed below the MPL in 3 out of 4 regions (Northeast,

Northwest, Southwest). The Asian population also performed below the MPL in 2 regions (Northeast and Northwest), and the 'Some Other Race' group performed below the MPL in 1 region (Southeast). It is also worth noting that the Black or African American and Hispanic or Latino groups were the only groups to perform above the 90th percentile in all regions (Graphs XVII – XX).

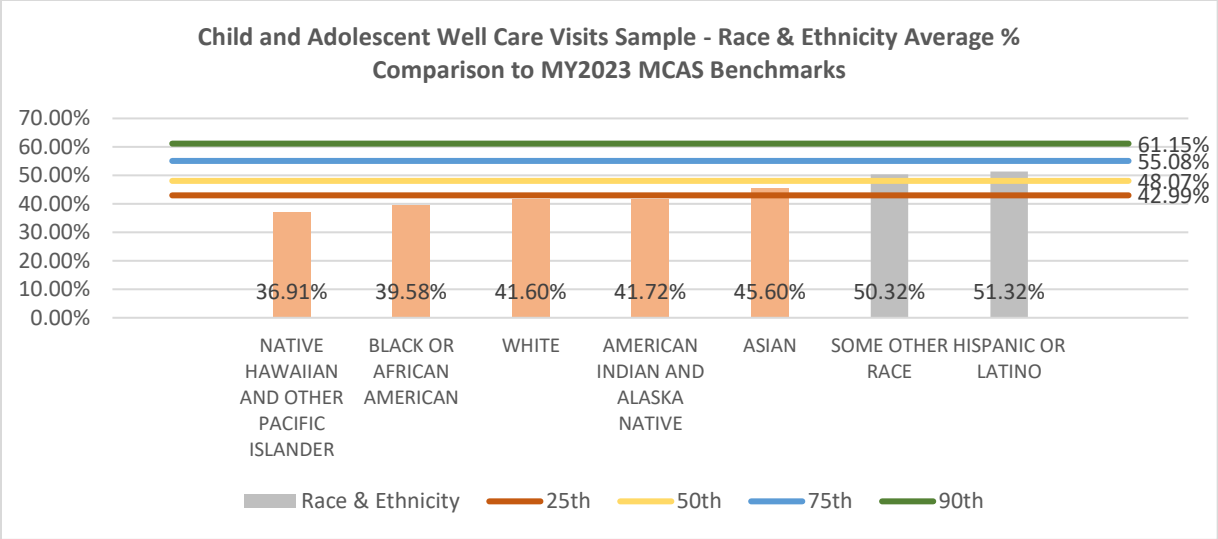


Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

When comparing the sample's average rate for each race/ethnicity group to the MCAS benchmarks, Partnership found that the American Indian and Alaska Native groups was the only group that performed below the MPL – 50th, and the Asian , 'Some Other Race', Hispanic or Latino, Black or African American, and Native Hawaiian and Other Pacific Islander groups all performed above the 90th percentile.

Child and Adolescent Well Care Visits (WCV):

When reviewing the MCAS sample for the measure, Partnership found that the majority of groups did not perform to the Minimum Performance Level (MPL – 50th) for WCVs throughout all 4 regions suggesting a greater concern in the infrastructure for attending WCVs. Interestingly, various groups performed statistically significantly better than the White group in the MCAS sample in all four reporting regions (n=167,450) despite still performing below the MPL. The American Indian and Alaska Native population had a significantly lower rate in the Southwest, and were even below the 25th percentile in 2 of 4 regions (Southeast and Southwest. The Black/African American and Native Hawaiian and Other Pacific Islander group had a significantly lower rate in comparison to the White group in the Southeast region, and both were also below the 25th percentile in the region. (Graphs XXII – XXV).



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

When comparing the sample's average rate for each race/ethnicity group to the MCAS benchmarks, Partnership found that the Native Hawaiian and Other Pacific Islander, Black or African American, White, American Indian and Alaska Native, and Asian groups all performed below the MPL – 50th, and no group performed above the 90th percentile.

Appendix 1: Table II: Controlling High Blood Pressure (CBP) HPA Statistical Significance Results

Appendix 2: Graph I: Controlling High Blood Pressure - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks

Appendix 3: Table III: Controlling High Blood Pressure (CBP) MCAS Statistical Significance Results

Appendix 4: Graph II: Controlling High Blood Pressure in Northeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 5: Graph III: Controlling High Blood Pressure in Northwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 6: Graph IV: Controlling High Blood Pressure in Southeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 7: Graph V: Controlling High Blood Pressure in Southwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 8: Table IV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) HPA Statistical Significance Results

Appendix 9: Graph XI: Hemoglobin A1c Control for Patients with Diabetes -- HbA1c Poor Control (>9%) - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks

Appendix 10: Table IV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) MCAS Statistical Significance Results

Appendix 11: Graph VII: Hemoglobin A1c Control for Patients with Diabetes in Northeast Region -- HbA1c Poor Control (>9%) - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 12: Graph VIII: Hemoglobin A1c Control for Patients with Diabetes in Northwest Region -- HbA1c Poor Control (>9%) - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 13: Graph IX: Hemoglobin A1c Control for Patients with Diabetes in Southeast Region -- HbA1c Poor Control (>9%) - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 14: Graph X: Hemoglobin A1c Control for Patients with Diabetes in Southwest Region -- HbA1c Poor Control (>9%) - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 15: Table VI: Timeliness of Prenatal Care (PPC-Pre) HPA Statistical Significance Results

Appendix 16: Graph XI: Timeliness of Prenatal Care - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks

Appendix 17: Table VII: Timeliness of Prenatal Care (PPC – Pre) MCAS Statistical Significance Results

Appendix 18: Graph XII: Timeliness of Prenatal Care in Northeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 19: Graph XIII: Timeliness of Prenatal Care in Northwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 20: Graph XIV: Timeliness of Prenatal Care in Southeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 21: Graph XV: Timeliness of Prenatal Care in Southwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 22: Table VIII: Postpartum Care (PPC – Post) HPA Statistical Significance Results

Appendix 23: Graph XVI: Postpartum Care in Northeast Region - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks

Appendix 24: Table IX: Postpartum Care (PPC – Post) MCAS Statistical Significance Results

Appendix 25: Graph XVII: Postpartum Care in Northeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 26: Graph XVIII: Postpartum Care in Northwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 27: Graph XIX: Postpartum Care in Southeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 28: Graph XX: Postpartum Care in Southwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 29: Table X: Child and Adolescent Well Care Visits (WCV) HPA Statistical Significance Results

Appendix 30: Graph XXI: Child and Adolescent Well Care Visits in Northeast Region - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks

Appendix 31: Table XI: Child and Adolescent Well Care Visits (WCV) MCAS Statistical Significance Results

Appendix 32: Graph XXII: Child and Adolescent Well Care Visits in Northeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 33: Graph XXIII: Child and Adolescent Well Care Visits in Northwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks
Appendix 34: Graph XXIV: Child and Adolescent Well Care Visits in Southeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks
Appendix 35: Graph XXV: Child and Adolescent Well Care Visits in Southwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Element B: Use of Data to Assess Disparities

Element Methodology: Partnership conducted the same steps highlighted in the Methodology section, however, stratifying based on preferred language and gender identity versus race/ethnicity. The sections below highlight the results of the statistical significance testing done for each measure stratified by language and gender identity. Each language was statistically compared to English. In addition, each language group was compared with the Minimum Performance Level (MPL – 50th). "Other" language data were excluded from the evaluation. For gender identity, Partnership is only able to assess comparisons between the Male and Female gender identities due to only being able to receive such information from the state member files. The Male group was designated as the dominant group, and both the Male and Female groups were compared with the Minimum Performance Level (MPL – 50th).

Element Summary: Partnership only found a statistically significant lower rate when comparing the Hmong language group to the English group while using the NCQA Health Plan Accreditation generated sample for WCV, per the analysis that was produced on July 24th, 2024. The Spanish and Farsi groups had significantly higher rates for this measure. The were no additional statistically significant differences for any additional groups in comparison to the English group for all other measures.

Partnership also found no statistically significant differences between the Female and Male gender identities for all measures.

Due to the low sample sizes for the hybrid measures included in the Health Plan Accreditation data (n=205 to 394 for language, n=205 to 405 for gender identity), a lack of statistically significant inequities identified for measures, and low number of disparities found through this analysis, Partnership chose to also evaluate the MCAS final sample measures (at sub region level) to assess, identify, and prioritize any disparities identified through this additional analysis for both language and gender identity.

Factor 1: Analyzing clinical performance measures by race/ethnicity

NA. Included in Element A.

Factor 2: Analyzing clinical performance measures by preferred language

Factor Summary: Overall, Partnership found that no linguistic group had a statistically significantly worse rate of CBP, PPC – Pre, PPC – Post when compared to the English-speaking group while using the MCAS generated hybrid sample in all four reporting regions

(n=885 to 1,489). The English-speaking group had worse HBD in at least 2 regions, when compared to the Spanish speaking population. Also, the English-speaking group had worse WCVs when compared to the Spanish speaking population in all 4 regions. The Vietnamese population had a significantly worse WCV in the SE region, however majority of the linguistic groups (except the Spanish population) were below the Minimum Performance Level (MPL – 50th).

Factor Methodology: The sections below highlight the results of the statistical significance testing done for each measure stratified by language. Each language was statistically compared to English. In addition, each language group was compared with the Minimum Performance Level (MPL – 50th). "Other" language data were excluded from the evaluation.

Controlling High Blood Pressure (CBP):

Partnership found that no linguistic group had a statistically significantly lower rate of CBP when compared to the English-speaking group while using the MCAS generated hybrid sample in all four reporting regions (Table XXIII). When comparing each group's performance in comparison to the National Medicaid benchmarks in each of Partnership's regions, the Spanish-speaking group had rates below the MPL – 50th in 2 regions (5.75% below in Northeast, 11.31% below in Northwest). The Tagalog speaking population also performed below the MPL – 50th in 2 regions (6.76% below in Southeast, 11.31% below in Southwest).

Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%):

Partnership found that the Spanish group performed significantly better than the English speaking group in the Northeast and Southwest regions respectively using the MCAS generated hybrid sample in all four reporting regions (Table XXV). Specifically, the Spanish-speaking group performed 14.40% above the MPL – 50th in the Northeast and 7.55% above the MPL – 50th in the Southwest.

Timeliness of Prenatal Care (PPC – Pre):

Partnership found that no linguistic group had a statistically significantly lower rate for PPC – Prenatal when compared to the English-speaking group while using the MCAS generated hybrid sample in all four reporting regions (Table XXVII). All regions had at least 1 linguistic group who had achieved 100% of timeliness in the prenatal care. The Spanish speaking group had the highest performance while the Southeast and Southwest regions had the highest number of linguistic groups who achieved the 100% of timeliness in the prenatal care.

Postpartum Care (PPC – Post):

Partnership found that no linguistic group had a statistically significantly lower rate of PPC – Postpartum when compared to the English-speaking group while using the MCAS generated hybrid sample in all four reporting regions (Table XXIX). The Spanish speaking group had a significantly higher performance postpartum care in the SW region and had the highest number of regions that achieved 100% of postpartum care.

Child and Adolescent Well Care Visits (WCV):

Partnership found that the Spanish speaking community performed significantly better in WCV in all four regions when compared to the English-speaking community with an average rate of 53.40% versus 44.98% in the English-speaking community. The English speaking community was below the MPL – 50th in all four regions with an average absolute percentage below of 3.09%. The Farsi speaking community also had a significantly higher rate of completion of WCVs in the SE region in comparison to the English community. Specifically, the Russian community (n=372) had a 25.41% higher rate when compared to the English-speaking community. Finally, the Vietnamese-speaking community had a significantly lower rate of WCV in the SE region. The Vietnamese-speaking community had a 9.35% lower rate when compared to the English community and was 12.21% below the MPL.

Appendix 36: Table XII: Controlling High Blood Pressure (CBP) Language HPA Statistical Significance Testing
Appendix 37: Table XIII: Controlling High Blood Pressure (CBP) Language MCAS Statistical Significance Testing
Appendix 38: Table XIV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Language HPA Statistical Significance Testing
Appendix 39: Table XV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Language MCAS Statistical Significance Testing
Appendix 40: Table XVI: Timeliness of Prenatal Care (PPC-Pre) Language HPA Statistical Significance Testing
Appendix 41: Table XVII: Timeliness of Prenatal Care (PPC-Pre) Language MCAS Statistical Significance Testing
Appendix 42: Table XVIII: Postpartum Care (PPC – Post) Language HPA Statistical Significance Testing
Appendix 43: Table XIX: Postpartum Care (PPC – Post) Language MCAS Statistical Significance Testing
Appendix 44: Table XX: Child and Adolescent Well Care Visits (WCV) Language HPA Statistical Significance Testing
Appendix 45: Table XXI: Child and Adolescent Well Care Visits (WCV) Language MCAS Statistical Significance Testing

Factor 3: Analyzing clinical performance measures by gender identity and/or sexual orientation

Factor Summary: In analyzing each measure based on gender identity and comparing each gender identity to the Male group, Partnership found that no significant difference between the two genders for CBP. Partnership did identify a significant difference between the Male and Female group for HBD and WCS with the Female group performing significantly better than Male group in the Southeast for HBD, and the Female group performing significantly better than the Male group in the Southwest for WCV.

Table XVII: Partnership Demographic Information per Gender Identity and/or Sexual Orientation

Estimated Total Population: 895,760 (As of August 2024)

Gender Identity	Membership (n, %)
Female	466,464 (55.1%)
Male	429,136 (47.9%)

Factor Methodology: Partnership stratified the clinical measures included in this report by using individual-level data to identify the members captured in the measures numerators and denominators, and stratified by individual's self-identified gender and/or sexual orientation. Partnership collects gender identity utilizing the two gender options of Male and Female. Therefore, analysis was conducted utilizing those two gender options with the Male population listed as the dominant group. Currently, Partnership does not directly collect sexual orientation data directly from members, as of 2024. As a result, Partnership only had Female members in the Timeliness of Prenatal Care and Postpartum Care measures, and therefore did not include the statistical significance testing outlined for the measure. The information below highlights the results of the statistical significance testing done for each measure by the two gender identities.

Controlling High Blood Pressure (CBP):

Partnership found no statistically significant difference when comparing each gender identity group to the Male gender identity group while using the MCAS generated sample (drawn from the eligible population) for Controlling High Blood Pressure (n=1,534) (Table XXIII).

Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%):

Partnership found no statistically significant difference when comparing each gender identity group to the Male gender identity group while using the MCAS generated sample (drawn from the eligible population) for HbA1c Poor Control in the Northeast, Northwest, and Southwest. Partnership found the Female group performed significantly better than Male group, with a rate 13% better than the Male group and 12.55% above the MPL – 50th, while the Male group performed below the MPL – 50th in the region (Table XXV).

Child and Adolescent Well Care Visits (WCV):

Partnership found that the Female group performed significantly better than the Male group in the Southwest region while using the MCAS generated sample (drawn from the eligible population) for Child and Adolescent Well Care Visits. Specifically, the Female population had a .77% higher rate of Child and Adolescent Well Care when compared to the Male population in the region. However, Partnership found no statistically significant difference between the Male and Female group for Child and Adolescent Well Care Visits in the remaining 3 regions. (Table XXVII).

Appendix 46: Table XXII: Controlling High Blood Pressure (CBP) Gender Identity HPA Statistical Significance Testing

Appendix 47: Table XXIII: Controlling High Blood Pressure (CBP) Gender Identity MCAS Statistical Significance Results

Appendix 48: Table XXIV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Gender Identity HPA Statistical Significance Testing

Appendix 49: Table XXV: A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Gender Identity MCAS Statistical Significance Results

Appendix 50: Table XXVI: Child and Adolescent Well Care Visits (WCV) Gender Identity HPA Statistical Significance Testing

Appendix 51: Table XXVII: Child and Adolescent Well Care Visits (WCV) Gender Identity MCAS Statistical Significance Results

Factor 4: Analyzing individual experience measures by race/ethnicity or preferred language

Factor Summary Findings: At the conclusion of the 2022 CAHPS® survey period, Partnership received 372 completed adult surveys, representative of a 14% survey completion rate for Partnership's adult member population. White adult members (n=246) reported lowest score in care coordination; African American/Black members reported the lowest score in customer service; Asian members reported the lowest score in getting needed care; Native Hawaiian members reported the lowest score in rating of health care, American Indian/Alaska Native reported the lowest score in rating of personal doctor and health plan; and Hispanic/Latino reported the lowest score in rating of customer service.

Factor Methodology: Partnership measured members' experience through monitoring of annual regulated and non-regulated surveys, and grievance and appeals reporting. The member experience and respective quality outcomes are driven and measured by interdepartmental health plan coordinated efforts that support operational and strategic member and provider-focused activities. For the analysis of individual experience by race and ethnicity, Partnership utilized MY 2022 annual CAHPS® survey for both adults and children to analyze individual experience measures for Partnership members by race and ethnicity.

Partnership contracts with an NCQA-certified vendor, PressGaney to administer the annual regulated survey and provide results of CAHPS® survey on a yearly basis, which are the data points used throughout this evaluation. Partnership reports on the eight CAHPS® composites categories, including Rating of Health Plan, Rating of Health Care, Rating of Personal Doctor, Rating of Specialist, Getting Needed Care, Getting Care Quickly, Care Coordination, and Customer Service. PressGaney provided category responses stratified by race and ethnicity in comparison to the overall health plan score (percentage in grey at top of table). The brighter red shading (highlighted in key below) indicates a larger disparity.

The Adult survey had the most completed surveys from the White population, with 246 member responses. All other groups had less than 100 responses respectively (Black/African American: 26, Asian: 34, Native Hawaiian and Other Pacific Islander: 8, American Indian/Alaska Native: 27, Other: 58, Hispanic/Latino: 90), which limits the applicability of the data.

In addition, the following limitations exists.

The CAHPS® regulated and non-regulated surveys provided insight, albeit some of the response data was limited. This fiscal year we created the foundation to continue to monitor member

satisfaction within the Health Equity framework. The established performance threshold is a starting point to observe year-over-year progress.

Important to note, the regulated and drill-down surveys are only offered in English and Spanish language formats, which limits Partnership's ability to proactively solicit members for all threshold languages. Partnership is actively exploring the option for adult population only that will include adding Chinese (Mandarin and Cantonese) as another threshold language to regulated and non-regulated surveys. Presently, Partnership's DHCS assigned Chinese population relative to all threshold languages is low. The 2021 DHCS Threshold and Concentration Languages report demonstrates lower Chinese population within Partnership's 24 county service area. The return on investment to include Chinese language format for CAHPS® surveys may be cost-prohibitive relative to the insight low response may offer. The CAHPS® program team will continue to evaluate and explore alternative options to measure member satisfaction for all threshold languages.

Since the survey response rate for [1]CAHPS® Non-Regulated Survey is low, and linked to 28 fewer survey field days, Partnership surmised the low performance gap to be an outlier and therefore we excluded this data set while focusing on improvement activity discussions. The performance for CAHPS® regulated survey noted, the plan service delivery for adult population is marginally below the 70th percentile threshold. Comparing both populations, the team concludes that members in general are satisfied with Partnership's service delivery. Moving forward, the internal team will continue to refine and facilitate transparent and consistent benefit coverage communication and training with Partnership's contracted providers.

The Quality Improvement (QI) CAHPS® program team in collaboration with key stakeholders are leading a process improvement that carried forward from prior fiscal year to this fiscal year 2023-2024. The premise is to use real-time operational data sources to proactive identify member abrasion, through theme related categories that link to provider network or health plan delivery barriers.

Table XXVII: Adult CAHPS® Survey Findings

		Rating of Health Plan	Rating of Health Care	Getting Needed Care	Getting Care Quickly	Coordination of Care
Demographic	**Total**	**54.5%**	**51.5%**	**76.0%**	**72.9%**	**81.3%**
White	*n =246*	-1%	-1%	1%	5%	-7%
Black / African American	*n =26*	-1%	7%	4%	-6%	19%
Asian	*n =34*	8%	6%	-18%	-15%	8%
Native Hawaiian/Pacific Islander	*n =8*	3%	-52%	24%	-6%	19%
American Indian/Alaska Native	*n =27*	-27%	-22%	-2%	-4%	19%

Other	*n =58*	13%	11%	10%	8%	19%
Hispanic/Latino	*n =90*	7%	13%	0%	3%	2%

		Rating of Personal Doctor	Rating of Specialist	Customer Service	How Well Doctors Communicate	Ease of Filling Out Forms
Demographic	**Total**	**61.8%**	**66.7%**	**87.2%**	**88.5%**	**91.8%**
White	*n =246*	-7%	-3%	1%	-3%	0%
Black / African American	*n =26*	16%	17%	-9%	3%	4%
Asian	*n =34*	21%	-3%	0%	4%	-1%
Native Hawaiian/Pacific Islander	*n =8*	-29%	-17%	NA	12%	8%
American Indian/Alaska Native	*n =27*	-29%	-22%	0%	-2%	-1%
Other	*n =58*	12%	22%	5%	12%	5%
Hispanic/Latino	*n =90*	9%	-4%	-3%	6%	0%

Group is performing…

- **Above the plan score by 5 or more points**
- **Above the plan score**
- **Below the plan score**
- **Below the plan score by 5 or more points**
- **Above/below plan score but has low base (<30)**

Factor Summary Findings: At the conclusion of the CAHPS® survey period, Partnership received 587 completed child surveys, representative of a 14.5% survey completion rate for Partnership's pediatric member population. The Hispanic/Latino group had the largest amount of survey completions (n=323) and did not have any low scores. The White group, had lowest scores in coordination of care—comparable to adult group; the Black/African American group and reported lowest scores in 'rating of health plan'; the Asian and American Indian/Alaska Native groups had lowest scores in rating of personal doctor; Native Hawaiian members reported the lowest score in rating of health plan.

Table XXVIII: Child CAHPS® Survey Findings

		Rating of Health Plan	Rating of Health Care	Getting Needed Care	Getting Care Quickly	Coordination of Care
Demographic	**Total**	**66.9%**	**65.6%**	**79.6%**	**84.1%**	**85.3%**
White	*n =312*	-3%	-4%	-1%	1%	-5%
Black / African American	*n =46*	-20%	-10%	9%	6%	4%
Asian	*n =57*	10%	14%	-7%	-9%	8%
Native Hawaiian/Pacific Islander	*n =16*	-11%	-2%	10%	7%	15%

American Indian/Alaska Native	*n =37*	-2%	-3%	-5%	9%	-4%
Other	*n =145*	5%	5%	8%	-3%	7%
Hispanic/Latino	*n =323*	7%	7%	4%	0%	6%

		Rating of Personal Doctor	Rating of Specialist	Customer Service	How Well Doctors Communicate	Ease of Filling Out Forms
Demographic	**Total**	**74.6%**	**70.4%**	**89.4%**	**94.7%**	**95.4%**
White	*n =312*	-3%	-6%	1%	1%	-1%
Black / African American	*n =46*	-2%	5%	-1%	-1%	2%
Asian	*n =57*	-5%	17%	-4%	-4%	3%
Native Hawaiian/Pacific Islander	*n =16*	10%	-10%	11%	2%	5%
American Indian/Alaska Native	*n =37*	-11%	-25%	-8%	-2%	2%
Other	*n =145*	4%	12%	-1%	1%	3%
Hispanic/Latino	*n =323*	6%	11%	3%	1%	0%

Element C: Use of Data to Monitor and Assess Services

Partnership conducts an annual Utilization and Experience review to identify potential areas of opportunity at the organizational level. At a health plan level, the annual member experience is monitored through various data sources. These data sources include Language Service Utilization Reports, Internal Satisfaction Survey, Member Satisfaction, Grievance and Appeals data, CAHPS® regulated and non-regulated[1] survey ratings for health plan and personal doctor encounters.

Factors 1 & 3: Utilization of language services for organization functions and staff experience with language services for organization functions

<u>Factors 1 & 3 Summary Findings:</u> Interpreting sessions increased by 10,372 sessions or a +13% growth, period over period. Spanish was the top requested language and accounted for 79.9% of total interpreting sessions reported within the current period. Vietnamese, Russian, Dari, and Punjabi rounded out the top 5 requested languages for interpreting. One thing to note is that one of Partnership's threshold language, Tagalog was not represented within the top 5 most requested languages. In regards to translations, Partnership experienced -19% or 80 less translation requests period over period. Similar to our interpreting results, Spanish as a whole (Latin America + Mexico) was the most requested language, contributing to 48% of total translation requests. Russian, Tagalog, Hmong made up the remaining top 5 languages requested for the current period. This slightly differs from the previous period in which Lao was represented in the top 5.

Overall, internal employee surveys suggested that Member Services (48%), Transportation (17%), and Care Coordination (13%) employees were the heaviest utilizers of translation / interpreter services within the organization. Of the 5 reporting categories, Partnership exceeded our internal threshold for the "An interpreter(s) was available at the time of request" and the

"Overall, the interpreter(s) met the interpreting needs of the member" categories. Partnership experienced either a positive trend or flat to last year for 2 of the categories that did not meet the established threshold. Additionally, the number of respondents increased by 69%.

Methodology: Language Services utilization reports are extracted through Partnership's vendor(s) reporting portal on a quarterly basis. In addition, Partnership administers an annual internal satisfaction survey to all member-facing positions. The objective of this survey is to assess staff experience with obtaining Language Services through Partnership's contracted providers. For transparency, all member-facing positions flow into the following departments:

- Member Services
- Population Health
- Care Coordination
- Utilization Management
- Grievance & Appeals
- Transportation

To track and trend Partnership's Language Service utilization, the team established a ratio of the number of translations and interpreting sessions per 1,000 members. The numerator will be the total amount of interpreting sessions or translations requests for the reporting period, and the denominator will be the average membership base of each reporting period. Note that Kaiser Members were excluded from this reporting as Kaiser was a delegated entity within our lookback period and Language Services fall under the scope of services that Kaiser provides. Additionally, the membership base is representative of members that have indicated a primary language other than English.

In regards to the reporting period, Partnership referenced reporting data from January 2023 through December 2023. The reporting data is divided into two periods. The "Previous Period" will include data from Quarter 1 and 2 (January – June) whereas the "Current Period" will include data from Quarter 3 and 4 (July – December). Note that for the purpose of this report, we observed the traditional calendar year, not fiscal.

To establish a threshold, Partnership determined that the interpreting and translation ratio would increase/decrease proportionally with any shift in the quarterly average member base of members who have indicated a primary language other than English. To meet the intent of this deliverable, Partnership identified the percentage shift in membership between the Previous and Current Period and compared that against the percentage shift in Language Services utilization. Moving forward, Partnership will implement a yearly look back period where the previous year ratio will be compared to the current year ratio. Partnership may re-evaluate utilization on a yearly basis and adopt a new threshold for the purpose of this deliverable. Table XXIX lists the membership base whereas Table XXX illustrates the established Current Period threshold for this initiative:

Table XXIX: Membership Base

*Membership Base		
Previous Period	**Current Period**	**% Difference**
130,905	132,345	+ 1.1%

** Representative of members that have indicated a primary language other than English*

Table XXX: Language Service Type

Language Service Type	Current Period Threshold
Interpreting	≥ 618.21
Translation	≥ 3.19

In addition, Partnership administers an internal satisfaction survey to gauge staff experience with language service providers. This internal survey contains five experience/service based questions with a five-point rating scale ("Strongly Disagree", "Disagree", "Neutral", "Agree", and "Strongly Agree"). To assess staff experience with the services received, Partnership established an internal threshold in which 80% of Partnership staff provide a favorable response for each of the experience/service based questions. Note that a favorable response is defined as a response that is either "Agree" or "Strongly Agree".

To assess the utilization of language services and staff experience, select staff conducted analysis work groups. Through these work groups, contributors reviewed the aforementioned data sources to understand the current state of Partnership's Language Service utilization and staff experience levels. The Member Services team compared the utilization data of the Current Period against the Previous Period and monitored any shifts in the utilization. As evidenced in Table XXIX, Partnership experienced a 1.1% increase in the analysis membership figures between periods. When looking at the results, Partnership exceeded the threshold established for the interpreting category only. When comparing the utilization ratio between periods, interpreting saw a 13% increase, whereas as translation requests experienced a 19% decrease in utilization (Table XXXI).

Table XXXI: Language Service Utilization Data

Category	# of Sessions / Requests - Per 1,000 Members		Threshold	Partnership ≥ Threshold
	Previous Period	Current Period		
Interpreting	611.48	683.20	≥ 618.21	**YES**
Translation	3.15	2.52	≥ 3.19	**NO**

Category	Total # of Sessions / Requests		
	Previous Period	Current Period	% Diff
Interpreting	80,046	90,418	**+13%**
Translation	413	333	**-19%**

Notable Findings – Utilization / Staff Experience

To better understand the utilization data, the team took a closer look at each Language Service category (Table XXXII) in an effort to understand the composition of the utilization data. While the demand for interpreting continues to grow, we noticed a significant percentage shift in the amount of translation requests. We attributed this decrease to timing of events in which Partnership provides translations. It's worth noting that Q1 typically sees an increase in translation requests as new member material may be distributed more frequently during the start of the year. This is evidenced through the data captured as Q1 2023 contributed 31% to the total number of translations in 2023 and 56% of translations for the reporting period. In addition, we saw an uptick in both interpreting and translation requests during Q4. This was primarily driven by the increase in call volume into our Call Center (+15%, Q4 2024 vs. Q4 2022) and a result of Partnership's expansion into 10 additional counties.

Table XXXII: Utilization Demographics

Interpreting - Previous Period			
	Language	# of Trans.	% to Total
1.	Spanish	63,852	79.8%
2.	Russian	2,524	3.2%
3.	Vietnamese	2,392	3.0%
4.	Punjabi	1,252	1.6%
5.	Dari	1,242	1.6%

Interpreting - Current Period			
	Language	# of Trans.	% to Total
1.	Spanish-Lat.Am	72,165	79.9%
2.	Spanish-Mexico	2,644	2.9%
3.	Russian	2,460	2.7%
4.	Tagalog	1,398	1.5%
5.	Hmong	1,346	1.5%

Translation - Previous Period			
	Language	# of Trans.	% to Total
1.	Spanish-Lat.Am	95	23.0%
2.	Spanish-Mexico	81	19.6%
3.	Tagalog	50	12.1%
4.	Russian	47	11.4%
5.	Lao	14	3.4%

Translation - Current Period			
	Language	# of Trans.	% to Total
1.	Spanish-Lat.Am	93	27.9%
2.	Spanish-Mexico	67	20.1%
3.	Russian	52	15.6%
4.	Tagalog	50	15.0%
5.	Hmong	8	2.4%

When reviewing the results of the internal survey, Partnership exceeded the internal threshold for two out of the five survey questions (Table XXXIV). While the "Overall, the interpreter(s) was professional, respectful, and polite" category did not meet our internal threshold, we saw a positive increase of 2% over last year's result. The most glaring opportunity was seen in the "The turnaround time in obtaining interpreting services was acceptable" category in which 12 additional respondent provided a neutral response over last year. The increase in neutral respondents led to the overall decrease in performance for the category. In an effort to mitigate further timeliness issues, Partnership will incorporate additional collaborative sessions

throughout the year with our contracted vendor. These collaborative sessions with have an emphasized focus on workforce planning as well as identifying potential process improvement efforts around our intake process.

Table XXXIV: Internal Survey Results

Internal Survey Question	Favorable Rating % to Total	Threshold Met?
An interpreter(s) was available at the time of request.	85%	YES
The turnaround time in obtaining interpreting services was acceptable.	77%	NO
Overall, the interpreter(s) was professional, respectful, and polite.	76%	NO
Overall, the interpreter(s) met the interpreting needs of the member.	84%	YES
Overall, I was satisfied with the level of services that the interpreter(s) provided.	79%	NO

Factors 2 & 4: Individual experience with language services for organization functions and during health care encounters

Factors 2 & 4 Summary Findings: In comparing Grievance & Appeals (G&A) 2023 to 2022 cases, Language Assistance Services decreased by 22 cases in 2023 compared 2022. Language Barrier / Limited English Proficiency case filings increase by five (5) cases. Non-Threshold Language case type consisted of an increase of one (1) new case for 2023 compared to zero (0) in 2022. Auxiliary Aids and Services had eight (8) cases in 2023, four (4), from prior year. CAHPS® Regulated Survey for Measure Year 2022 sample frame consisted of 2,700 Adults, and 4,125 Child, achieving are response rate of 14.3% (380) Adult, and 14.9% Child (611).

In comparing survey performance by health plan target at or above 70th percentile threshold, Adult satisfaction was -2.3% below target and Child performed slightly above the target at 0.7%. Comparing survey performance by provider at or above 70th percentile threshold, Adult satisfaction was 1% above the target and 4.8% for Child satisfaction.

Methodology: In addition to the quantitative analysis above, we evaluated utilization data and results of the internal satisfaction survey and CAHPS® regulated and non-regulated[1] member experience survey questions specific to interpreting and translation language services. Qualitative findings and observations are detailed within this section. Grievance and Appeals (G&A) data is another source the analysis workgroup uses to evaluate real time member abrasion or dissatisfaction. Custom G&A reports provide case filings by type, category, status, outcome and whether grievances involve the health plan or provider network. The following category types and definitions support the intent to reduce healthcare disparities.

Category Type	Definition
Language Assistance Services	Case involves interpretation services that help people with a Limited English Proficiency communicate in English.
Language Barrier / Limited English Proficiency	Case involves a person whose first language is not English and has trouble reading, writing, speaking, or understanding English.
Non-threshold Language	Case involves a non-threshold spoken language. Threshold languages are; English, Armenian, Cambodian, Chinese, Farsi, Korean, Tagalog, Russian, Spanish and Vietnamese.
Auxiliary Aids and Services	Case involving services used by a member who is deaf, blind, hard of hearing or seeing to help them communicate. These services include sign language, text telephones, or other such devices to get information. This also includes any effective method to improve reading such as large print.

Notable Findings - Grievance & Appeals (G&A)

The analysis workgroup observed two notable findings while comparing year-over-year covered member benefit and G&A case filings: One) an increase in 2023 member utilization of interpreter or language services (UILS), and 2) a decrease in Culturally and Linguistically Appropriate Services (CLAS) member filed G&A cases compared to 2022. The overall assessment is the member UILS rate relative to the G&A CLAS case filings are low.

Referenced below is a year-over-year case comparison by category type.

Language Assistance Services

- 2023 - 2 Cases
- 2022 - 24 Cases
- - 22 Cases
- Noted improvement

Non-threshold Language

- 2023 - 1 Case
- 2022 - 0 Cases
- + 1 Case
- Noted increase

Language Barrier / Limited English Proficiency

- 2023 - 15 Cases
- 2022 - 10 Cases
- + 5 Cases
- Noted increase

Auxiliary Aids and Services

- 2023 - 8 Cases
- 2022 - 4 Cases
- + 4 Cases
- Noted increase

The 2023 case filings yielded a score of 0.03% relative to language service utilization and was below the threshold target of (1/10th of one percent) 0.10%. Although the goal was met the analysis workgroup established a priority ranking based the on number of case filings by category (Table XXXV).

Table XXXV

2023 Annual Grievance & Appeals Priority By Category Type	
Language Barrier / Limited English Proficiency	15
Auxiliary Aids and Services	8
Language Assistance Services	2

The workgroup focused on the top three case category types to identify service abrasion/dissatisfaction themes. Partnership further compiled case filings by service delivery and identified correlating themes (italicized) for Health Plan and Provider/Network (Table XXXVI) and NCQA Health Equity (HE) 6 Case Analyses (Table XXXVII).

Table XXXVI: Member Dissatisfaction Theme

Service Delivery	Member Dissatisfaction Theme
Partnership	• Service provider - technical/connectivity issues • *Service provider - dialect/translation issues* • *Covered member - translation and interpreter benefit literacy*
Provider/Network	• Customer service/cultural sensitivity training • *Covered benefit awareness and training* • *Service provider - dialect/translation issues*

Table XXXVII: NCQA Health Equity (HE) 6 Case Analyses

Case Category Type	2023 Grievance & Appeals Case Totals	NCQA Health Equity (HE) 6 Case Analyses
Language Assistance Services	2	Case filings offer different perspectives specific to Language Assistance Services. Theme: Familiarity of benefit literacy and breakdown in communication.
Language Barrier / Limited English Proficiency	15	Case filings offer a combination of unconfirmed and confirmed perceptions of discrimination associated with language barriers. Case filing themes: benefit literacy, scheduling, and communication breakdown. Per the Partnership Member Hand-book, members are encouraged to schedule interpreter services when confirming a medical appointment. In some instances, provider sensitivity training, and reminders of CLAS-covered benefits are warranted.

Non-threshold Language	1	Partnership Member Services (MS) employee created an unintended abrasion/experience while following procedure to authenticate plan covered member over the phone. The language barrier occurred between member ad hoc interpreter (family member) and MS employee. Assessment: Although plan MS employee adhered to procedure, there is an employee lesson learned/training opportunity. Learn to take verbal/conversation ques to know when to transfer to a bilingual MS employee or qualified interpreter services (AMN) delegated vendor.
Auxiliary Aids and Services	8	Case filings offer different perspectives specific to Auxiliary Aids and Services. Theme: Familiarity with covered benefits (varied clinical settings) literacy and breakdown in communication.

CAHPS® Survey Data

The CAHPS® program added NCQA approved supplemental questions specific to interpreting and translation language services for adult and child 2022 Measure Year (MY) CAHPS® regulated survey. Important to note, the survey is only available in two language formats, English and Spanish. A targeted focus to improve child survey scores, and to address regulated survey limitations, we included additional questions in English and Spanish in the child non-regulated[1] CAHPS® drill-down survey. Partnership has implemented this strategic step to align with NCQA standards and NCQA Health Equity Accreditation requirements. The survey oversample frame for the CAHPS® regulated consisted of; Adult 2,700, and Child 4,125, members survey and for the CAHPS® non-regulated[1] survey, Child 2,000. The following regulated supplemental questions were assessed:

Adult Experience with Language Services

Question
Q42. In the last 6 months, if you utilized an interpreter or language services to help speak with your Health Plan, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?
Q43. In the last 6 months, if you utilized an interpreter or language services to help speak with your doctors or other healthcare providers, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?

Medicaid Adult Regulated Survey		Category Responses Based on Valid Responses Per Question			MY 2022 Performance Target
Valid Responses (n= 99)	Q42. Overall experience with interpreter/language services utilized with plan (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	70th Percentile
Not Applicable 244		67.7%	25.3%	7.1%	
Valid Responses (n= 100)	Q43. Overall experience with interpreter/language services utilized with Dr. (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	
Not Applicable 240		71.0%	21.0%	8.0%	

Child Experience with Language Services

Question
Q43. In the last 6 months, if you utilized an interpreter or language services to help speak with your Health Plan, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?
Q44. In the last 6 months, if you utilized an interpreter or language services to help speak with your child's doctors or other healthcare providers, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?

Medicaid Child Regulated Survey		Category Responses Based on Valid Responses Per Question			MY 2022 Performance Target
Valid Responses (n= 239)	Q43. Overall experience with interpreter/language services utilized with plan (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	70th Percentile
Not Applicable 308		70.7%	17.6%	11.7%	
Valid Responses (n= 238)	Q44. Overall experience with interpreter/language services utilized with Dr. (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	
Not Applicable 304		74.8%	16.8%	8.4%	

Survey Section: Your Child's Personal Doctor

Question
Q13. In the last 6 months, have you ever had a hard time speaking with or understanding your child's doctor or other health care provider because you spoke different languages?
Q14. In the last 6 months, if you used an interpreter or language services to help speak with your child's doctors or other healthcare providers, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?
14a. Please share more about your rating.

Survey Section: Your Child's Health Plan

Question
21. In the last 6 months, if you used an interpreter or language services to help speak with your child's Health Plan, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?
21a. Please share more about your rating.

Performance Summary by Survey and Service Delivery

The analyst workgroup evaluated the CAHPS® Regulated and [1]CAHPS® Non-Regulated Drill-Down Surveys (Section II) results against the Plan 70th percentile performance threshold (Section III) to determine if we met or exceeded the performance target (Table XXXVIII).

Located below is a summary of the survey findings:

Table XXXVIII

Population	Survey Type	Plan Satisfaction Rating Score (% 9 or 10)	Performance Target Met?	Provider Satisfaction Rating Score (% 9 or 10)	Performance Target Met?
Adult	Regulated	67.7%	NO	71.0%	YES
Child		70.7%	YES	74.8%	YES
Child	Non-Regulated	62.5%	NO	57.1%	NO

- Adult Population:
  - Plan Satisfaction: Performance -2.3% below threshold target
  - Provider Satisfaction: Performance 1% above threshold target
- Child Population
  - Plan Satisfaction: Performance 0.7% above threshold target
  - Provider Satisfaction: Performance 4.8% above threshold target

[1]CAHPS® Non-Regulated Survey

- Child Population
  - Plan Satisfaction: Performance -8.5% below threshold target
  - Provider Satisfaction: Performance -12.9% below threshold target

CAHPS® Regulated Survey

Survey scores for adult and child questions (Table XXXIX) and (Table XL).

- **Adult CAHPS® Regulated Survey (Table XXXIX)**
  - **Q42** (utilization with plan) 244 chose "not applicable"
  - Valid response (n = 99)
  - Experience rating scale 0 - 10 (0=worst 10=best)

        - 9 or 10 (67.7%), 7-8 (25.3%), 0-6 (7.1%)
        - Target Met: **No**
    - **Q43** (utilization with provider) 240 chose “not applicable”
    - Valid response (n=100)
    - Experience rating scale 0 - 10 (0=worst 10=best)
        - 9 or 10 (71.0%), 7-8 (21.0%), 0-6 (8.0%)
        - Target Met: **Yes**

Table XXXIX

Medicaid Adult Regulated Survey		Category Responses Based on Valid Responses Per Question			MY 2022 Performance Target
Valid Responses (n= 99)	Q42. Overall experience with interpreter/language services utilized with plan (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	70th Percentile
Not Applicable 244		67.7%	25.3%	7.1%	
Valid Responses (n= 100)	Q43. Overall experience with interpreter/language services utilized with Dr. (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	
Not Applicable 240		71.0%	21.0%	8.0%	

- **Child CAHPS® Regulated Survey (Table XL)**
    - **Q43** (utilization with plan) 308 chose “not applicable”
    - Valid response (n = 239)
    - Experience rating scale 0 - 10 (0=worst 10=best)
        - 9 or 10 (70.7%), 7-8 (17.6%), 0-6 (11.7%)
        - Target Met: **Yes**
    - **Q44** (utilization with provider) 240 chose “not applicable”
    - Valid response (n=304)
    - Experience rating scale 0 - 10 (0=worst 10=best)
        - 9 or 10 (74.8%), 7-8 (16.8%), 0-6 (8.4%)
        - Target Met: **Yes**

Table XL

Medicaid Child Regulated Survey		Category Responses Based on Valid Responses Per Question			MY 2022 Performance Target
Valid Responses (n= 239)	Q43. Overall experience with interpreter/language services utilized with plan (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	70th Percentile
Not Applicable 308		70.7%	17.6%	11.7%	
Valid Responses (n= 238)	Q44. Overall experience with interpreter/language services utilized with Dr. (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	
Not Applicable 304		74.8%	16.8%	8.4%	

The child MY 2022 [1]CAHPS® non-regulated drill-down survey (Section III) sample frame of 2,000 members, of the surveyed we had a respondent rate of 9.5% and/or 189 completed surveys.

[1]CAHPS® Non-Regulated Survey
Survey scores by child questions only (Table XL).

- **Child [1]CAHPS® Non-Regulated Drill-Down Survey**
  - **Q14** (utilization with provider)
  - Valid response (n=8)
  - Experience rating scale 0 - 10 (0=worst 10=best)
    - 9 or 10 (62.5%), 7-8 (0%), 0-6 (37.5%)
    - Target Met: **No**
  - **Q21** (utilization with plan)
  - Valid response (n=14)
  - Experience rating scale 0 - 10 (0=worst 10=best)
    - 9 or 10 (57.1%), 7-8 (29%), 0-6 (13.9%)
    - Target Met: **No**

Table XL

Medicaid Child Non-regulated Drill Down Survey		Category Responses Based on Valid Responses Per Question			MY 2022 Performance Target
Valid Responses (n= 8)	Q14. Overall experience with interpreter/language services utilized with Dr. (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	70th Percentile
Not Applicable 181		62.5%	--	37.5%	
Valid Responses (n = 14)	Q21. Overall experience with interpreter/language services utilized with plan (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	
Not Applicable 175		57.1%	29%	13.9%	

Grievance & Appeals
The workgroup priority to evaluate Language Assistance Services case filings started with causal factor analysis. Through the discovery process, we identified linked dissatisfaction themes between the Health Plan and Provider/Network service delivery. Additionally, Partnership's analysis includes specific examples of service abrasion (Table XLI).

Table XLI

Service Delivery	Member Dissatisfaction Theme	Examples
Partnership	• Service provider - dialect/interpreter issues • Covered member - translation and interpreter benefit literacy	• Interpreter is not adequately communicating because of dialect grammar, word usage/ variations.

Provider/Network	• Covered benefit awareness and training • Service provider - dialect/interpreter issues	• Provider education. Not aware of covered benefit. Members misinformed or general communication barriers.

The concept of inverse logic was used while evaluating G&A case filings as a method to measure member satisfaction for all language thresholds. The logical premise is low G&A-CLAS case filings relative to the utilization of interpreter and translation services demonstrates satisfaction (26/85,605[+]).

[+]Language Service Utilization includes services for Language or Interpreter. Threshold (Combined Category Total / Annual Utilization Average)

Element D: Use of Data to Measure CLAS and Inequities

Factor 1: Identifies and prioritizes opportunities to reduce health care inequities

Factor Summary:

Overall, researchers found that Well Care Visits (WCV) was the clinical measure with a majority of race/ethnic groups not meeting the minimum performance threshold in all of Partnership's regions. The American Indian/Alaska Native, African American/Black, and White groups had a Strong Disparity for this measure. The Black/African American group, the additional disparity of focus is Timeliness of Prenatal Care due to some findings that were statistically significant and having an average percentage below the MPL across various regions. The American Indian/Alaska Native group, had a Strong Disparity in prenatal care, postpartum care due to having an average rate of performance 13% below the MPL across 3 regions.

Methodology:

Partnership's original goal in defining and prioritizing disparities to reduce health care disparities was to utilize statistical significance to identify measures with an opportunity for improvement. Currently, there are no gold standards for evaluating disparities, therefore Partnership developed the following disparity classification system to aid in prioritizing disparities based upon measure findings. This is based upon the Strength of recommendation taxonomy used in various clinical guidelines to stratify recommendations. Partnership identified opportunities to reduce health care inequities after evaluating both Health Plan Accreditation and MCAS final rates for the measures of focus for the Grand Analysis Report. Identified opportunities to reduce inequities were then prioritized using the strong/moderate/weak disparity classification system referenced in Table XLII, with Partnership ultimately prioritizing opportunities classified as a Strong Disparity.

Table XLII: Strength of Disparity Classification

Disparity Classification
Strong Disparity (Disparity is clearly present when compared to comparator group or goal) • Meets at least three of any of following factors below o MCAS Sample Measure ▪ Group is performing statistically worse in at least one region when compared to the comparator group ▪ Absolute Average Percentage Difference between specific group and minimum performance level is at least 10% (multiple regions) or 15% in single region in MCAS/HEA measure ▪ Multiple regions (≥2) where specific group falls below 25th percentile per MCAS measure
Moderate Disparity (Disparity is moderately present when compared to comparator group or goal) • Meets at least three of any of the following factors o MCAS Sample Measure ▪ Absolute Average Percentage deficit between group and comparator (minimum performance level) is at least 10% (multiple regions) or 15% in single region ▪ No group is performing significantly better than comparator group yet at least one group is performing significantly worse per MCAS measure ▪ Multiple regions (≥2) where group falls below 50th percentile ▪ At least 1 region where group falls below 25th percentile
Weak Disparity (Disparity is uncertain when compared to comparator group or goal) • Meets at least two of any of the following factors: o MCAS Sample Measure ▪ No statistical difference between groups in a region ▪ Absolute Average Percentage deficit between group and comparator (minimum performance level) is at least 5% (multiple regions) or 7% in single region ▪ Only 1 region where group falls below 50th percentile and no region fall below 25th percentile

Partnership created the table below (Table XLII) to not only highlight the disparities identified from all analyses, but to classify the level of priority for each identified disparity based on the utilization of the Strength of Disparity Classification table (Table XLIII). The table below lists the overall disparity findings with prioritization for each race/ethnicity group included in this Grand Analysis.

Table XLIII: Health Inequities Areas of Focus

Group	Key HEA Measure	MCAS Number of Regions with Statistically Worse Disparity	MCAS Number of Regions with disparity (below 25th)	MCAS Number of additional Regions with disparity (below MPL – 50th)	Absolute % Average BELOW MPL across regions below 50th Percentile	Category of Disparity (S/M/W)	Number of Years with Same Disparity from 2024
White	Controlling High Blood Pressure (CBP)	-	1	0	-1.21%	WEAK	N/A
	Poor HbA1c Control (>9%)	-	0	1	-5.54%	WEAK	N/A
	Postpartum Care	-	0	0	-----	N/A	N/A
	Timeliness of Prenatal Care	-	0	1	-4.33%	WEAK	N/A
	Well Child Visits (WCV)	-	1	3	-6.02%	MODERATE	N/A
Native Hawaiian and Other Pacific Islander	Controlling High Blood Pressure (CBP)	0	1	0	-61%	MODERATE	N/A
	Poor HbA1c Control (>9%)	0	2	0	-12.04%	STRONG	N/A
	Postpartum Care**	0	-	-	---	N/A	N/A
	Timeliness of Prenatal Care**	0	-	-	---	N/A	N/A
	Well Child Visits (WCV)	1	3	1	-11.16%	STRONG	N/A
Hispanic or Latino	Controlling High Blood Pressure (CBP)	0	0	1	4.22%	WEAK	N/A
	Poor HbA1c Control (>9%)	0	0	1	-1%	WEAK	N/A
	Postpartum Care	0	0	0	N/A	NONE	N/A
	Timeliness of Prenatal Care	0	0	0	N/A	NONE	N/A
	Well Child Visits (WCV)	0	0	1	-3.08%	WEAK	N/A
Black or African American	Controlling High Blood Pressure (CBP)	0	0	0	N/A	NONE	N/A
	Poor HbA1c Control (>9%)	0	1	1	12%	STRONG	N/A
	Postpartum Care	0	0	0	N/A	NONE	N/A
	Timeliness of Prenatal Care	0	2	0	-30.12%	STRONG	N/A
	Well Child Visits (WCV)	1	2	2	-6.57%	STRONG	N/A
Asian	Controlling High Blood Pressure (CBP)	0	0	2	-0.17%	WEAK	N/A
	Poor HbA1c Control (>9%)	0	0	0	N/A	NONE	N/A
	Postpartum Care	0	0	1	-6.71%	WEAK	N/A

	Timeliness of Prenatal Care	0	1	0	-6.53%	WEAK	N/A
	Well Child Visits (WCV)	0	0	4	-2.81%	WEAK	N/A
American Indian and Alaska Native	Controlling High Blood Pressure (CBP)	0	2	0	-11.26%	MODERATE	N/A
	Poor HbA1c Control (>9%)	1	1	2	-33%	STRONG	N/A
	Postpartum Care	1	0	2	-15.57%	STRONG	N/A
	Timeliness of Prenatal Care	1	3	0	-21.78%	STRONG	N/A
	Well Child Visits (WCV)	1	1	3	-5.91%	MODERATE	N/A

Native Hawaiian and other pacific islander measures not evaluated due to lack of sample size in each region to be sufficient

From the table above, Partnership prioritized the following identified health inequities (highlighted in orange) based on their inclusion in the "strong" disparity category:

1. Timeliness of Prenatal Care (PPC – Pre): Black/African American Members
2. Timeliness of Prenatal Care (PPC – Pre): American Indian/Alaska Natives
3. Timeliness of Postpartum Care (PPC – Post): American Indian/Alaska Natives
4. Well Care Visits (WCV): All Pediatric Members

However, there are some significant limitations to note in Partnership's analysis. The major limitation is the lack of a gold standard to evaluate and quantify disparities between various groups. Experts have debated and have not developed a consensus on how to effectively measure disparities between groups. While team members reviewed this information, we developed modifications of such systems of evaluating the disparities, which may produce bias. Also, the system and metrics previously used have not been tested to validate their accuracy. For example, in utilizing the scoring model and analyzing findings, Partnership prioritized Controlling High Blood Pressure, Hemoglobin A1c Control, and Prenatal and Postpartum Care for Black members. While a disparity was identified for the Black/African American population for CBP, only 20 members identified as Black/African American were included in the MCAS hybrid sample, and of those 20, only 8 (40%) were noncompliant in the measure over all four regions. The small denominator for this group made the Black population a larger priority in addressing inequities identified for this measure.

Additionally, Partnership's utilization of state data for the race and ethnicity information included in this analysis was done to provide the most up to date member demographic information for members included in each measure sample. However, members where race or ethnicity were unknown fell into the "Unknown" category, and as such, these members were not included in the final analysis. As shown in Element A, 59,918 (8.9%) of Partnership members have "Unknown" listed for their race and ethnicity demographic information. Partnership is exploring ways to strengthen race and ethnicity demographic information for members in this category, to more appropriately impact them in future analysis and create more tailored interventions.

Another major limitation was evaluating and integrating CAHPS® responses. In addition to the prioritized opportunities listed above, Partnership also identified a need to explore potential

solutions to impact CAHPS® responses. Partnership recognizes that the CAHPS® response rate from members is low, and is exploring options to increase survey access, and acknowledge the diverse language demographics of Partnership members. As such, Partnership is also exploring how to ensure the survey is available in additional languages to Spanish and English to encourage responses are being received from a diverse population of eligible survey recipients, findings are more representative of the communities served, and can be acted upon.

Finally, as highlighted previously, a major limitation of all of these findings is that the sample sizes were significantly smaller, therefore significantly lowering the likelihood of finding significant differences. NCQA team auditors may want to suggest threshold demographic sample sizes for each measure to improve likelihood of validity when comparing stratified languages while working with plans that utilize the MCAS measures.

Factor 2: Identifies and prioritizes opportunities to improve CLAS

When reviewing the utilization data, Spanish was the most requested language for both interpreting sessions and translation requests. To continue to support the demand for Spanish Language Services, Partnership's Member Services Call Center strives to ensure Member Service Representatives (MSR) are bilingual. At the department level, there is an internal goal to maintain ¾ or 75% of Partnership's MSR's are bilingual. To be considered a "bilingual" employee, applicable staff must pass a Partnership administered language competency exam. Upon completion, bilingual staff are able to provide customer support in the language in which they exemplified competency. With that said, the Department is currently at 70% and will continue to work towards achieving and sustaining this internal goal.

In regard to Partnership's threshold languages, we noticed that Tagalog was not within the top seven requested languages for interpreting. Although the volume was small, Tagalog accounted for 12.9% of the translation requests in the Current Period. Another language that is gaining adoption is Vietnamese. Vietnamese was the second most requested language for interpreting. In terms of translation requests. Knowing that Vietnamese is not a threshold language, there may be future opportunities for Partnership to further understand the demand for this language through the continued analysis of utilization data.

When looking at the results of the Internal Satisfaction Survey, Partnership provided staff with the opportunity to provide candid feedback through an open-ended/optional question. Through this question, we were able to understand some of the challenges that Partnership staff experienced. One of the leading causes of staff dissatisfaction was that interpreters disconnected from the session prematurely. To address this opportunity, Partnership will collaborate with contracted vendors to reiterate expectations and ensure that the interpreters are adequately trained on closing each interpreting session. Another common concern was that select languages had a longer hold time than usual. This typically happens with languages of lesser diffusion, such as Samoan and Mixteco. This concern has been thoroughly discussed with Partnership's provider base. Contracted providers will continue to make a good-faith effort to ensure that their internal workforce-planning department is aware of these deficits. Another solution is that Partnership has the ability to pre-schedule interpreting sessions for the

languages of lesser diffusion. Partnership will continue to assess staff experience and work with contracted providers on areas of opportunities in an effort to improve staff experience with the interpreting services received.

In identifying opportunities to improve CLAS, Partnership utilized measure performance stratified by language and sexual orientation, CAHPS® and Grievance and Appeals data. Partnership's original goal when assessing opportunities to improve CLAS was defined as:

Goal: There will be no statistically significant lower performance for each measure included in this report for each language group in comparison to the English group.

Status: Goal Met.

Goal: There will be no statistically significant lower performance for each measure included in this report for the Female group in comparison to the Male group.

Status: Goal Met.

As each of these goals was met, Partnership reviewed the CAHPS® data findings. Although the CAHPS® survey yields insight into the interpreting and translation language services, respondent samples specific to each supplemental question in the CAHPS® regulated and non-regulated survey are statistically insignificant relative to the non-English speaking surveyed member population. Important to note, the regulated and drill-down surveys are only offered in English and Spanish language formats, which limits Partnership's ability to proactively solicit members for all threshold languages. As a result of the barriers identified, Partnership did not identify any opportunities based on responses to CAHPS® questions.

Partnership also created a goal to evaluate member satisfaction relative to language service utilization. This goal was defined as:

Goal: Maintain member abrasion or dissatisfaction below 1/10th of one percent (0.10%).

Status: Goal Met.

As outlined in Element C, Partnership met or performed better than the member satisfaction target. The 2023 case filings yielded a score of 0.03% relative to language service utilization and was slightly above the threshold target of (1/10th of one percent) 0.10%. The analysis workgroup established a priority ranking based the on number of case filings by category (Table XLIV). As illustrated in Table XLIV, the Language Barrier/Limited English Proficiency category type resulted in roughly 60% of the total grievances within the 2023 Annual Grievance & Appeals Priority by Category Type, which highlights an opportunity for improvement.

Table XLIV

2023 Annual Grievance & Appeals Priority By Category Type	
Language Barrier / Limited English Proficiency	15
Auxiliary Aids and Services	8

Language Assistance Services	2

Based on the priority, the workgroup approached each Language Assistance Service case (TTL: 26) with the purpose to identify service abrasion/dissatisfaction themes. Partnership further compiled case filings by service delivery and identified correlating themes (italicized) for Health Plan and Provider/Network (Table XLV) and NCQA Health Equity (HE) 6 Case Analyses (Table XLVI).

Table XLV

Service Delivery	Member Dissatisfaction Theme
Partnership	• Service provider - technical/connectivity issues • *Service provider - dialect/translation issues* • *Covered member - translation and interpreter benefit literacy*
Provider/Network	• Customer service/cultural sensitivity training • *Covered benefit awareness and training* • *Service provider - dialect/translation issues*

Table XLVI: NCQA Health Equity (HE) 6 Case Analyses

Case Category Type	2023 Grievance & Appeals Case Totals	NCQA Health Equity (HE) 6 Case Analyses
Language Assistance Services	2	Case filings offer different perspectives specific to Language Assistance Services. Theme: Familiarity of benefit literacy and breakdown in communication.
Language Barrier / Limited English Proficiency	15	Case filings offer a combination of unconfirmed and confirmed perceptions of discrimination associated with language barriers. Case filing themes: benefit literacy, scheduling, and communication breakdown. Per the Partnership Member Handbook, members are encouraged to schedule interpreter services when confirming a medical appointment. In some instances, provider sensitivity training, and reminders of CLAS-covered benefits are warranted.
Non-threshold Language	1	Partnership Member Services (MS) employee created an unintended abrasion/experience while following procedure to authenticate plan covered member over the phone. The language barrier occurred between member ad hoc interpreter (family member) and MS employee. Assessment: Although plan MS employee adhered to procedure, there is an employee lesson learned/training opportunity. Learn

		to take verbal/conversation ques to know when to transfer to a bilingual MS employee or qualified interpreter services (AMN) delegated vendor.
Auxiliary Aids and Services	8	Case filings offer different perspectives specific to Auxiliary Aids and Services. Theme: Familiarity with covered benefits (varied clinical settings) literacy and breakdown in communication.

Factor 3: Implements at least one intervention to address an inequity

In addressing disparities and impacting health equity at a global scale, Partnership has worked to improve tools used both internally and externally to ensure they address disparities at the plan-wide level. Race and ethnicity data has been added to external tools to allow network practitioners to facilitate targeted outreach, and understand demographic information for members seen at their clinics. Demographic information has been added to Partnership's eReports (an online system built by Partnership's Web team for the PCP QIP Clinical measures; it is the mechanism by which providers can monitor their performance and submit supplemental medical record data to Partnership to enhance their performance), and member lists available to providers like Partnership's Preventive Care dashboard.

Furthermore, Partnership is adding race and ethnicity data to internal tools like the Maternity Services dashboard to bring more visibility to this data, and facilitate targeted outreach when tools are utilized. Health equity has also been added to the *Improving Measure Outcomes* webinar series Partnership hosts to QI teams within the network to ensure teams understand measure specifications and performance, and best practices for each of the measures included. The addition of health equity focus and member demographic information to these externally facing webinars was done to help QI teams within Partnership's network develop strategies for measure improvement with this information in mind. This has been added to webinars that address all measures of focus included in this report.

Lastly, Partnership identified a number of opportunities to improve health and CLAS inequities based on the analysis included in Factor 1 (Table XLIII). Opportunities to address inequities have been highlighted below by measure category.

Timeliness of Prenatal Care (PPC – Pre)	
Group(s) of Focus	Black/African American Members
Percentage Below Minimum Performance Level (MPL)	*NE Region: 9.28% below* *NW Region:50.97* % below Non-Weighted Average: 30.12%
Goal for Specific Group	Improve prenatal visits by at least 5% in the NE or NW region in the Black/African American Member Population within 12 months with the global goal of improvement by 30% in the next 5 years.
Root Cause Analysis	Timely prenatal care is recommended to promote healthy pregnancies via screening and preventative management of a woman's risk factors. Unfortunately, various studies have suggested that fewer timely prenatal visits are associated with poorer pregnancy outcomes such as severe maternal morbidity, maternal death, and infant mortality (Howell, 2018). Research has suggested that insurance availability, transportation, and access to specific providers are key driving factors for receiving timely prenatal care. Partnership identified inequities for Black/African American members in the Northeast and Northwest regions for Timeliness of Prenatal Care.
Barrier Analysis	For prenatal care, researchers found that policy changes that improved eligibility for individuals, made insurance coverage more comprehensive, and improved maternity reimbursement rate was associated with greater attendance in postpartum visits (Saldanha et al., 2023). There has been limited research evaluating prenatal care and postpartum interventions in specific patient groups—namely Black/African American patients. Currently, Black/African American women are at least 3x more likely to experience a pregnancy-related death when compared to White women and have the largest disparity among all the conventional population perinatal health measures (Howell, 2018). However, partnership is currently exploring interventions to positively impact their prenatal and postpartum care. In 2023, the Department of Health Care Services (DHCS) added doula services as a covered benefit. In 2023, Sobczak et al. conducted a literature review of 16 studies (cohort and randomized trials) to evaluate the benefits of utilizing a doula. Their findings suggested that doula support decreased incidence of cesarean or premature labor, low birth weight, and epidural/medical pain management. Finally, Partnership conducted a focus-group-like survey of Black prenatal and postpartum members (n=12) to conduct a survey to better understand if the member attended their appointments, as well as to understand the barriers faced, if any at the Solano County Family Health Services site—which has the largest population of Black/African American members. Overall, the members highlighted that they didn't attend their visits due to one of the following three categories: (1)

	Incorrect Staff Actions, (2) Schedule Unavailability, (3) Lack Of Transportation. This has motivated Partnership to explore utilizing group visits to streamline staff actions, schedule availability, and coordinate transportation. In 2017, Byerley and Hass conducted a systematic review of 38 studies (8 randomized trials, 23 nonrandomized studies, 6 reports of group outcomes without controls) to evaluate group prenatal care in 20,000+ women. Overall, Byerley et al. (2017) found a significant increase in rates of breastfeeding and satisfaction in Black/African American members after implementing group prenatal care interventions. Partnership may explore whether clinical site locations will be interested in conducting a pilot to validate the efficacy of utilizing such group visits with Doulas. Long-term, Partnership will explore utilizing a combination of interventions to likely meet the large threshold of members who are not meeting the goal.
Actions for Direct Clinical/Service Measure Improvement	**<u>Intervention #1: Contracting Doulas in Partnership Network:</u>** Partnership is also investigating what education doulas share with utilizing members, to ensure members are receiving appropriate information on the importance of early access to prenatal care as well as postpartum care. Partnership has worked to add doulas to the network, and has at least one doula in each region of the network. The health equity officer and other staff have ventured into various community events to help with recruiting various Doulas. **<u>Intervention #2: Increase Diversity of OB GYNs:</u>** Partnership is investigating how to improve the diversity among Obstetrics-Gynecology doctors. To this, Partnership is exploring how to do a baseline assessment of the race and ethnicity demographics of OBs within the network to assess. Partnership will then share this information with respective HR departments to provide guidance to the provider recruitment team at Partnership and incentivize increasing diversity hiring throughout the network to reflect the populations served. Partnership has launched a new provider retention initiative. Specifically, partnership will provide $45,000 award to a doctor of medicine/doctor of osteopathic medicine (DO) or $30,000 award to a nurse practitioner/physician assistant for a 3-year commitment. This intervention will be applicable to all clinical sites—especially OB/GYN sites that inhabit locations that serve a large Black/African American population. **<u>Intervention #3: Encourage Clinical Sites to Utilize Dyadic Care Models</u>** Dyadic care models are considered effective for optimizing the care of both the mother and infant. Dyadic care is considered when a provider provides care for a birthing mother and their infant during the same visit. Specifically, the American Academy of Pediatrics recommends prenatal visits to establish pediatric medical homes and postnatal depression screening for the birthing person during pediatric visit (Choy et al. *PLoS One*. 2024 Apr 16;19(4):e0298927). This is based upon the

	postnatal period being seen as a critical time to support and improve health outcomes of birthing people and their infants. Unfortunately, pregnancy-related morbidity and mortality often occurs within the 6-week postpartum period and this has been attributed to difficulty in accessing care. Partnership will continue to advocate for sites to adopt dyadic care models—especially in regions where there are limited OB/GYNs and primary care providers.

Prenatal and Postpartum Care (PPC)	
Group(s) of Focus	American Indian/Alaska Native
Prenatal Percentage Below Minimum Performance Level (MPL)	*NE Region: 9% Below* *NW Region:* 22% below *SW Region:* 34% below *Non-Weighted Average:* 21.78% Below
Goal for Specific Group	Improve prenatal visits by at least 5% in the NE or NW region in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement of 22% in the next 5 years.
Postpartum Percentage Below Minimum Performance Level (MPL)	*NE Region: 28% Below* *NW Region:* 3% below *SW Region:* 3% below *Non-Weighted Average:* 11.4% Below
Goal for Specific Group	Improve postpartum visits by at least 5% in the NE region in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement by 12% in the next 5 years.
Root Cause Analysis	Currently, majority of our American Indian/Alaska Native members are located in Humboldt, Mendocino, and Shasta Counties in our NW and NE regions. Tertiary research has suggested that there is a significantly higher rate of maternal morbidity and mortality among this group due to centuries of human rights violations (e.g. massacres, forced relocation, boarding schools) which has translated into generational trauma via epigenetics (Burns et al. *Soc Sci Med*. 2023 Jan;317:115584.). In addition, researchers has identified the following predictors of maternal mortality: older maternal age, pre-existing conditions, prior cesarean section, transportation issues, travel time, administrative burdens which limit Medicaid enrollment and prenatal care update; and various structural racism incidents during healthcare interactions.
Barrier Analysis	Research suggests that there are structural barriers that are exacerbating poor outcomes in our American Indian/Alaska Native community. For example, there are purported to be transportation infrastructure, family welfare system, poor prenatal care infrastructure, and blatant racism that are the key upstream factors that are acting as barriers for improving disparities.

	Within Partnership's service landscape, the region that is experiencing the greatest disparity for this measure is the NW rural region. Currently, many of Partnership's AI/AN members inhabit this area and likely are experiencing lack of clinic access for all providers. Also, various tribal centers utilize various are held financially accountable to government performance and results act (GPRA) versus HEDIS measures—which are considered less stringent. Therefore, various tribal centers do not have the financial incentive to be intensive with hypertension treatments versus non-tribal health centers. To improve relations, Manage Care Organizations (MCOs) and Partnership specifically, has explored hiring tribal health center liaisons to improve the collaboration between MCOs and tribal centers.
Actions for Direct Clinical/Service Measure Improvement	**<u>Intervention #1: Tribal Health Liaison Hiring and Hosting Tribal Center Event</u>** Partnership has hired a full-time Tribal health liaison to positively impact relationships with tribal health centers, tribal health community members, and provide guidance to help support Tribal member needs. Partnership has recognized partnering with the Tribal community as an organizational initiative, and is working to positively impact all care received by Tribal members through this partnership and communication with Tribal Health Centers within the network at this time. This work has the potential to improve the member experience of American Indian/Alaska Native members, ensure they are receiving culturally appropriate care, and positively impacting the care received by members who identify with this group. Also, the tribal health liaison will be able to conduct various focal group interviews and possibly identify community based organizations to able to provide tele-nutrition counseling sessions, funds for delivery of DASH-diet aligned foods. **<u>Intervention #2: Contracting Doulas in Partnership Network:</u>** Partnership is also investigating what education doulas share with utilizing members, to ensure members are receiving appropriate information on the importance of early access to prenatal care as well as postpartum care. Partnership has worked to add doulas to the network, and has at least one doula in each region of the network. The health equity officer and other staff have ventured into various community events to help with recruiting various Doulas. In addition, Partnership is trying to contract with doula's in the NE/NW regions to ensure that we are able to outreach to our Tribal community members. **<u>Intervention #3: Advertisements of Transportation Benefit with Translation into Tribal Languages:</u>** Partnership is also investigating what education we can share with utilizing members, to ensure members are receiving appropriate information on the importance of

	early access to prenatal care as well as postpartum care. For example, Partnership has recognized that many members are unaware of the transportation benefit afforded to them. Therefore, they may be unaware that Partnership is able to pay for the lodging fees and transportation for a tribal member anywhere they would like to go if they are seeking prenatal/postpartum care in a separate county. Finally, Partnership will like to engage with and survey members to assess whether they should advertise certain education materials into different languages to ensure they are receptive to our various tribal communities.

Well Care Visits (WCV)	
Group(s) of Focus	American Indian/Alaska Native Black/African American White
Goal for Specific Group	Improve Well Care Visit attendance by at least 2.5% across multiple regions or at least 5% in 1 single region in any group (e.g.) Black/African American, American Indian/Alaska Native, White within 12 months with global goal of improvement by 5% in the next 5 years.
Root Cause Analysis	Per the DHCS Bold goals, the state is looking to close all racial/ethnic disparities in WCVs by 50% by 2025. Currently, WCVs are low for all populations. A proposed hypothesis of the root cause is that there is a significant shortage of pediatrician providers—who are able to conduct the WCVs. Therefore, there is a limitation of conducting the absolute number of visits for all pediatric members—regardless of race/ethnicity/gender identity. Also, by having certain members miss at least 1 visit, this will likely cause a shift to make it impossible to attain the key number of visits by a certain age. Currently, the American Academy of Pediatrics recommends at least 13 well-child visits between birth and 6 years of life.
Barrier Analysis	Overall, researchers found that Well Care Visits (WCV) was the clinical measure that majority of race/ethnic groups have a disparity of not meeting the minimum performance threshold throughout the regions. This suggests that the low WCV rate is more of a quality concern versus a demographic specific concern. Within the American Indian/Alaska Native community, there is a community concern of children being reported for child protective services referrals. Historically, AI/AN children were consistently removed from their homes to adopt western cultures. This has resulted in various family members being concerned with exposing their child to unfamiliar members of the community. Also, Partnership tribal health centers have a challenge with engaging with members due to the ongoing difficulties with recruitment and consistent retention of health

	workers and leadership. This is due to the Indian health serves being consistently underfunded, leading to rationing of needed services and a crumbling infrastructure. Therefore, Partnership may consider helping with provider recruitment and retention since tribal centers are unlikely to financially compete with other centers. Within the Black/African American community, there is an association with low well child visit attendance due to low levels of maternal education, low income, and poor prenatal care (Wolfe et al., 2018). Partnership can explore implementing interventions to improve tailored interventions to improve well-child care in African American/Black groups. For example, in a systematic review of well care visit redesigns researchers highlighted the efficacy of doing group WCVs. (Coker et al., 2013)
Actions for Direct Clinical/Service Measure Improvement	**Intervention #1: Provider Recruitment Program and Provider Retention Initiatives** Partnership has launched a new provider retention initiative. Specifically, partnership will provide $45,000 award to a doctor of medicine/doctor of osteopathic medicine (DO) or $30,000 award to a nurse practitioner/physician assistant for a 3-year commitment. This intervention will be applicable to all of clinical sites—especially Partnership's tribal centers and sites that inhabit locations that serve a large Black/African American population. **Intervention #2: Group Well Child Visits** Partnership is conducting a pilot with a clinical site to start group well child visits in a clinical site in Solano county—which has the greatest diversity among Partnership's 14 counties. Long-term, Partnership can explore utilizing a combination of interventions to likely meet the large threshold of members who are not meeting the goal throughout the network. **Intervention #3: Increase Access to BIPOC-related children's book regarding improving immunizations and attending WCVs** Partnership's HEO previously published a children's book, Andres Armor, which teaches BIPOC children the importance of vaccines using knight and dragon analogies. He is exploring donating copies of the book and videos to clinical sites to hopefully increase the number of children wanting to attend WCVs and watching the free information play during their provider visits.

Factor 4: Implements at least one intervention to improve CLAS

The CLAS team will continue to focus on continued root-cause analyses and improvement activities specific to Grievance & Appeals categories related to language. As illustrated in Table XLIV, the Language Barrier/Limited English Proficiency category type resulted in roughly 60% of the total grievances within the 2023 Annual Grievance & Appeals Priority by Category Type, which highlights an opportunity for improvement.

Table XLIV

2023 Annual Grievance & Appeals Priority by Category Type	
Language Barrier / Limited English Proficiency	15
Auxiliary Aids and Services	8
Language Assistance Services	2

Based on member satisfaction with language related services and the HE 6 Case Analyses (Table XLVI), Member Services and Quality Improvement will implement an intervention in the form of an inter/intradepartmental workgroup. This workgroup will place an emphasized focus on analyzing the leading causes of member dissatisfaction as it relates to CLAS. As a result of the associated grievance volume, the Language Barrier/Limited English Proficiency category type will serve as the basis through which Partnership's intervention workgroup will develop improvement activities.

Table XLVI: NCQA Health Equity (HE) 6 Case Analyses

Case Category Type	2023 Grievance & Appeals Case Totals	NCQA Health Equity (HE) 6 Case Analyses
Language Assistance Services	2	Case filings offer different perspectives specific to Language Assistance Services. Theme: Familiarity of benefit literacy and breakdown in communication.
Language Barrier / Limited English Proficiency	15	Case filings offer a combination of unconfirmed and confirmed perceptions of discrimination associated with language barriers. Case filing themes: benefit literacy, scheduling, and communication breakdown. Per the Partnership Member Hand-book, members are encouraged to schedule interpreter services when confirming a medical appointment. In some instances, provider sensitivity training, and reminders of CLAS-covered benefits are warranted.
Non-threshold Language	1	Partnership Member Services (MS) employee created an unintended abrasion/experience while following procedure to authenticate plan covered member over the phone. The language barrier occurred between member ad hoc interpreter (family member) and MS employee. Assessment: Although plan MS employee adhered to procedure, there is an employee lesson learned/training opportunity. Learn to take verbal/conversation ques to know when to transfer to a bilingual MS employee or qualified interpreter services (AMN) delegated vendor.
Auxiliary Aids and Services	8	Case filings offer different perspectives specific to Auxiliary Aids and Services. Theme: Familiarity with covered benefits (varied clinical settings) literacy and breakdown in communication.

Member Services and Quality Improvement stakeholders will design, assemble, and implement the workgroup that will be comprised of key stakeholders within the organization. The overall deliverable will be focused on addressing and identifying commonalties associated with CLAS member grievances with the intent of reducing the number of member grievances associated with Language Barrier/Limited English Proficiency. This will be accomplished through addressing the Member Dissatisfaction Themes related to translation and interpreter benefit literacy and covered benefit awareness and training, which were both highlighted in the Partnership and Provider/Network service delivery categories in Table XLV.

Through this workgroup, Partnership will engage the impacted stakeholders to understand current state and offering of informative material for both members and providers. This intervention workgroup will also focus on CLAS benefit literacy, educational material, and provider education/communication cadence. Additionally, this workgroup may work with external stakeholders to solicit feedback as we look to refine our communication/education approach while identifying any pertinent causal factors lined to CLAS member dissatisfaction. This intervention also allows internal stakeholders the opportunity to provide direct education and feedback to external stakeholders in an effort to mitigate related grievances in the future.

Measure	Intervention	Goal	Stakeholders
Member Grievances Filed	Internal workgroup to lead intervention efforts centered around CLAS Member Grievances and Provider Education	10% reduction in Member Grievances associated with the *Language Barrier / Limited English Proficiency* filed, using CY2023 Q3/Q4 as the baseline. Results will be assessed no later than July 2025, in which the workgroup will determine the future state of the intervention workgroup and may identify additional areas of opportunity.	Internal: • Member Services • Quality Improvement • Grievance & Appeals • Provider Relations External: • Provider Network • Interpreting Vendor

Partnership will evaluate the effectiveness of the workgroup and its goal of a 10% reduction in Member Grievances associated with the Language Barrier / Limited English Proficiency filed, no later than July 2025. The workgroup will evaluate the effectiveness of the intervention work related to CLAS benefit literacy, educational material, and provider education/communication cadence. This evaluation will determine the future state of the intervention workgroup and may identify additional areas of opportunity.

Furthermore, Partnership's Population Health department will address this goal by addressing the need to provide written materials to members in their choice of format (such as large print, Braille, audio format, or other) to ensure vision-impaired members are able to understand the information Partnership shares. This goal is monitored through the annual C&L Work Plan. This will be done to provide a more proactive approach for language services.

Factor 5: Evaluates the effectiveness of an intervention to reduce an inequity

Partnership has not previously evaluated the effectiveness of an intervention to improve CLAS and reduce inequities in a specific group. Listed below is the plan to evaluate the effectiveness of certain interventions in the future, and these evaluations will be completed by July 2025.

Partnership's Population Health team will evaluate the effectiveness of their hosted events. This will be done through an analysis of the number of members who attended each event, the number of blood pressure cuffs distributed and diabetes checks conducted, the number of members enrolled in Population Health's Healthy Living Tools program, as well as an evaluation of member surveys conducted at these events. Analysis of event impact and member engagement and satisfaction will be used to evaluate if these events should be adapted, spread to additional counties within the network, or abandoned for more impactful events and interactions to address within this population of focus. However, the Population Health team will collaborate with the Health Equity Officer and Quality Improvement Department to identify and implement these activities.

Prenatal and Postpartum Care (PPC):

Partnership will be evaluating the current utilization of the doula benefit, as highlighted in Factor 3. Partnership will also explore additional intervention opportunities to impact the Black population, and will conduct interventions for at least 3 months.

Population	Key Intervention(s)	Effectiveness to Improve Culture and Linguistically Appropriate Services (CLAS)	Effectiveness of Intervention to Reduce Inequities
American Indian/Alaska Native	Tribal Health Liaison Appointment	**Measure (Indirect):** Number of Community Events Attended Number of American Indian/Alaska Native Members Interviewed **Goal:** Engagement with at least 20% of American Indian/Alaska Native attendees **Measure:** Not Collected During Event	**Measure (Direct):** PPC-Pre visit rate in AI/AN community **Preliminary Goal:** 5% Improvement from baseline in 12 months **Global Goal:** Improve prenatal visits by at least 5% in the NE or NW region in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement by 22% in the next 5 years.

Black/African American	Doula Appointments in Regions	**Measure (Indirect):** Number of Events Attended Number of Black/African American Members engaged during Community Screening Event **Goal:** Engagement with at least 20% of Black/African American attendees **Measure:** Not Collected During Event	**Measure (Direct):** Percentage of Black/African American members with adequately controlled BP (<140/90) during measurement year **Goal:** Improve prenatal visits by at least 5% in the NE or NW region in the Black/African American Member Population within 12 months with the global goal of improvement by 30% in the next 5 years. **Measure:** Not Collected During Event

Factor 6: Evaluates the effectiveness of an intervention to improve CLAS

Partnership has not previously evaluated the effectiveness of an intervention to improve CLAS and reduce inequities in a specific group. Listed below is the plan to evaluate the effectiveness of certain interventions in the future.

Partnership will evaluate the effectiveness of the workgroup and its goal of a 10% reduction in Member Grievances associated with the Language Barrier / Limited English Proficiency filed, no later than July 2025. The workgroup will evaluate the effectiveness of the intervention work related to CLAS benefit literacy, educational material, and provider education/communication cadence. This evaluation will determine the future state of the intervention workgroup and may identify additional areas of opportunity.

Partnership's Population Health team will also evaluate member satisfaction with materials received. Grievances can also be evaluated to see if there is a reduction in grievances received related to format.

Measure	Intervention	Effectiveness to Improve Culture and Linguistically Appropriate Services (CLAS)
Member Grievances Filed	Internal workgroup to lead intervention efforts centered around CLAS Member Grievances and Provider Education	**Goal:** 10% reduction in Member Grievances associated with the Language Barrier / Limited English Proficiency filed, using CY2023 Q3/Q4 as the baseline.

References

Byerley, B. M., & Haas, D. M. (2017). A systematic overview of the literature regarding group prenatal care for high-risk pregnant women. *BMC Pregnancy and Childbirth*, *17*(1). https://doi.org/10.1186/s12884-017-1522-2

Coker, T. R., Windon, A., Moreno, C., Schuster, M. A., & Chung, P. J. (2013). Well-Child Care Clinical Practice Redesign for Young Children: A Systematic Review of Strategies and tools. *Pediatrics*, *131*(Supplement_1), S5–S25. https://doi.org/10.1542/peds.2012-1427c

Howell, E. A. (2018). Reducing disparities in severe maternal morbidity and mortality. *Clinical Obstetrics and Gynecology*, *61*(2), 387–399. https://doi.org/10.1097/grf.0000000000000349

Iqbal, A. M. (2023, July 20). *Essential hypertension*. StatPearls - NCBI Bookshelf. https://ncbi.nlm.nih.gov/books/NBK539859/

Malat, J., Mayorga-Gallo, S., & Williams, D. R. (2018). The effects of Whiteness on the health of Whites in the USA. *Social Science & Medicine*, *199*, 148–156. https://doi.org/10.1016/j.socscimed.2017.06.034

Mills, K. T., Ştefănescu, A., & He, J. (2020). The global epidemiology of hypertension. *Nature Reviews Nephrology*, *16*(4), 223–237. https://doi.org/10.1038/s41581-019-0244-2

National Academies Press (US). (2017, January 11). *The state of health disparities in the United States*. Communities in Action - NCBI Bookshelf. https://www.ncbi.nlm.nih.gov/books/NBK425844/

Pasha, M., Brewer, L. C., Sennhauser, S., Alsawas, M., & Murad, M. H. (2021). Health care delivery interventions for hypertension management in underserved populations in the United States: a Systematic review. *Hypertension*, *78*(4), 955–965. https://doi.org/10.1161/hypertensionaha.120.15946

Saldanha, I. J., Adam, G. P., Kanaan, G., Zahradnik, M. L., Steele, D. W., Chen, K. K., Peahl, A., Danilack-Fekete, V. A., Stuebe, A. M., & Balk, E. M. (2023). Health insurance coverage and postpartum outcomes in the US. *JAMA Network Open*, *6*(6), e2316536. https://doi.org/10.1001/jamanetworkopen.2023.16536

Sinclair, K., Nikolaus, C. J., Wetherill, M. S., Nelson, K., Jackson, A., Taniguchi, T., Jernigan, V. B. B., & Buchwald, D. (2023). Native opportunities to stop hypertension: study protocol for a randomized controlled trial among urban American Indian and Alaska Native adults with hypertension. Frontiers in Public Health, 11. https://doi.org/10.3389/fpubh.2023.1117824

Sobczak, A., Taylor, L. L., Solomon, S., Ho, J. T., Kemper, S., Phillips, B., Jacobson, K., Castellano, C., Ring, A., Castellano, B., & Jacobs, R. J. (2023). The Effect of doulas on maternal and birth Outcomes: A scoping review. *Cureus*. https://doi.org/10.7759/cureus.39451

Wolf, E. R., Hochheimer, C. J., Sabo, R. T., DeVoe, J. E., Wasserman, R. C., Geissal, E., Opel, D. J., Warren, N., Puro, J., O'Neil, J., Pecsok, J., & Krist, A. H. (2018). Gaps in Well-Child care attendance among primary care clinics serving Low-Income families. Pediatrics, 142(5). https://doi.org/10.1542/peds.2017-4019

Appendix

1. *Table II: Controlling High Blood Pressure (CBP) HPA Statistical Significance Results*

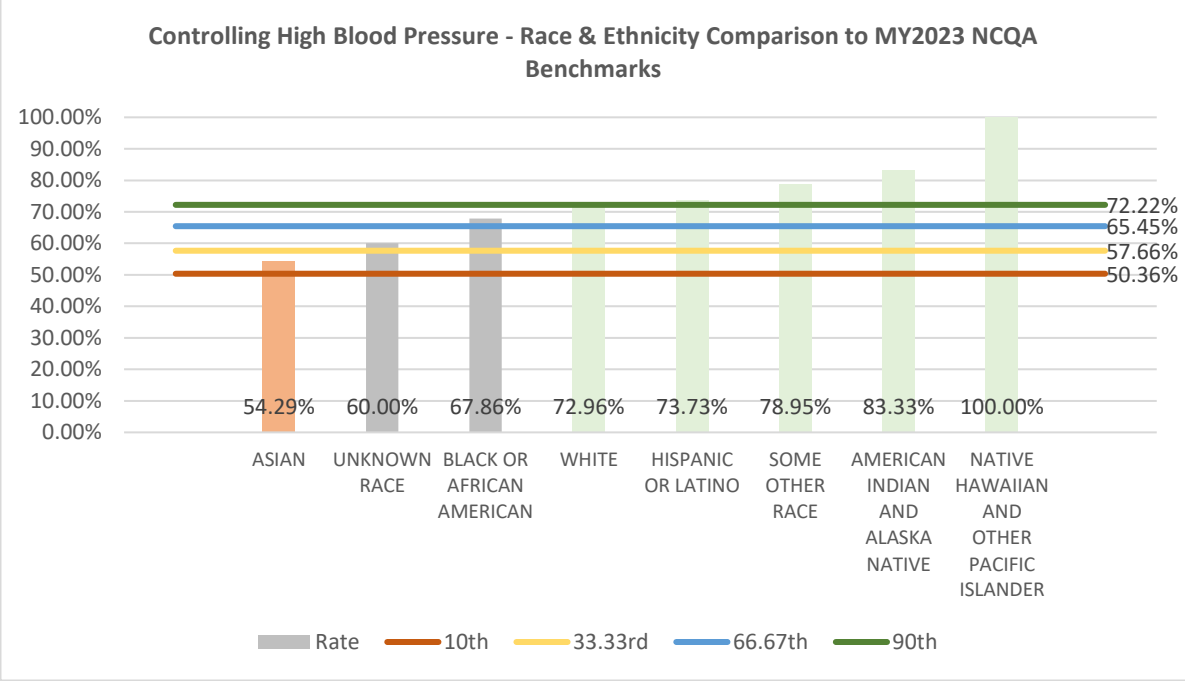
   MY 2023, Run Date: 7/24/2024

   Sample Size: 401

   Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Race	Numerator	Denominator	Rate	Interpretation
WHITE	116	159	73%	Reference
HISPANIC OR LATINO	87	118	74%	There is no statistically significant difference in rates between the WHITE population, (72.93%), and the `HISPANIC OR LATINO` population, (Rate =73.70%, Chi-Square=0.021, p=.8857)
AMERICAN INDIAN AND ALASKA NATIVE	5	6	83%	There is no statistically significant difference in rates between the WHITE population, (72.93%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =83.38%, Chi-Square=0.342, p=1.000)
ASIAN	19	35	54%	The WHITE population had a statistically significantly higher rate, (72.93%), compared to the `ASIAN` population, (Rate =54.34%, Chi-Square=4.725, p=.0297)
BLACK OR AFRICAN AMERICAN	19	28	68%	There is no statistically significant difference in rates between the WHITE population, (72.93%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =67.87%, Chi-Square=0.308, p=.5787)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (72.93%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.731, p=1.000)
SOME OTHER RACE	15	19	79%	There is no statistically significant difference in rates between the WHITE population, (72.93%), and the `SOME OTHER RACE` population, (Rate =78.98%, Chi-Square=0.314, p=.5755)

2. *Graph I*



Note: Bars highlighted orange indicate a group had lowest percentile performance of all groups included in measure sample, and were only group to fall into the percentile. Bars highlighted green indicate groups performed above the 90th percentile.

Partnership only found a statistically significant difference in compliance when comparing the Asian group to the White group while using the NCQA Health Plan Accreditation generated sample for Controlling High Blood Pressure (CBP) (n=401) (Table II). Furthermore, after reviewing stratified data in comparison to the National All Lines of Business benchmarks, the Asian population had a numerically lower rate for CBP and was the only racial group that scored below the 33.33rd percentile for the measure. All of the other groups were able to achieve at least the 33.33rd percentile defined by the National Medicaid benchmarks (Graph I).

3. *Table III: Controlling High Blood Pressure (CBP) MCAS Statistical Significance Results*

   MY 2023, Run Date: 7/24/2024

   Sample Size: 1,395

   Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	172	274	63%	
HISPANIC OR LATINO	24	42	57%	There is no statistically significant difference in rates between the WHITE population, (62.81%), and the `HISPANIC OR LATINO` population, (Rate =57.09%, Chi-Square=0.490, p=.4838)
AMERICAN INDIAN AND ALASKA NATIVE	6	9	67%	There is no statistically significant difference in rates between the WHITE population, (62.81%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =66.66%, Chi-Square=0.057, p=.8120)
ASIAN	9	16	56%	There is no statistically significant difference in rates between the WHITE population, (62.81%), and the `ASIAN` population, (Rate =56.21%, Chi-Square=0.274, p=.6005)
BLACK OR AFRICAN AMERICAN	7	9	78%	There is no statistically significant difference in rates between the WHITE population, (62.81%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =77.77%, Chi-Square=0.197, p=.4932)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	0	1	%	There is no statistically significant difference in rates between the WHITE population, (62.81%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =0.000%, Chi-Square=0.375, p=.3745)
SOME OTHER RACE	1	2	50%	There is no statistically significant difference in rates between the WHITE population, (62.81%), and the `SOME OTHER RACE` population, (Rate =50.05%, Chi-Square=0.470, p=1.000)

Northwest

Race	Numerator	Denominator	Rate	Interpretation
WHITE	155	261	59%	
HISPANIC OR LATINO	31	45	69%	There is no statistically significant difference in rates between the WHITE population, (59.40%), and the `HISPANIC OR LATINO` population, (Rate =68.86%, Chi-Square=1.454, p=.2279)
AMERICAN INDIAN AND ALASKA NATIVE	11	16	69%	There is no statistically significant difference in rates between the WHITE population, (59.40%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =68.75%, Chi-Square=0.550, p=.4582)
ASIAN	11	17	65%	There is no statistically significant difference in rates between the WHITE population, (59.40%), and the `ASIAN` population, (Rate =64.68%, Chi-Square=0.188, p=.6648)

BLACK OR AFRICAN AMERICAN	9	13	69%	There is no statistically significant difference in rates between the WHITE population, (59.40%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =69.19%, Chi-Square=0.499, p=.4798)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (59.40%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.595, p=1.000)
SOME OTHER RACE	2	4	50%	There is no statistically significant difference in rates between the WHITE population, (59.40%), and the `SOME OTHER RACE` population, (Rate =50.05%, Chi-Square=0.352, p=1.000)

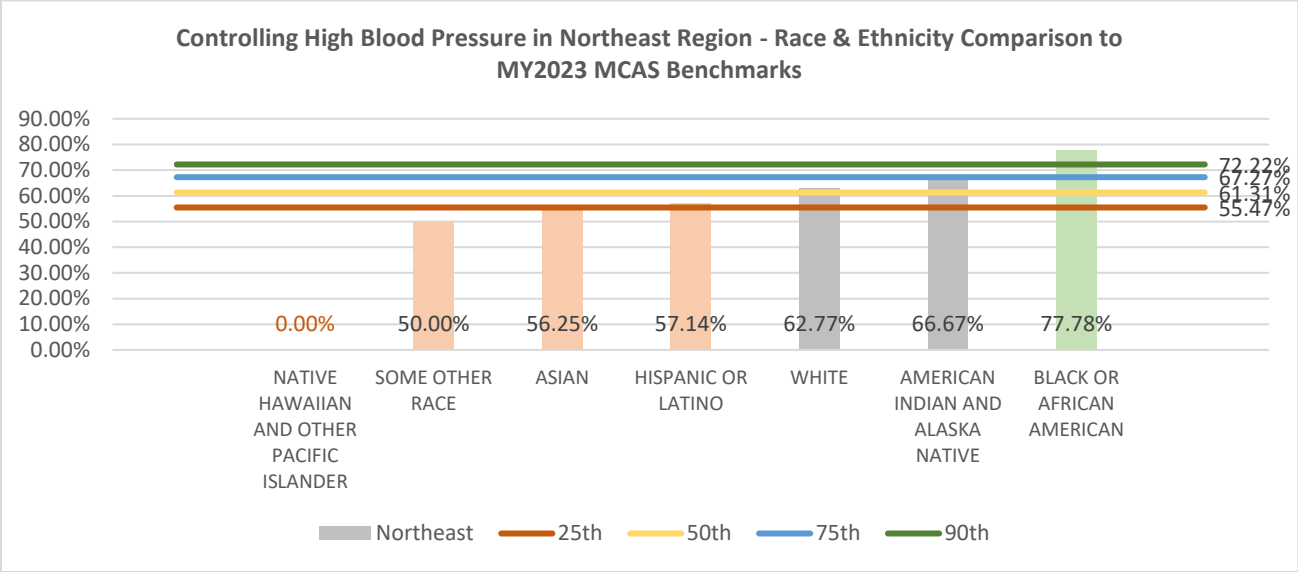
Southeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	57	88	65%	
HISPANIC OR LATINO	84	130	65%	There is no statistically significant difference in rates between the WHITE population, (64.79%), and the `HISPANIC OR LATINO` population, (Rate =64.57%, Chi-Square=0.001, p=.9810)
AMERICAN INDIAN AND ALASKA NATIVE	0	1	%	There is no statistically significant difference in rates between the WHITE population, (64.79%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =0.000%, Chi-Square=1.801, p=.1795)
ASIAN	45	75	60%	There is no statistically significant difference in rates between the WHITE population, (64.79%), and the `ASIAN` population, (Rate =59.95%, Chi-Square=0.394, p=.5303)
BLACK OR AFRICAN AMERICAN	26	40	65%	There is no statistically significant difference in rates between the WHITE population, (64.79%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =65.01%, Chi-Square=0.001, p=.9801)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (64.79%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.652, p=1.000)
SOME OTHER RACE	6	9	67%	There is no statistically significant difference in rates between the WHITE population, (64.79%), and the `SOME OTHER RACE` population, (Rate =66.66%, Chi-Square=0.285, p=1.000)

Southwest

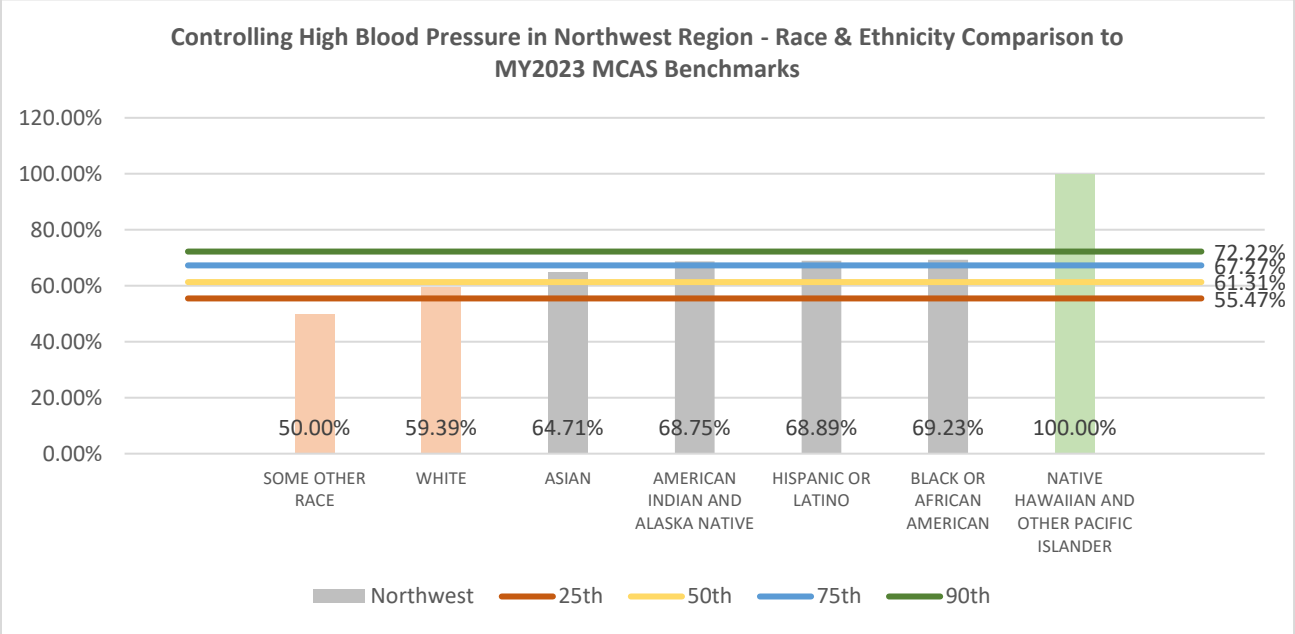
Race	Numerator	Denominator	Rate	Interpretation
WHITE	98	148	66%	
HISPANIC OR LATINO	90	135	67%	There is no statistically significant difference in rates between the WHITE population, (66.22%), and the `HISPANIC OR LATINO` population, (Rate =66.66%, Chi-Square=0.006, p=.9361)
AMERICAN INDIAN AND ALASKA NATIVE	1	2	50%	There is no statistically significant difference in rates between the WHITE population, (66.22%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =50.05%, Chi-Square=0.231, p=.6306)
ASIAN	10	14	71%	There is no statistically significant difference in rates between the WHITE population, (66.22%), and the `ASIAN` population, (Rate =71.39%, Chi-Square=0.222, p=.7758)
BLACK OR AFRICAN AMERICAN	5	8	62%	There is no statistically significant difference in rates between the WHITE population, (66.22%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =62.48%, Chi-Square=0.283, p=1.000)
SOME OTHER RACE	18	34	53%	There is no statistically significant difference in rates between the WHITE population, (66.22%), and the `SOME OTHER RACE` population, (Rate =52.91%, Chi-Square=2.108, p=.1465)

4. *Graph II*



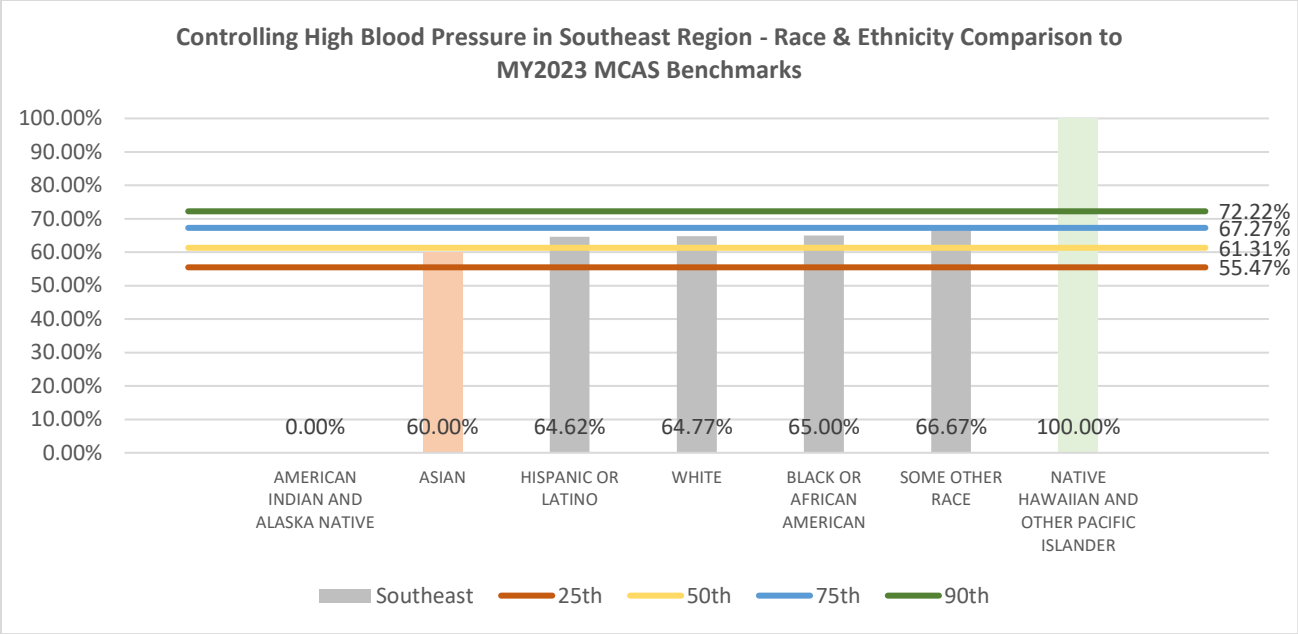
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

5. *Graph III*



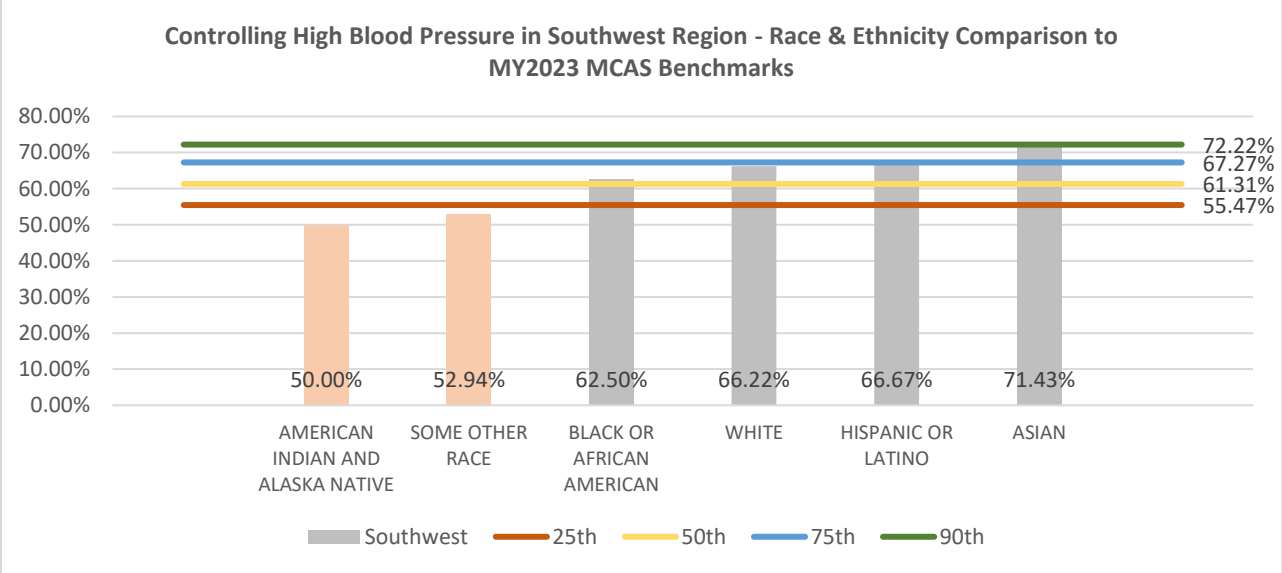
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

6. *Graph IV*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

7. *Graph V*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

8. *Table IV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) HPA Statistical Significance Results*

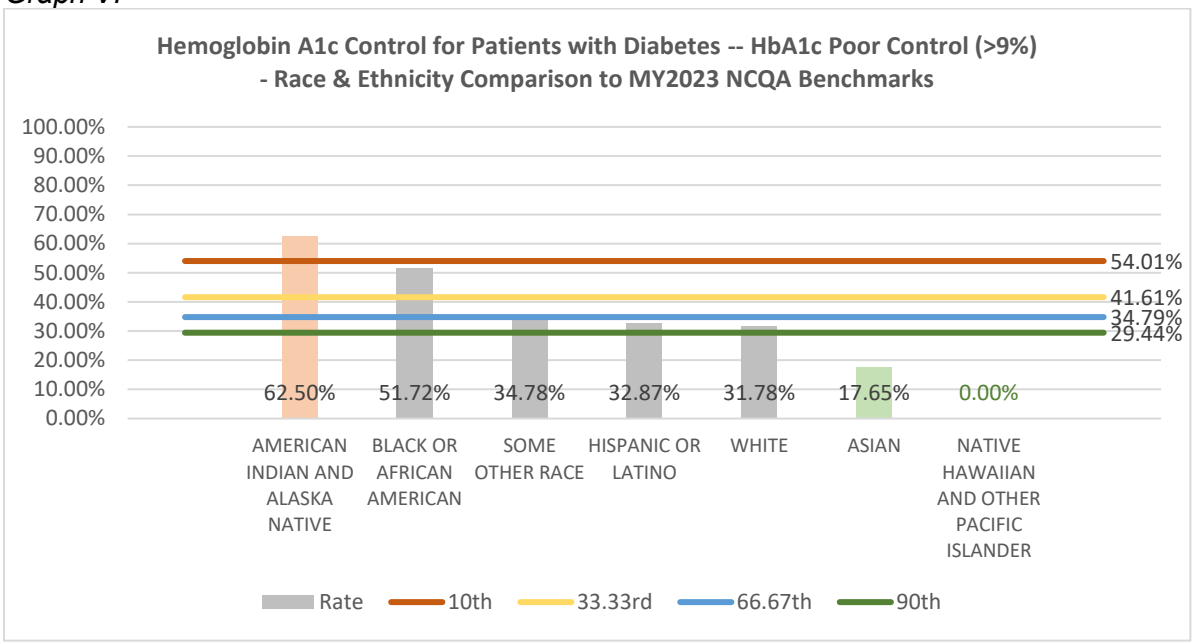
MY 2023, Run Date: 7/24/2024

Sample Size: 405

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Race	Numerator	Denominator	Rate	Interpretation
WHITE	41	129	32%	Reference
HISPANIC OR LATINO	47	143	33%	There is no statistically significant difference in rates between the WHITE population, (31.79%), and the `HISPANIC OR LATINO` population, (Rate =32.89%, Chi-Square=0.036, p=.8486)
AMERICAN INDIAN AND ALASKA NATIVE	5	8	62%	There is no statistically significant difference in rates between the WHITE population, (31.79%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =62.48%, Chi-Square=0.067, p=.1180)
ASIAN	6	34	18%	There is no statistically significant difference in rates between the WHITE population, (31.79%), and the `ASIAN` population, (Rate =17.60%, Chi-Square=2.620, p=.1055)
BLACK OR AFRICAN AMERICAN	15	29	52%	The WHITE population had a statistically significantly lower rate, (31.79%), compared to the `BLACK OR AFRICAN AMERICAN` population, (Rate =51.70%, Chi-Square=4.115, p=.0425)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	0	2	%	There is no statistically significant difference in rates between the WHITE population, (31.79%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =0.000%, Chi-Square=0.470, p=1.000)
SOME OTHER RACE	8	23	35%	There is no statistically significant difference in rates between the WHITE population, (31.79%), and the `SOME OTHER RACE` population, (Rate =34.76%, Chi-Square=0.080, p=.7768)

9. *Graph VI*



Note: Bars highlighted orange indicate a group had lowest percentile performance of all groups included in measure sample, and were only group to fall into the percentile. Bars highlighted green indicate groups performed above the 90th percentile.

The Native Hawaiian and Other Pacific Islander group had the lowest rate of HbA1c Poor Control, however the sample size (n=2) was too small for their performance to be

considered statistically significant using Fishers Exact. Therefore, the Asian population was the next group with a lower rate of HbA1c Poor Control (suggesting high rate of good control) when compared to the White population per the NCQA Health Plan Accreditation associated sample (n=405) (Table IV). The White population had a higher rate of poor control when compared to the Asian population, but the American Indian and Alaska Native population was the worst performing group. Specifically, the rate of poor control was 30% higher in the American Indian or Alaska Native population when compared to the White population, however, the sample size (n=8) was too small for their performance to be considered statistically significant. The only group with a statistically significant difference in compliance in comparison to the White group was the Black or African American group, with a rate of 51.72%. The Hispanic or Latino, White, and 'Some Other Race' groups performed above the 66.67th, While the Black or African American population performed at the 10th, and the American Indian and Alaska Native population performed below the 10th.

10. *Table V: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%)MCAS Statistical Significance Results*

    MY 2023, Run Date: 7/24/2024

    Sample Size: 1,352

    Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	94	238	39%	
HISPANIC OR LATINO	21	55	38%	There is no statistically significant difference in rates between the WHITE population, (39.49%), and the `HISPANIC OR LATINO` population, (Rate =38.17%, Chi-Square=0.032, p=.8573)
AMERICAN INDIAN AND ALASKA NATIVE	6	20	30%	There is no statistically significant difference in rates between the WHITE population, (39.49%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =30.03%, Chi-Square=0.701, p=.4025)
ASIAN	7	19	37%	There is no statistically significant difference in rates between the WHITE population, (39.49%), and the `ASIAN` population, (Rate =36.85%, Chi-Square=0.052, p=.8197)
BLACK OR AFRICAN AMERICAN	4	13	31%	There is no statistically significant difference in rates between the WHITE population, (39.49%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =30.80%, Chi-Square=0.394, p=.5300)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	0	1	%	There is no statistically significant difference in rates between the WHITE population, (39.49%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =0.000%, Chi-Square=0.607, p=1.000)
SOME OTHER RACE	0	4	%	There is no statistically significant difference in rates between the WHITE population, (39.49%), and the `SOME OTHER RACE` population, (Rate =0.000%, Chi-Square=0.138, p=.1596)

Northwest

Race	Numerator	Denominator	Rate	Interpretation
WHITE	58	198	29%	
HISPANIC OR LATINO	22	60	37%	There is no statistically significant difference in rates between the WHITE population, (29.26%), and the `HISPANIC OR LATINO` population, (Rate =36.63%, Chi-Square=1.170, p=.2793)
AMERICAN INDIAN AND ALASKA NATIVE	20	46	43%	There is no statistically significant difference in rates between the WHITE population, (29.26%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =43.45%, Chi-Square=3.454, p=.0631)

ASIAN	4	17	24%	There is no statistically significant difference in rates between the WHITE population, (29.26%), and the `ASIAN` population, (Rate =23.54%, Chi-Square=0.203, p=.7831)
BLACK OR AFRICAN AMERICAN	5	9	56%	There is no statistically significant difference in rates between the WHITE population, (29.26%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =55.55%, Chi-Square=0.075, p=.1346)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (29.26%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.297, p=.2965)
SOME OTHER RACE	2	4	50%	There is no statistically significant difference in rates between the WHITE population, (29.26%), and the `SOME OTHER RACE` population, (Rate =50.05%, Chi-Square=0.263, p=.5837)

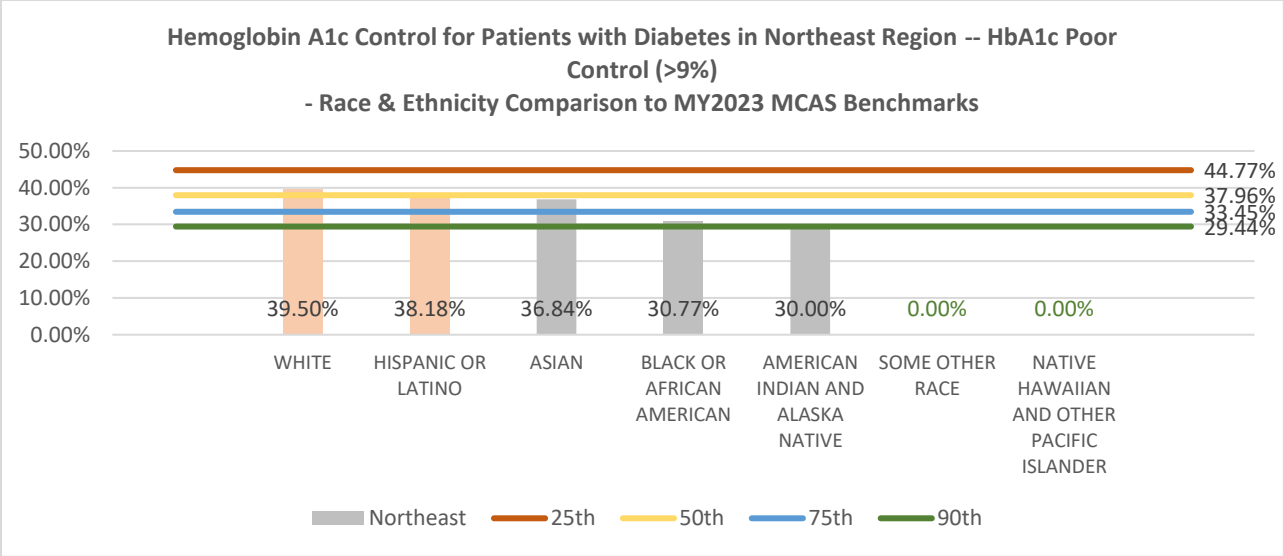
Southeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	23	69	33%	
HISPANIC OR LATINO	46	155	30%	There is no statistically significant difference in rates between the WHITE population, (33.33%), and the `HISPANIC OR LATINO` population, (Rate =29.70%, Chi-Square=0.299, p=.5843)
AMERICAN INDIAN AND ALASKA NATIVE	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (33.33%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =99.99%, Chi-Square=1.944, p=.1632)
ASIAN	11	62	18%	The WHITE population had a statistically significantly higher rate, (33.33%), compared to the `ASIAN` population, (Rate =17.71%, Chi-Square=4.131, p=.0421)
BLACK OR AFRICAN AMERICAN	14	32	44%	There is no statistically significant difference in rates between the WHITE population, (33.33%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =43.78%, Chi-Square=1.022, p=.3121)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (33.33%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.343, p=.3429)
SOME OTHER RACE	6	16	38%	There is no statistically significant difference in rates between the WHITE population, (33.33%), and the `SOME OTHER RACE` population, (Rate =37.51%, Chi-Square=0.100, p=.7514)

Southwest

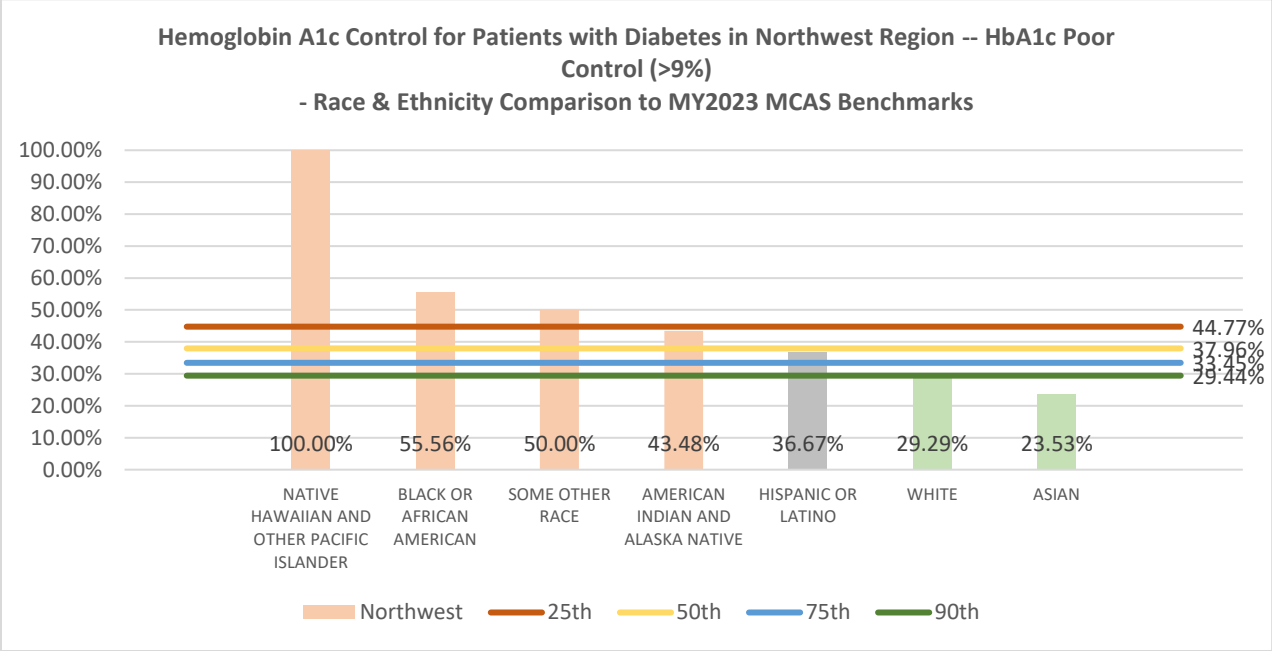
Race	Numerator	Denominator	Rate	Interpretation
WHITE	34	98	35%	
HISPANIC OR LATINO	49	166	29%	There is no statistically significant difference in rates between the WHITE population, (34.65%), and the `HISPANIC OR LATINO` population, (Rate =29.48%, Chi-Square=0.766, p=.3815)
AMERICAN INDIAN AND ALASKA NATIVE	7	10	70%	The WHITE population had a statistically significantly lower rate, (34.65%), compared to the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =69.96%, Chi-Square=4.803, p=.0284)
ASIAN	1	8	13%	There is no statistically significant difference in rates between the WHITE population, (34.65%), and the `ASIAN` population, (Rate =12.54%, Chi-Square=0.154, p=.2662)
BLACK OR AFRICAN AMERICAN	3	11	27%	There is no statistically significant difference in rates between the WHITE population, (34.65%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =27.28%, Chi-Square=0.242, p=.7464)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	0	1	%	There is no statistically significant difference in rates between the WHITE population, (34.65%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =0.000%, Chi-Square=0.657, p=1.000)
SOME OTHER RACE	13	37	35%	There is no statistically significant difference in rates between the WHITE population, (34.65%), and the `SOME OTHER RACE` population, (Rate =35.09%, Chi-Square=0.002, p=.9617)

11. *Graph VII*



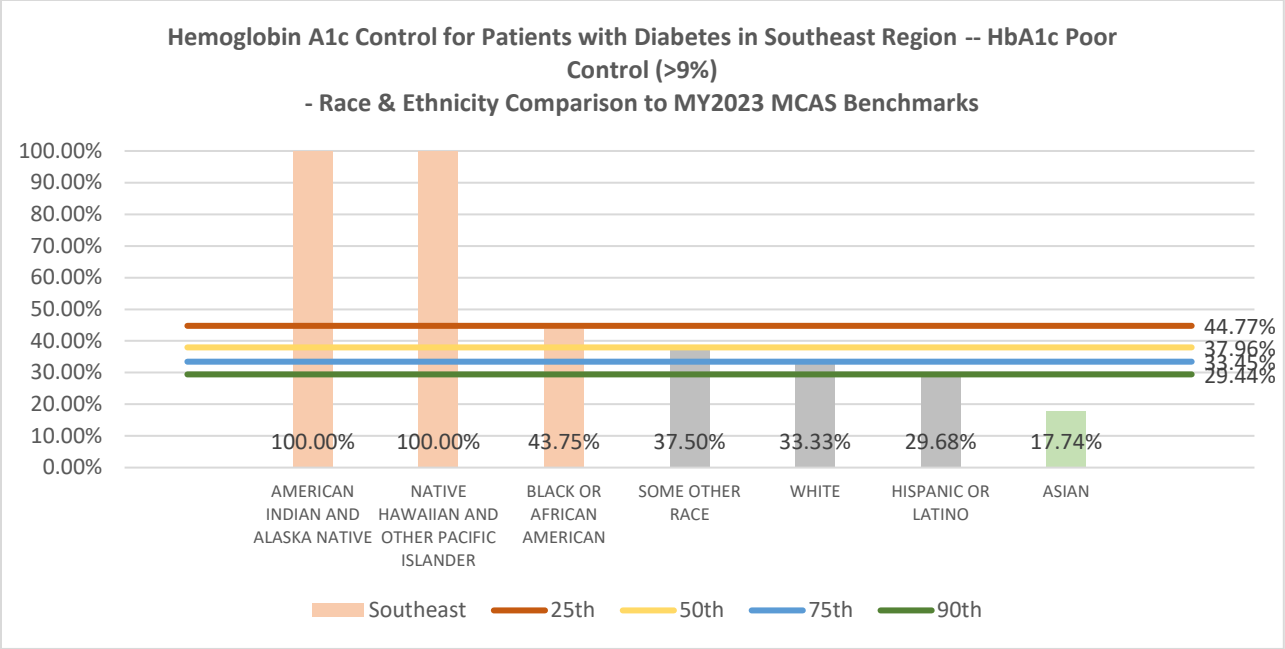
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

12. *Graph VIII*



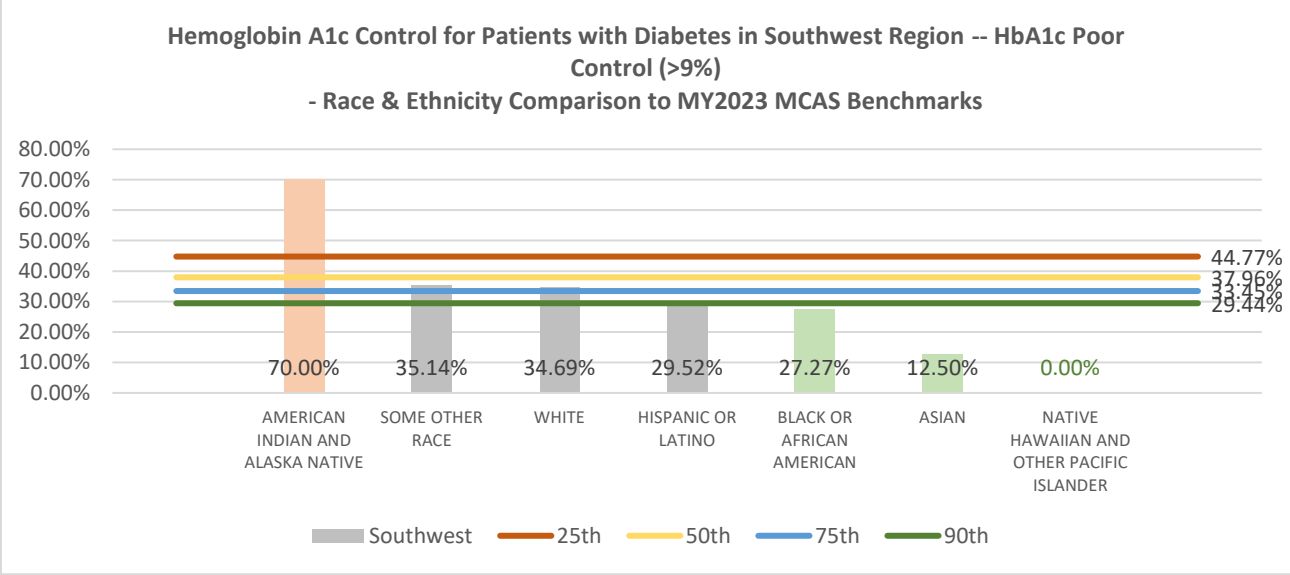
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

13. *Graph IX*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

14. *Graph X*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

15. *Table VI: Timeliness of Prenatal Care (PPC – Pre) HPA Statistical Significance Results*

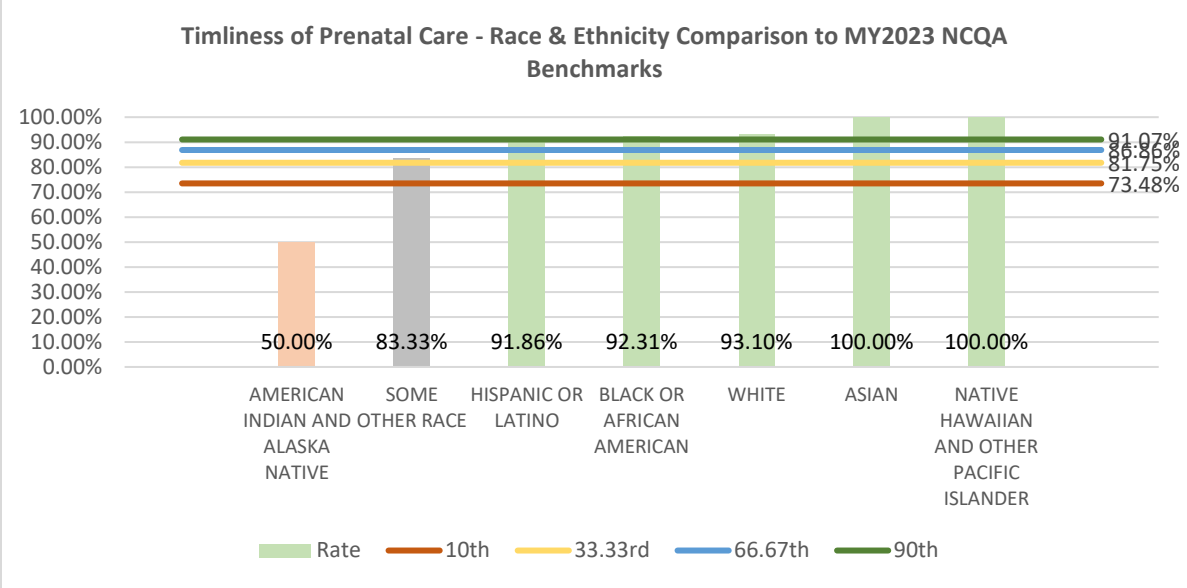
MY 2023, Run Date: 7/24/2024

Sample Size: 186

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Race	Numerator	Denominator	Rate	Interpretation
WHITE	54	58	93%	Reference
HISPANIC OR LATINO	79	86	92%	There is no statistically significant difference in rates between the WHITE population, (93.06%), and the `HISPANIC OR LATINO` population, (Rate =91.85%, Chi-Square=0.244, p=1.000)
AMERICAN INDIAN AND ALASKA NATIVE	4	8	50%	The WHITE population had a statistically significantly higher rate, (93.06%), compared to the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =50.05%, Chi-Square=0.005, p=.0055)
ASIAN	8	8	100%	There is no statistically significant difference in rates between the WHITE population, (93.06%), and the `ASIAN` population, (Rate =99.99%, Chi-Square=0.589, p=1.000)
BLACK OR AFRICAN AMERICAN	12	13	92%	There is no statistically significant difference in rates between the WHITE population, (93.06%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =92.29%, Chi-Square=0.424, p=1.000)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (93.06%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.932, p=1.000)
SOME OTHER RACE	10	12	83%	There is no statistically significant difference in rates between the WHITE population, (93.06%), and the `SOME OTHER RACE` population, (Rate =83.38%, Chi-Square=0.214, p=.2719)

16. *Graph XI*



Note: Bars highlighted orange indicate a group had lowest percentile performance of all groups included in measure sample, and were only group to fall into the percentile. Bars highlighted green indicate groups performed above the 90th percentile.

Partnership found the American Indian and Alaska Native group performed significantly worse when compared to the White group in PPC – Pre rates per the Health Plan Accreditation Timeliness of Prenatal Care sample (n=207) (Table VI). When comparing each group's performance to the NCQA benchmarks (Graph XI), all groups achieved at least the 33.33rd percentile or greater, except the American Indian and Alaska Native population (n=8). The Native Hawaiian and Other Pacific Islander and Asian populations had the highest rates, surpassing the 90th percentile with 100% compliance, indicating all members

included in the Health Plan Accreditation sample for this measure within these groups successfully completed a timely prenatal care visit during the measurement year.

17. *Table VII: Timeliness of Prenatal Care (PPC – Pre) MCAS Statistical Significance Results*

MY 2023, Run Date: 7/24/2024

Sample Size: 812

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	157	182	86%	
HISPANIC OR LATINO	49	58	84%	There is no statistically significant difference in rates between the WHITE population, (86.24%), and the `HISPANIC OR LATINO` population, (Rate =84.48%, Chi-Square=0.115, p=.7348)
AMERICAN INDIAN AND ALASKA NATIVE	6	8	75%	There is no statistically significant difference in rates between the WHITE population, (86.24%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =75.02%, Chi-Square=0.797, p=.3718)
ASIAN	7	9	78%	There is no statistically significant difference in rates between the WHITE population, (86.24%), and the `ASIAN` population, (Rate =77.77%, Chi-Square=0.254, p=.6173)
BLACK OR AFRICAN AMERICAN	3	4	75%	There is no statistically significant difference in rates between the WHITE population, (86.24%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =75.02%, Chi-Square=0.361, p=.4553)
SOME OTHER RACE	4	5	80%	There is no statistically significant difference in rates between the WHITE population, (86.24%), and the `SOME OTHER RACE` population, (Rate =79.97%, Chi-Square=0.388, p=.5311)

Northwest

Race	Numerator	Denominator	Rate	Interpretation
WHITE	92	115	80%	
HISPANIC OR LATINO	41	47	87%	There is no statistically significant difference in rates between the WHITE population, (79.97%), and the `HISPANIC OR LATINO` population, (Rate =87.23%, Chi-Square=1.188, p=.2757)
AMERICAN INDIAN AND ALASKA NATIVE	15	24	62%	There is no statistically significant difference in rates between the WHITE population, (79.97%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =62.48%, Chi-Square=3.431, p=.0640)
ASIAN	6	7	86%	There is no statistically significant difference in rates between the WHITE population, (79.97%), and the `ASIAN` population, (Rate =85.69%, Chi-Square=0.377, p=1.000)
BLACK OR AFRICAN AMERICAN	1	3	33%	There is no statistically significant difference in rates between the WHITE population, (79.97%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =33.33%, Chi-Square=0.105, p=.1131)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (79.97%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.802, p=1.000)
SOME OTHER RACE	3	4	75%	There is no statistically significant difference in rates between the WHITE population, (79.97%), and the `SOME OTHER RACE` population, (Rate =75.02%, Chi-Square=0.418, p=1.000)

Southeast

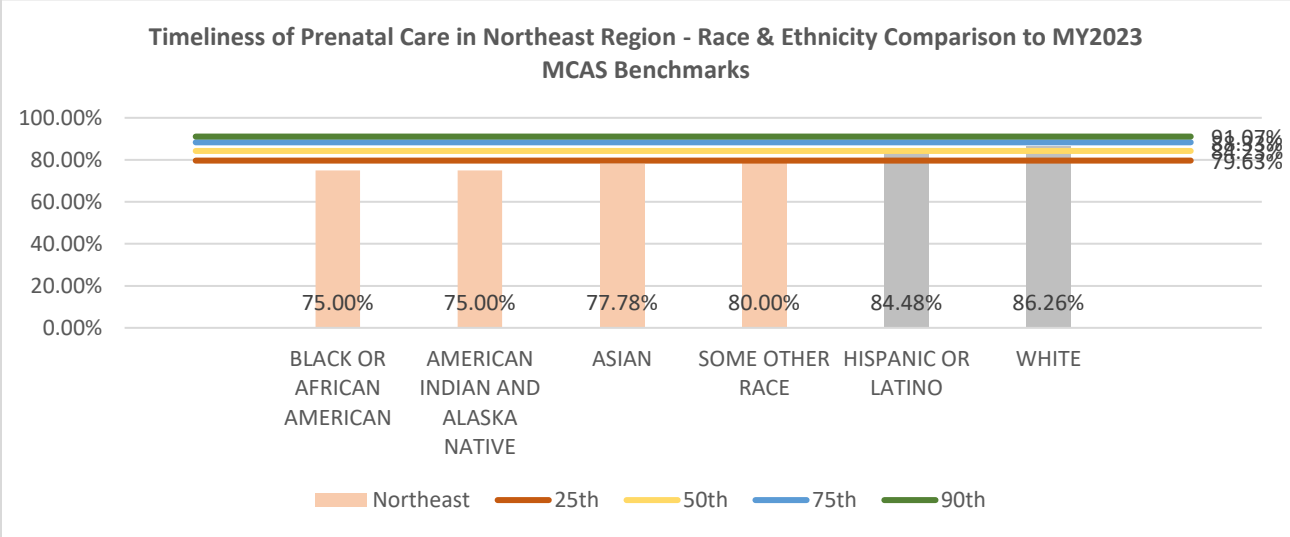
Race	Numerator	Denominator	Rate	Interpretation
WHITE	31	36	86%	

HISPANIC OR LATINO	110	123	89%	There is no statistically significant difference in rates between the WHITE population, (86.13%), and the `HISPANIC OR LATINO` population, (Rate =89.43%, Chi-Square=0.191, p=.5591)
ASIAN	16	16	100%	There is no statistically significant difference in rates between the WHITE population, (86.13%), and the `ASIAN` population, (Rate =99.99%, Chi-Square=0.145, p=.3077)
BLACK OR AFRICAN AMERICAN	22	25	88%	There is no statistically significant difference in rates between the WHITE population, (86.13%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =88.00%, Chi-Square=0.294, p=1.000)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	0	1	%	There is no statistically significant difference in rates between the WHITE population, (86.13%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =0.000%, Chi-Square=0.162, p=.1622)
SOME OTHER RACE	11	13	85%	There is no statistically significant difference in rates between the WHITE population, (86.13%), and the `SOME OTHER RACE` population, (Rate =84.59%, Chi-Square=0.342, p=1.000)

Southwest

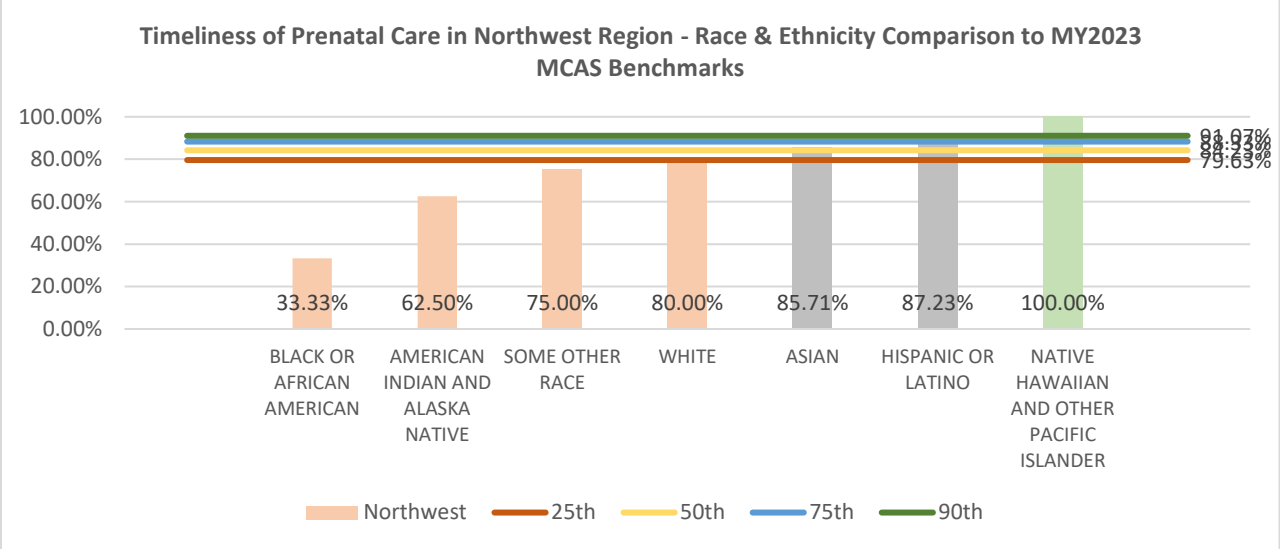
Race	Numerator	Denominator	Rate	Interpretation
WHITE	26	29	90%	
HISPANIC OR LATINO	76	80	95%	There is no statistically significant difference in rates between the WHITE population, (89.65%), and the `HISPANIC OR LATINO` population, (Rate =95.04%, Chi-Square=0.194, p=.3800)
AMERICAN INDIAN AND ALASKA NATIVE	2	4	50%	The WHITE population had a statistically significantly higher rate, (89.65%), compared to the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =50.05%, Chi-Square=4.300, p=.0381)
ASIAN	4	4	100%	There is no statistically significant difference in rates between the WHITE population, (89.65%), and the `ASIAN` population, (Rate =99.99%, Chi-Square=0.670, p=1.000)
BLACK OR AFRICAN AMERICAN	3	3	100%	There is no statistically significant difference in rates between the WHITE population, (89.65%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =99.99%, Chi-Square=0.737, p=1.000)
SOME OTHER RACE	11	11	100%	There is no statistically significant difference in rates between the WHITE population, (89.65%), and the `SOME OTHER RACE` population, (Rate =99.99%, Chi-Square=0.370, p=.5480)

18. *Graph XII*



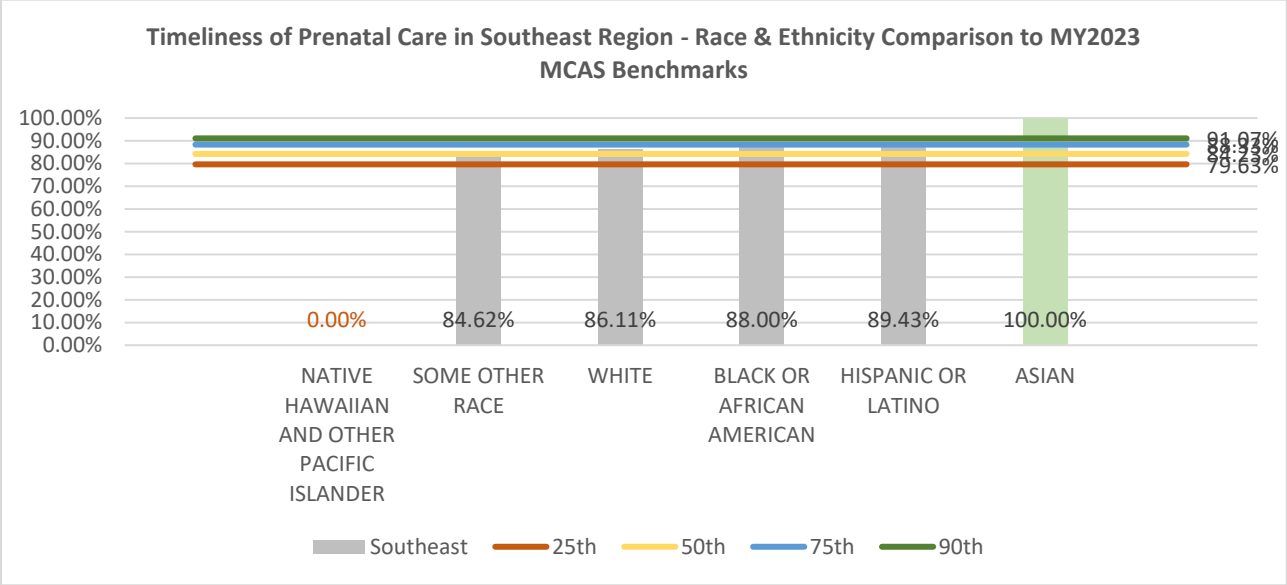
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

19. *Graph XIII*



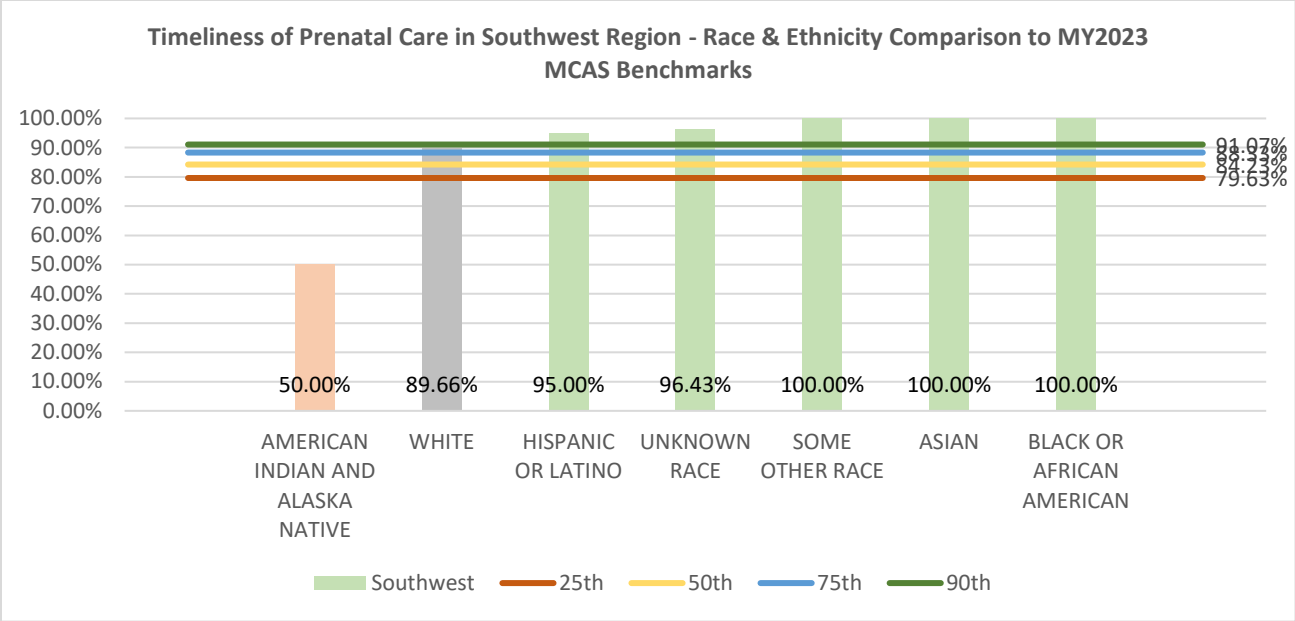
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

20. *Graph XIV*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

21. *Graph XV*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

22. *Table VII: Postpartum Care (PPC – Post) HPA Statistical Significance Results*

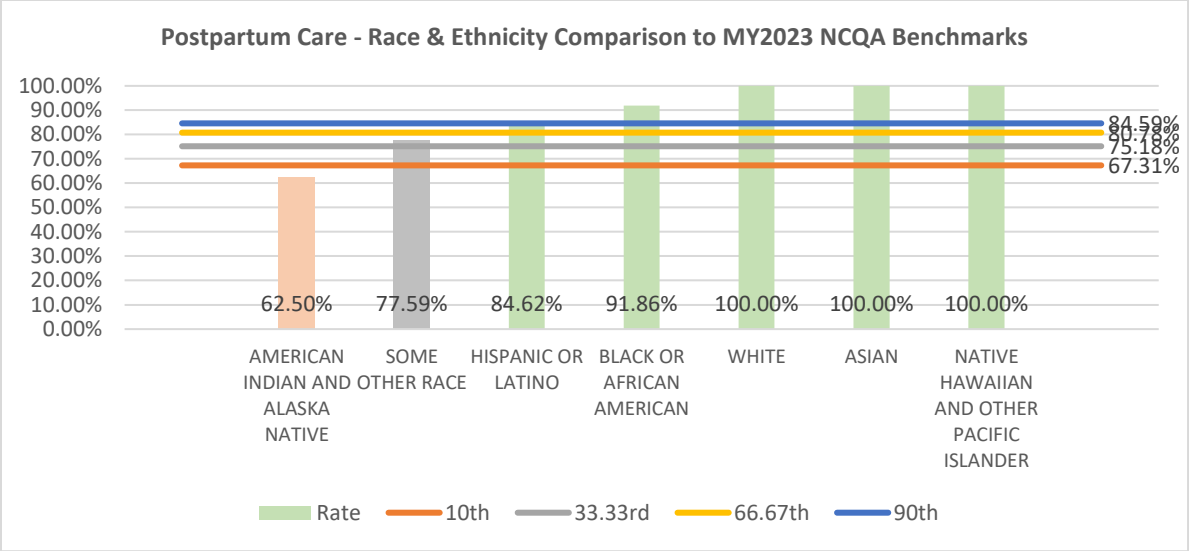
MY 2023, Run Date: 7/24/2024

Sample Size: 186

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Race	Numerator	Denominator	Rate	Interpretation
WHITE	45	58	78%	Reference
HISPANIC OR LATINO	79	86	92%	The WHITE population had a statistically significantly lower rate, (77.55%), compared to the `HISPANIC OR LATINO` population, (Rate =91.85%, Chi-Square=5.901, p=.0151)
AMERICAN INDIAN AND ALASKA NATIVE	5	8	62%	There is no statistically significant difference in rates between the WHITE population, (77.55%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =62.48%, Chi-Square=0.207,p=.3897)
ASIAN	8	8	100%	There is no statistically significant difference in rates between the WHITE population, (77.55%), and the `ASIAN` population, (Rate =99.99%, Chi-Square=0.154, p=.3393)
BLACK OR AFRICAN AMERICAN	11	13	85%	There is no statistically significant difference in rates between the WHITE population, (77.55%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =84.59%, Chi-Square=0.269, p=.7212)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (77.55%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.780, p=1.000)
SOME OTHER RACE	12	12	100%	There is no statistically significant difference in rates between the WHITE population, (77.55%), and the `SOME OTHER RACE` population, (Rate =99.99%, Chi-Square=0.067, p=.1050)

23. *Graph XVI*



Note: Bars highlighted orange indicate a group had lowest percentile performance of all groups included in measure sample, and were only group to fall into the percentile. Bars highlighted green indicate groups performed above the 90th percentile.

Researchers found no group performed statistically significantly worse than the White group, although the Hispanic or Latino group performed significantly better than the White population in Postpartum care rates in the Health Plan Accreditation Postpartum Care sample (n=207) (Table VIII). When comparing groups to the NCQA benchmarks (Graph XVI), only the American Indian and Alaska Native and 'Some Other Race' groups did not surpass the 90th percentile benchmark as all other groups, with the American Indian and Alaska Native being the only group below the 10th.

24. *Table VIV: Postpartum Care (PPC – Post) MCAS Statistical Significance Results*

MY 2023, Run Date: 7/24/2024

Sample Size: 812

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	145	182	80%	
HISPANIC OR LATINO	50	58	86%	There is no statistically significant difference in rates between the WHITE population, (79.64%), and the `HISPANIC OR LATINO` population, (Rate =86.24%, Chi-Square=1.234, p=.2667)
AMERICAN INDIAN AND ALASKA NATIVE	4	8	50%	The WHITE population had a statistically significantly higher rate, (79.64%), compared to the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =50.05%, Chi-Square=3.986, p=.0459)
ASIAN	7	9	78%	There is no statistically significant difference in rates between the WHITE population, (79.64%), and the `ASIAN` population, (Rate =77.77%, Chi-Square=0.311, p=1.000)
BLACK OR AFRICAN AMERICAN	4	4	100%	There is no statistically significant difference in rates between the WHITE population, (79.64%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =99.99%, Chi-Square=0.409, p=.5859)

SOME OTHER RACE	5	5	100%	There is no statistically significant difference in rates between the WHITE population, (79.64%), and the `SOME OTHER RACE` population, (Rate =99.99%, Chi-Square=0.328, p=.5848)

Northwest

Race	Numerator	Denominator	Rate	Interpretation
WHITE	94	115	82%	
HISPANIC OR LATINO	41	47	87%	There is no statistically significant difference in rates between the WHITE population, (81.73%), and the `HISPANIC OR LATINO` population, (Rate =87.23%, Chi-Square=0.725, p=.3944)
AMERICAN INDIAN AND ALASKA NATIVE	18	24	75%	There is no statistically significant difference in rates between the WHITE population, (81.73%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =75.02%, Chi-Square=0.576, p=.4478)
ASIAN	5	7	71%	There is no statistically significant difference in rates between the WHITE population, (81.73%), and the `ASIAN` population, (Rate =71.39%, Chi-Square=0.270, p=.6152)
BLACK OR AFRICAN AMERICAN	3	3	100%	There is no statistically significant difference in rates between the WHITE population, (81.73%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =99.99%, Chi-Square=0.552, p=1.000)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (81.73%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.819, p=1.000)
SOME OTHER RACE	4	4	100%	There is no statistically significant difference in rates between the WHITE population, (81.73%), and the `SOME OTHER RACE` population, (Rate =99.99%, Chi-Square=0.455, p=1.000)

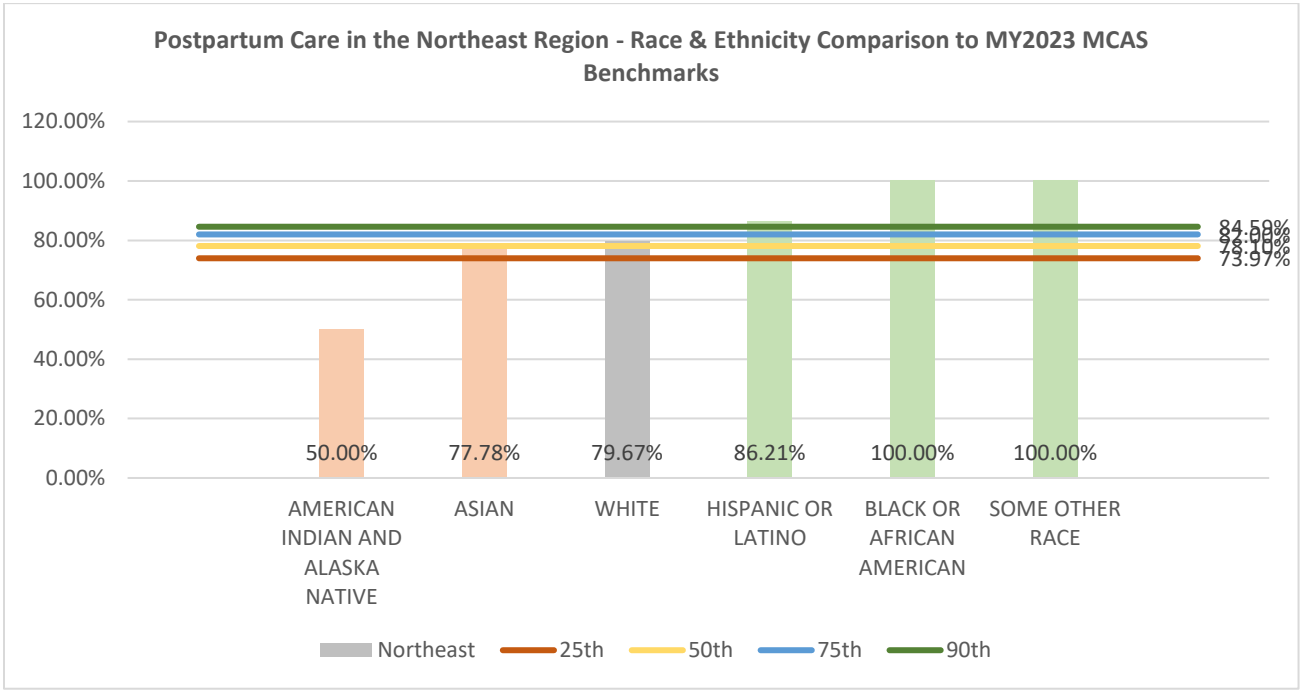
Southeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	30	36	83%	
HISPANIC OR LATINO	111	123	90%	There is no statistically significant difference in rates between the WHITE population, (83.38%), and the `HISPANIC OR LATINO` population, (Rate =90.20%, Chi-Square=0.116, p=.2452)
ASIAN	15	16	94%	There is no statistically significant difference in rates between the WHITE population, (83.38%), and the `ASIAN` population, (Rate =93.72%, Chi-Square=0.233, p=.4153)
BLACK OR AFRICAN AMERICAN	22	25	88%	There is no statistically significant difference in rates between the WHITE population, (83.38%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =88.00%, Chi-Square=0.258, p=.7250)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (83.38%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.838, p=1.000)
SOME OTHER RACE	10	13	77%	There is no statistically significant difference in rates between the WHITE population, (83.38%), and the `SOME OTHER RACE` population, (Rate =76.89%, Chi-Square=0.271, p=.6831)

Southwest

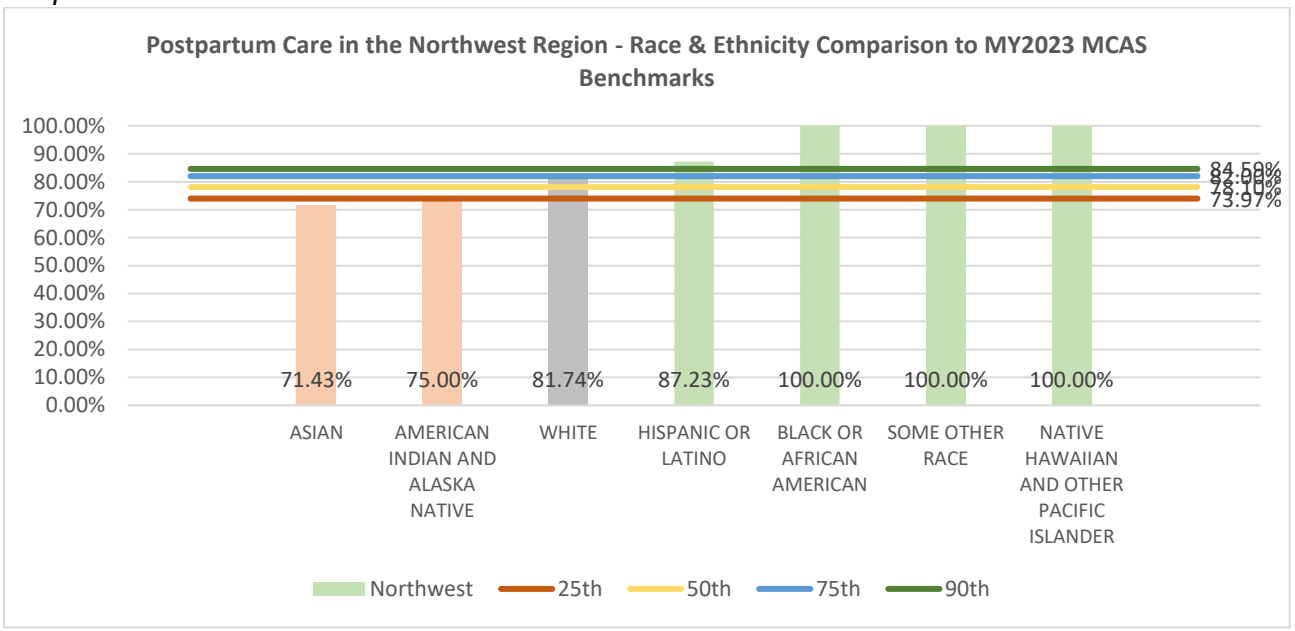
Race	Numerator	Denominator	Rate	Interpretation
WHITE	24	29	83%	
HISPANIC OR LATINO	79	80	99%	The WHITE population had a statistically significantly lower rate, (82.72%), compared to the `HISPANIC OR LATINO` population, (Rate =98.78%, Chi-Square=0.005, p=.0049)
AMERICAN INDIAN AND ALASKA NATIVE	3	4	75%	There is no statistically significant difference in rates between the WHITE population, (82.72%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =75.02%, Chi-Square=0.142, p=.7061)
ASIAN	4	4	100%	There is no statistically significant difference in rates between the WHITE population, (82.72%), and the `ASIAN` population, (Rate =99.99%, Chi-Square=0.500, p=1.000)
BLACK OR AFRICAN AMERICAN	3	3	100%	There is no statistically significant difference in rates between the WHITE population, (82.72%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =99.99%, Chi-Square=0.590, p=1.000)
SOME OTHER RACE	10	11	91%	There is no statistically significant difference in rates between the WHITE population, (82.72%), and the `SOME OTHER RACE` population, (Rate =90.86%, Chi-Square=0.340, p=1.000)

25. *Graph XVII*



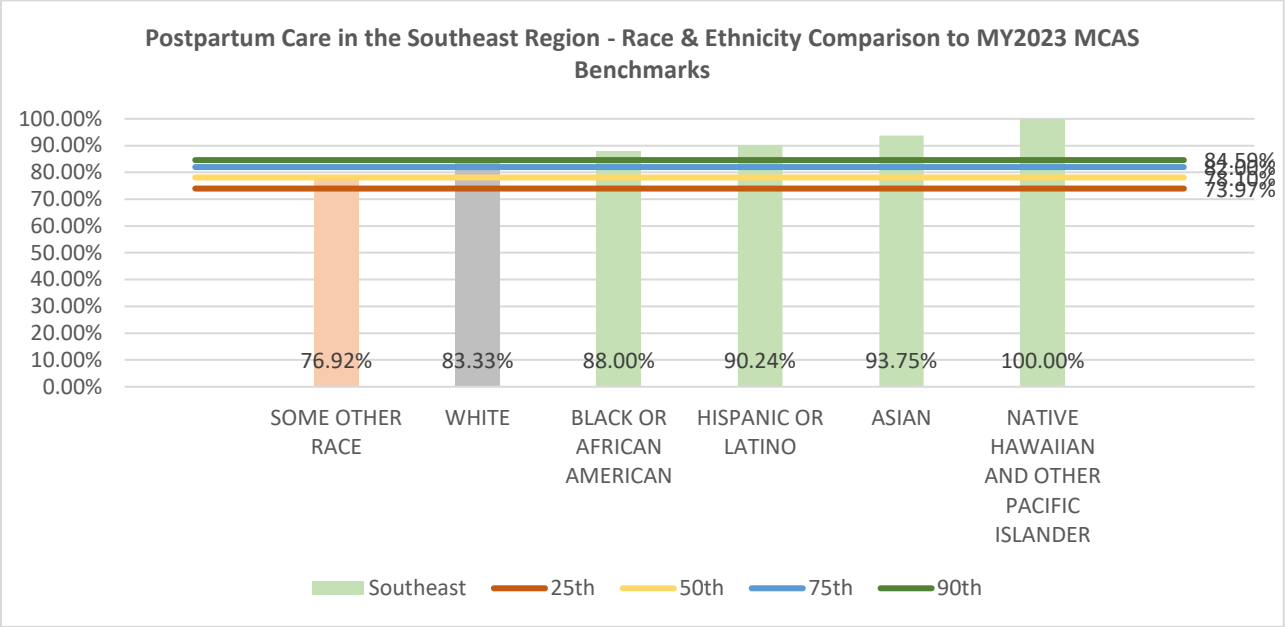
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

26. *Graph XVIII*



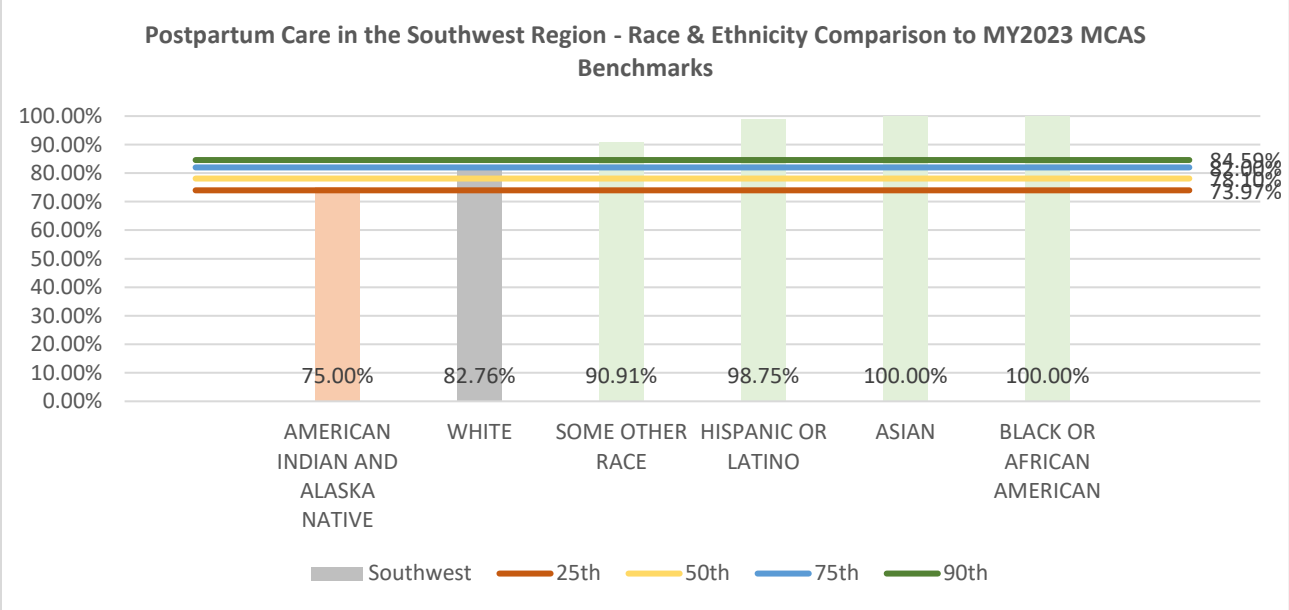
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

27. *Graph XIX*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

28. *Graph XX*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

29. *Table VIV: Child and Adolescent Well Care Visits (WCV) HPA Statistical Significance Results*

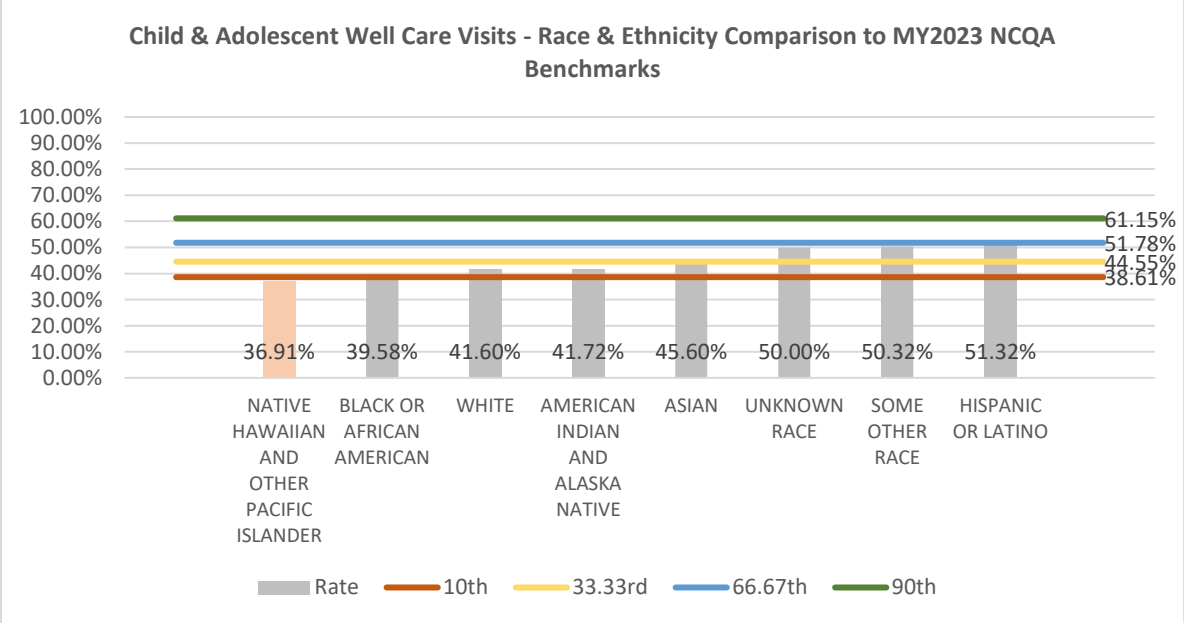
MY 2023, Run Date: 7/24/2024

Sample Size: 167,450

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Race	Numerator	Denominator	Rate	Interpretation
WHITE	22119	53167	42%	Reference
HISPANIC OR LATINO	44145	86027	51%	The WHITE population had a statistically significantly lower rate, (41.58%), compared to the `HISPANIC OR LATINO` population, (Rate =51.37%, Chi-Square=1242.7, p=.0000)
AMERICAN INDIAN AND ALASKA NATIVE	1853	4442	42%	There is no statistically significant difference in rates between the WHITE population, (41.58%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =41.69%, Chi Square=0.021, p=.8837)
ASIAN	2998	6574	46%	The WHITE population had a statistically significantly lower rate, (41.58%), compared to the `ASIAN` population, (Rate =45.65%, Chi-Square=38.436, p=.0000)
BLACK OR AFRICAN AMERICAN	3256	8226	40%	The WHITE population had a statistically significantly higher rate, (41.58%), compared to the `BLACK OR AFRICAN AMERICAN` population, (Rate =39.60%, Chi-Square=12.000, p=.0005)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	148	401	37%	There is no statistically significant difference in rates between the WHITE population, (41.58%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =36.96%, Chi-Square=3.612, p=.0574)
SOME OTHER RACE	4334	8613	50%	The WHITE population had a statistically significantly lower rate, (41.58%), compared to the `SOME OTHER RACE` population, (Rate =50.27%, Chi-Square=230.01, p=.0000)

30. *Graph XXI*



Note: Bars highlighted orange indicate a group had lowest percentile performance of all groups included in measure sample, and were only group to fall into the percentile. Bars highlighted green indicate groups performed above the 90th percentile

The Hispanic/Latino, Asian, and 'Some Other Race' groups had a significantly higher rate of Child and Adolescent Well Care Visits (WCV) completions when compared to the White population per the HPA sample. Specifically, the Hispanic/Latino group had the highest rate

of completion with a rate of 51.32%. The Black/African American had a statistically significantly lower rate of completed WCV in comparison to the White group, and numerically had the lowest rate of completion. They were also the only group below the 10th percentile (Graph XXI) (n=167,450) (Table X).

31. *Table VIV: Child and Adolescent Well Care Visits (WCV) MCAS Statistical Significance Results*

    MY 2023, Run Date: 7/24/2024

    Sample Size: 167,450

    Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	7084	18461	38%	
HISPANIC OR LATINO	2245	4986	45%	The WHITE population had a statistically significantly lower rate, (38.39%), compared to the `HISPANIC OR LATINO` population, (Rate=44.99%, Chi-Square=72.537, p=.0000)
AMERICAN INDIAN AND ALASKA NATIVE	441	1079	41%	There is no statistically significant difference in rates between the WHITE population, (38.39%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =40.92%, Chi-Square=2.687, p=.1012)
ASIAN	398	926	43%	The WHITE population had a statistically significantly lower rate, (38.39%), compared to the `ASIAN` population, (Rate =43.01%, Chi-Square=7.900, p=.0049)
BLACK OR AFRICAN AMERICAN	160	428	37%	There is no statistically significant difference in rates between the WHITE population, (38.39%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =37.40%, Chi-Square=0.173, p=.6772)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	9	33	27%	There is no statistically significant difference in rates between the WHITE population, (38.39%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =27.28%, Chi-Square=1.717, p=.1901)
SOME OTHER RACE	237	498	48%	The WHITE population had a statistically significantly lower rate, (38.39%), compared to the `SOME OTHER RACE` population, (Rate =47.63%, Chi-Square=17.381, p=.0000)

Northwest

Race	Numerator	Denominator	Rate	Interpretation
WHITE	4261	9519	45%	
HISPANIC OR LATINO	1919	3733	51%	The WHITE population had a statistically significantly lower rate, (44.77%), compared to the `HISPANIC OR LATINO` population, (Rate=51.37%, Chi-Square=47.551, p=.0000)
AMERICAN INDIAN AND ALASKA NATIVE	779	1813	43%	There is no statistically significant difference in rates between the WHITE population, (44.77%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =43.01%, Chi-Square=1.988, p=.1585)
ASIAN	257	552	47%	There is no statistically significant difference in rates between the WHITE population, (44.77%), and the `ASIAN` population, (Rate =46.53%, Chi-Square=0.680, p=.4098)
BLACK OR AFRICAN AMERICAN	103	224	46%	There is no statistically significant difference in rates between the WHITE population, (44.77%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =45.98%, Chi-Square=0.132, p=.7169)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	12	30	40%	There is no statistically significant difference in rates between the WHITE population, (44.77%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =40.04%, Chi-Square=0.274, p=.6004)
SOME OTHER RACE	158	315	50%	There is no statistically significant difference in rates between the WHITE population, (44.77%), and the `SOME OTHER RACE` population, (Rate =50.16%, Chi-Square=3.588, p=.0582)

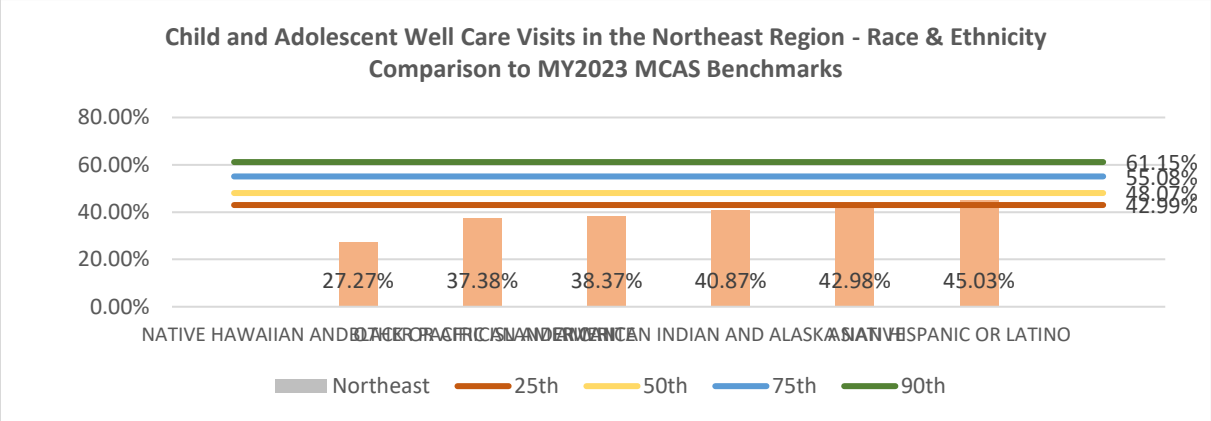
Southeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	3327	7949	42%	
HISPANIC OR LATINO	17716	34611	51%	The WHITE population had a statistically significantly lower rate, (41.80%), compared to the `HISPANIC OR LATINO` population, (Rate=51.15%, Chi-Square=225.20, p=.0000)
AMERICAN INDIAN AND ALASKA NATIVE	79	178	44%	There is no statistically significant difference in rates between the WHITE population, (41.80%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =44.33%, Chi-Square=0.457, p=.4991)
ASIAN	1760	3809	46%	The WHITE population had a statistically significantly lower rate, (41.80%), compared to the `ASIAN` population, (Rate =46.20%, Chi-Square=19.870, p=.0000)
BLACK OR AFRICAN AMERICAN	2508	6469	39%	The WHITE population had a statistically significantly higher rate, (41.80%), compared to the `BLACK OR AFRICAN AMERICAN` population, (Rate =38.72%, Chi-Square=14.087, p=.0002)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	86	249	35%	The WHITE population had a statistically significantly higher rate, (41.80%), compared to the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =34.54%, Chi-Square=5.318, p=.0211)
SOME OTHER RACE	1526	3094	49%	The WHITE population had a statistically significantly lower rate, (41.80%), compared to the `SOME OTHER RACE` population, (Rate=49.28%, Chi-Square=50.409, p=.0000)

Southwest

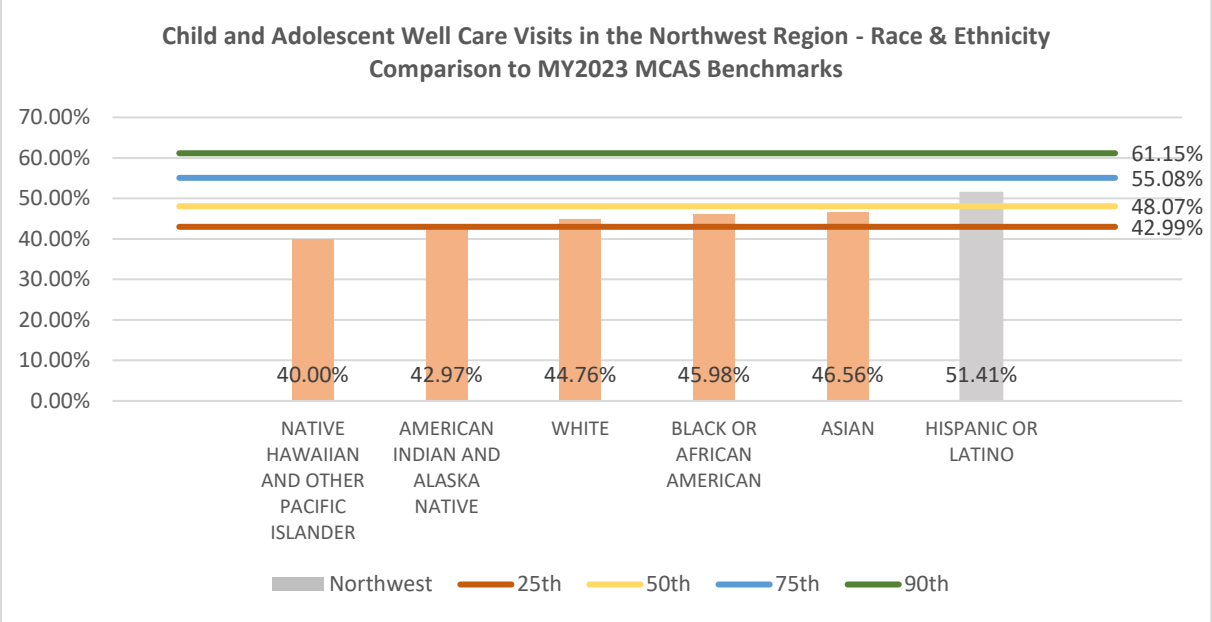
Race	Numerator	Denominator	Rate	Interpretation
WHITE	7447	17238	43%	
HISPANIC OR LATINO	22265	42697	52%	The WHITE population had a statistically significantly lower rate, (43.23%), compared to the `HISPANIC OR LATINO` population, (Rate=52.14%, Chi-Square=393.10, p=.0000)
AMERICAN INDIAN AND ALASKA NATIVE	554	1372	40%	The WHITE population had a statistically significantly higher rate, (43.23%), compared to the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =40.37%, Chi-Square=4.130, p=.0421)
ASIAN	583	1287	45%	There is no statistically significant difference in rates between the WHITE population, (43.23%), and the `ASIAN` population, (Rate =45.32%, Chi-Square=2.147, p=.1429)
BLACK OR AFRICAN AMERICAN	485	1105	44%	There is no statistically significant difference in rates between the WHITE population, (43.23%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =43.89%, Chi-Square=0.202, p=.6534)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	41	89	46%	There is no statistically significant difference in rates between the WHITE population, (43.23%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =46.09%, Chi-Square=0.296, p=.5861)
SOME OTHER RACE	2413	4706	51%	The WHITE population had a statistically significantly lower rate, (43.23%), compared to the `SOME OTHER RACE` population, (Rate=51.26%, Chi-Square=97.394, p=.0000)

32. *Graph XXII*



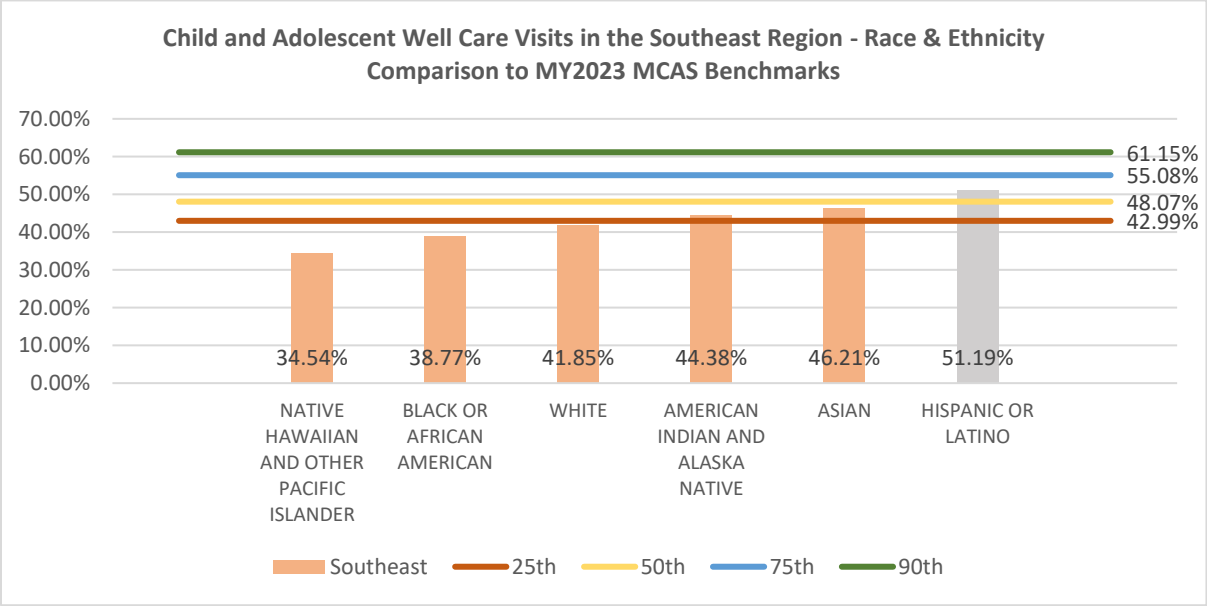
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

33. *Graph XXIII*



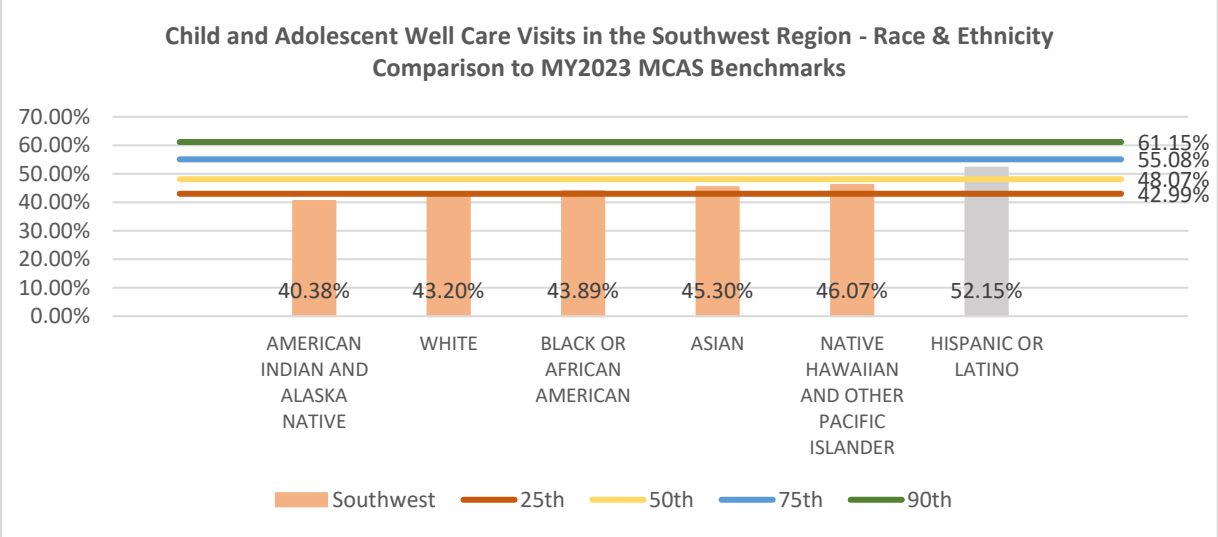
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

34. *Graph XXIV*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

35. *Graph XXV*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

36. *Table XII: Controlling High Blood Pressure (CBP) Language HPA Statistical Significance Testing*

Sample Size: 392

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	204	289	71%	Reference
SPANISH	70	95	74%	There is no statistically significant difference in rates between the ENGLISH population, (70.62%), and the `SPANISH` population, (Rate=73.70%, Chi-Square=0.335, p=.5626)
TAGALOG	3	6	50%	There is no statistically significant difference in rates between the ENGLISH population, (70.62%), and the `TAGALOG` population, (Rate=50.05%, Chi-Square=0.184, p=.3677)
RUSSIAN	1	2	50%	There is no statistically significant difference in rates between the ENGLISH population, (70.62%), and the `RUSSIAN` population, (Rate=50.05%, Chi-Square=0.418, p=.5044)

37. *Table XIII: Controlling High Blood Pressure (CBP) Language MCAS Statistical Significance Testing*

Sample Size: 1,489

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	223	359	62%	
SPANISH	10	18	56%	There is no statistically significant difference in rates between the ENGLISH population, (62.15%), and the `SPANISH` population, (Rate=55.55%, Chi-Square=0.313, p=.5761)

Northwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	234	366	64%	
SPANISH	6	12	50%	There is no statistically significant difference in rates between the ENGLISH population, (63.91%), and the `SPANISH` population, (Rate=50.05%, Chi-Square=0.144, p=.3675)

Southeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	166	265	63%	
SPANISH	66	98	67%	There is no statistically significant difference in rates between the ENGLISH population, (62.59%), and the `SPANISH` population, (Rate=67.32%, Chi-Square=0.687, p=.4073)
TAGALOG	6	11	55%	There is no statistically significant difference in rates between the ENGLISH population, (62.59%), and the `TAGALOG` population, (Rate=54.56%, Chi-Square=0.209, p=.7523)
RUSSIAN	3	5	60%	There is no statistically significant difference in rates between the ENGLISH population, (62.59%), and the `RUSSIAN` population, (Rate=59.95%, Chi-Square=0.346, p=1.000)

Southwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	150	237	63%	
SPANISH	76	116	66%	There is no statistically significant difference in rates between the ENGLISH population, (63.25%), and the `SPANISH` population, (Rate=65.56%, Chi-Square=0.168, p=.6823)
TAGALOG	1	2	50%	There is no statistically significant difference in rates between the ENGLISH population, (63.25%), and the `TAGALOG` population, (Rate=50.05%, Chi-Square=0.467, p=1.000)

38. *Table XIV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Language HPA Statistical Significance Testing*

    Sample Size: 394

    Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	97	276	35%	Reference
SPANISH	34	114	30%	There is no statistically significant difference in rates between the ENGLISH population, (35.09%), and the `SPANISH` population, (Rate=29.81%, Chi-Square=1.024, p=.3116)
TAGALOG	0	2	%	There is no statistically significant difference in rates between the ENGLISH population, (35.09%), and the `TAGALOG` population, (Rate=0.000%, Chi-Square=0.423, p=.5440)
RUSSIAN	2	2	100%	There is no statistically significant difference in rates between the ENGLISH population, (35.09%), and the `RUSSIAN` population, (Rate=99.99%, Chi-Square=0.126, p=.1260)

39. *Table XV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Language MCAS Statistical Significance Testing*

Sample Size: 1,441

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	138	338	41%	
SPANISH	4	21	19%	The ENGLISH population had a statistically significantly higher rate, (40.81%), compared to the `SPANISH` population, (Rate =19.03%, Chi-Square=3.923, p=.0476)

Northwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	116	346	34%	
SPANISH	5	14	36%	There is no statistically significant difference in rates between the ENGLISH population, (33.55%), and the `SPANISH` population, (Rate =35.75%, Chi-Square=0.220, p=1.000)

Southeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	87	248	35%	
SPANISH	29	112	26%	There is no statistically significant difference in rates between the ENGLISH population, (35.09%), and the `SPANISH` population, (Rate =25.85%, Chi-Square=2.982, p=.0842)
TAGALOG	0	7	%	There is no statistically significant difference in rates between the ENGLISH population, (35.09%), and the `TAGALOG` population, (Rate =0.000%, Chi-Square=0.052, p=.0991)
RUSSIAN	0	1	%	There is no statistically significant difference in rates between the ENGLISH population, (35.09%), and the `RUSSIAN` population, (Rate =0.000%, Chi-Square=0.651, p=1.000)

Southwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	82	214	38%	
SPANISH	36	139	26%	The ENGLISH population had a statistically significantly higher rate, (38.28%), compared to the `SPANISH` population, (Rate =25.85%, Chi-Square=5.840, p=.0157)
TAGALOG	1	1	100%	There is no statistically significant difference in rates between the ENGLISH population, (38.28%), and the `TAGALOG` population, (Rate =99.99%, Chi-Square=0.386, p=.3860)

40. *Table XVI: Timeliness of Prenatal Care (PPC – Pre) Language HPA Statistical Significance Testing*

Sample Size: 205

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	143	158	91%	Reference
SPANISH	42	47	89%	There is no statistically significant difference in rates between the ENGLISH population, (90.53%), and the `SPANISH` population, (Rate=89.32%, Chi-Square=0.208, p=.7837)

41. *Table XVII: Timeliness of Prenatal Care (PPC – Pre) Language MCAS Statistical Significance Testing*

Sample Size: 885

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	224	265	84%	
SPANISH	12	12	100%	There is no statistically significant difference in rates between the ENGLISH population, (84.48%), and the `SPANISH` population, (Rate =99.99%, Chi-Square=0.140, p=.2243)

Northwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	163	208	78%	
SPANISH	8	9	89%	There is no statistically significant difference in rates between the ENGLISH population, (78.32%), and the `SPANISH` population, (Rate =88.88%, Chi-Square=0.284, p=.6880)

Southeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	159	177	90%	
SPANISH	44	52	85%	There is no statistically significant difference in rates between the ENGLISH population, (89.87%), and the `SPANISH` population, (Rate =84.59%, Chi-Square=1.086, p=.2973)
TAGALOG	1	1	100%	There is no statistically significant difference in rates between the ENGLISH population, (89.87%), and the `TAGALOG` population, (Rate =99.99%, Chi-Square=0.899, p=1.000)
RUSSIAN	2	2	100%	There is no statistically significant difference in rates between the ENGLISH population, (89.87%), and the `RUSSIAN` population, (Rate =99.99%, Chi-Square=0.809, p=1.000)

Southwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	100	108	93%	
SPANISH	48	50	96%	There is no statistically significant difference in rates between the ENGLISH population, (92.62%), and the `SPANISH` population, (Rate =96.03%, Chi-Square=0.216, p=.5059)
RUSSIAN	1	1	100%	There is no statistically significant difference in rates between the ENGLISH population, (92.62%), and the `RUSSIAN` population, (Rate =99.99%, Chi-Square=0.927, p=1.000)

42. *Table XVIII: Postpartum Care (PPC – Post) Language HPA Statistical Significance Testing*

Sample Size: 205

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Language	Numerator	Denominator	Rate	Interpretation

ENGLISH	134	158	85%	Reference
SPANISH	44	47	94%	There is no statistically significant difference in rates between the ENGLISH population, (84.81%), and the `SPANISH` population, (Rate=93.61%, Chi-Square=2.457, p=.1170)

43. *Table XIX: Postpartum Care (PPC – Post) Language MCAS Statistical Significance Testing*

Sample Size: 885

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	213	265	80%	
SPANISH	12	12	100%	There is no statistically significant difference in rates between the ENGLISH population, (80.41%), and the `SPANISH` population, (Rate=99.99%, Chi-Square=0.078, p=.1312)

Notheast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	169	208	81%	
SPANISH	9	9	100%	There is no statistically significant difference in rates between the ENGLISH population, (81.29%), and the `SPANISH` population, (Rate=99.99%, Chi-Square=0.162, p=.3684)

Southeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	154	177	87%	
SPANISH	46	52	88%	There is no statistically significant difference in rates between the ENGLISH population, (87.01%), and the `SPANISH` population, (Rate=88.44%, Chi-Square=0.077, p=.7814)
TAGALOG	1	1	100%	There is no statistically significant difference in rates between the ENGLISH population, (87.01%), and the `TAGALOG` population, (Rate=99.99%, Chi-Square=0.871, p=1.000)
RUSSIAN	2	2	100%	There is no statistically significant difference in rates between the ENGLISH population, (87.01%), and the `RUSSIAN` population, (Rate=99.99%, Chi-Square=0.759, p=1.000)

Southwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	98	108	91%	
SPANISH	50	50	100%	The ENGLISH population had a statistically significantly lower rate, (90.75%), compared to the `SPANISH` population, (Rate =99.99%, Chi-Square=0.019, p=.0313)
RUSSIAN	1	1	100%	There is no statistically significant difference in rates between the ENGLISH population, (90.75%), and the `RUSSIAN` population, (Rate=99.99%, Chi-Square=0.908, p=1.000)

44. *Table XX: Child and Adolescent Well Care Visits (WCV) Language HPA Statistical Significance Testing*

Sample Size: 187,458

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	59368	131999	45%	Reference
SPANISH	28864	54051	53%	The ENGLISH population had a statistically significantly lower rate, (44.99%), compared to the `SPANISH` population, (Rate =53.35%, Chi-Square=1091.8, p=.0000)
TAGALOG	61	155	39%	There is no statistically significant difference in rates between the ENGLISH population, (44.99%), and the `TAGALOG` population, (Rate=39.38%, Chi-Square=1.977, p=.1597)
RUSSIAN	197	424	46%	There is no statistically significant difference in rates between the ENGLISH population, (44.99%), and the `RUSSIAN` population, (Rate=46.42%, Chi-Square=0.377, p=.5391)
FARSI	121	172	70%	The ENGLISH population had a statistically significantly lower rate, (44.99%), compared to the `FARSI` population, (Rate =70.40%, Chi-Square=44.679, p=.0000)
HMONG	45	125	36%	The ENGLISH population had a statistically significantly higher rate, (44.99%), compared to the `HMONG` population, (Rate =35.97%, Chi-Square=4.066, p=.0438)
MANDARIN	51	123	41%	There is no statistically significant difference in rates between the ENGLISH population, (44.99%), and the `MANDARIN` population, (Rate=41.47%, Chi-Square=0.613, p=.4338)
PORTUGUESE	50	102	49%	There is no statistically significant difference in rates between the ENGLISH population, (44.99%), and the `PORTUGUESE` population, (Rate =49.06%, Chi-Square=0.673, p=.4119)
VIETNAMESE	131	307	43%	There is no statistically significant difference in rates between the ENGLISH population, (44.99%), and the `VIETNAMESE` population, (Rate =42.68%, Chi-Square=0.658, p=.4174)

45. Table XXI: Child and Adolescent Well Care Visits (WCV) Language MCAS Statistical Significance Testing

Sample Size: 187,070

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	12748	31029	41%	
SPANISH	658	1179	56%	The ENGLISH population had a statistically significantly lower rate, (41.03%), compared to the `SPANISH` population, (Rate =55.77%, Chi-Square=101.37, p=.0000)
RUSSIAN	4	8	50%	There is no statistically significant difference in rates between the ENGLISH population, (41.03%), and the `RUSSIAN` population, (Rate =50.05%, Chi-Square=0.240, p=.7243)

Northwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	9087	19045	48%	
SPANISH	662	1233	54%	The ENGLISH population had a statistically significantly lower rate, (47.74%), compared to the `SPANISH` population, (Rate =53.68%, Chi-Square=16.572, p=.0000)
TAGALOG	3	4	75%	There is no statistically significant difference in rates between the ENGLISH population, (47.74%), and the `TAGALOG` population, (Rate =75.02%, Chi-Square=0.227, p=.3538)

Southeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	17893	39571	45%	
SPANISH	10631	20118	53%	The ENGLISH population had a statistically significantly lower rate, (45.21%), compared to the `SPANISH` population, (Rate =52.80%, Chi-Square=310.85, p=.0000)
TAGALOG	52	135	39%	There is no statistically significant difference in rates between the ENGLISH population, (45.21%), and the `TAGALOG` population, (Rate =38.50%, Chi-Square=2.438, p=.1185)
RUSSIAN	170	372	46%	There is no statistically significant difference in rates between the ENGLISH population, (45.21%), and the `RUSSIAN` population, (Rate =45.65%, Chi-Square=0.034, p=.8527)
FARSI	113	160	71%	The ENGLISH population had a statistically significantly lower rate, (45.21%), compared to the `FARSI` population, (Rate =70.62%, Chi-Square=41.512, p=.0000)
VIETNAMESE	56	156	36%	The ENGLISH population had a statistically significantly higher rate, (45.21%), compared to the `VIETNAMESE` population, (Rate =35.86%, Chi-Square=5.450, p=.0196)

Southwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	19639	42354	46%	
SPANISH	16914	31521	54%	The ENGLISH population had a statistically significantly lower rate, (46.42%), compared to the `SPANISH` population, (Rate =53.68%, Chi-Square=384.28, p=.0000)
TAGALOG	6	16	38%	There is no statistically significant difference in rates between the ENGLISH population, (46.42%), and the `TAGALOG` population, (Rate =37.51%, Chi-Square=0.506, p=.4769)
RUSSIAN	23	44	52%	There is no statistically significant difference in rates between the ENGLISH population, (46.42%), and the `RUSSIAN` population, (Rate =52.25%, Chi-Square=0.616, p=.4325)
VIETNAMESE	61	125	49%	There is no statistically significant difference in rates between the ENGLISH population, (46.42%), and the `VIETNAMESE` population, (Rate =48.84%, Chi-Square=0.296, p=.5862)

46. *Table XXII: Controlling High Blood Pressure (CBP) Gender HPA Statistical Significance Testing*

Gender	Numerator	Denominator	Rate	Interpretation
MALE	133	178	75%	Reference
FEMALE	150	223	67%	There is no statistically significant difference in rates between the Male population, (74.69%), and the Female population, (Rate =67.21%, Chi-Square=2.649, p=.1036)

Partnership found no statistically significant difference when comparing each gender identity group to the Male gender identity group while using the NCQA Health Plan Accreditation generated sample (drawn from the eligible population) for Controlling High Blood Pressure (n=401) (Table XXII).

47. *Table XXIII: Controlling High Blood Pressure (CBP) Gender Identity MCAS Statistical Significance Results*

Northeast

Gender	Numerator	Denominator	Rate	Interpretation
MALE	99	173	57%	
FEMALE	139	215	65%	There is no statistically significant difference in rates between the Male population, (57.20%), and the Female population, (Rate =64.68%, Chi-Square=2.229, p=.1354)

Northwest

Gender	Numerator	Denominator	Rate	Interpretation
MALE	133	209	64%	
FEMALE	112	179	63%	There is no statistically significant difference in rates between the Male population, (63.69%), and the Female population, (Rate =62.59%, Chi-Square=0.047, p=.8281)

Southeast

Gender	Numerator	Denominator	Rate	Interpretation
MALE	104	161	65%	
FEMALE	148	231	64%	There is no statistically significant difference in rates between the Male population, (64.57%), and the Female population, (Rate =64.02%, Chi-Square=0.011, p=.9147)

Southwest

Gender	Numerator	Denominator	Rate	Interpretation
MALE	106	167	63%	
FEMALE	131	199	66%	There is no statistically significant difference in rates between the Male population, (63.47%), and the Female population, (Rate =65.78%, Chi-Square=0.221, p=.6384)

48. *Table XXIV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Gender HPA Statistical Significance Testing*

Gender	Numerator	Denominator	Rate	Interpretation
MALE	68	189	36%	Reference
FEMALE	66	216	31%	There is no statistically significant difference in rates between the Male population, (35.97%), and the Female population, (Rate=30.58%, Chi-Square=1.339, p=.2472)

Partnership found no statistically significant difference when comparing each gender identity group to the Male gender identity group while using the NCQA Health Plan Accreditation generated sample (drawn from the eligible population) for HbA1c Poor Control (n=405) (Table XXIV).

49. *Table XXV: A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Gender Identity MCAS Statistical Significance Results*

Northeast

Gender	Numerator	Denominator	Rate	Interpretation
MALE	71	170	42%	
FEMALE	73	201	36%	There is no statistically significant difference in rates between the Male population, (41.80%), and the Female population, (Rate =36.30%, Chi-Square=1.150, p=.2835)

Northwest

Gender	Numerator	Denominator	Rate	Interpretation
MALE	60	156	39%	
FEMALE	63	215	29%	There is no statistically significant difference in rates between the Male population, (38.50%), and the Female population, (Rate =29.26%, Chi-Square=3.422, p=.0643)

Southeast

Gender	Numerator	Denominator	Rate	Interpretation
MALE	66	171	39%	
FEMALE	53	209	25%	The Male population had a statistically significantly higher rate, (38.61%), compared to the Female population, (Rate =25.41%, Chi-Square=7.662, p=.0056)

Southwest

Gender	Numerator	Denominator	Rate	Interpretation
MALE	57	172	33%	
FEMALE	62	188	33%	There is no statistically significant difference in rates between the Male population, (33.11%), and the Female population, (Rate =33.00%, Chi-Square=0.001, p=.9742)

50. *Table XXVI: Child and Adolescent Well Care Visits (WCV) Gender Identity HPA Statistical Significance Testing*

Gender	Numerator	Denominator	Rate	Interpretation
MALE	45513	96466	47%	Reference
FEMALE	43714	91730	48%	The Female population had a statistically significantly higher rate, (47.63%), compared to the Male population, (Rate =47.19%, Chi-Square=4.250, p=.0393)

Partnership found that the Female gender identity significantly performed better to the Male-group while using the NCQA Health Plan Accreditation generated sample (drawn from the eligible population) for Child and Adolescent Well Care Visits (n=188,196, Table XXVI). Specifically, the Female population had a 1% higher rate of Child and Adolescent Well Care when compared to the Male population.

51. *Table XXVII: Child and Adolescent Well Care Visits (WCV) Gender Identity MCAS Statistical Significance Results*

Northeast

Gender	Numerator	Denominator	Rate	Interpretation
MALE	6964	16665	42%	
FEMALE	6520	15719	41%	There is no statistically significant difference in rates between the Male population, (41.80%), and the Female population, (Rate =41.47%, Chi-Square=0.319, p=.5720)

Northwest

Gender	Numerator	Denominator	Rate	Interpretation

MALE	4952	10440	47%	
FEMALE	4840	9948	49%	There is no statistically significant difference in rates between the Male population, (47.41%), and the Female population, (Rate =48.62%, Chi-Square=3.038, p=.0813)

Southeast

Gender	Numerator	Denominator	Rate	Interpretation
MALE	14866	31164	48%	
FEMALE	14320	29908	48%	There is no statistically significant difference in rates between the Male population, (47.74%), and the Female population, (Rate =47.85%, Chi-Square=0.193, p=.6603)

Southwest

Gender	Numerator	Denominator	Rate	Interpretation
MALE	18731	38198	49%	
FEMALE	18034	36154	50%	The Female population had a statistically significantly higher rate, (49.83%), compared to the Male population, (Rate =49.06%, Chi-Square=5.299, p=.0213)

Healthcare Effectiveness Data and Information Set (HEDIS®)

Measurement Year 2025 / Reporting Year 2026

Managed Care Accountability Set (MCAS)

Summary of Performance

June 2026

Table of Contents

NCQA's Notice of Copyright and Disclaimers 4
1.0 Introduction 5
2.0 Notable Changes to the Measurement Year (MY) 2025 Annual Summary of Performance Report 6
3.0 Plan-Wide MCAS Performance Relative to Quality Compass® Medicaid Benchmarks 13
4.0 MCAS Summary of Performance by Region 14
4.1 MCAS Measures at or Above the High Performance Level (HPL) – 90th Percentile 14
4.2 MCAS Measures below the Minimum Performance Level (MPL) - 50th Percentile 15
5.0 MCAS Summary of Performance by County 16
5.1 MCAS Distribution of Percentile Rankings by County 16
5.2 MCAS Percentile Ranking Change from Prior Year 17
5.2.1 MCAS Percentile Ranking Change MY2024-2025 – Auburn Region: Nevada, Placer, Plumas, Sierra Counties 18
5.2.2 MCAS Percentile Ranking Change MY2024-2025 – Chico Region: Butte, Colusa, Glenn, Sutter, Yuba Counties 19
5.2.3 MCAS Percentile Ranking Change MY2024-2025 – Eureka Region: Del Norte, Humboldt, Lake, Mendocino Counties 20
5.2.4 MCAS Percentile Ranking Change MY2024-2025 – Fairfield Region: Napa, Solano, Yolo Counties 21
5.2.5 MCAS Percentile Ranking Change MY2024-2025 – Redding Region: Lassen, Modoc, Shasta, Siskiyou, Tehama, Trinity Counties 22
5.2.6 MCAS Percentile Ranking Change MY2024-2025 – Santa Rosa Region: Marin, Sonoma Counties 23
5.3 MY2025 MCAS Annual Performance by County 24
5.3.1 MCAS Auburn Region: Nevada, Placer, Plumas, Sierra Counties 24
5.3.2 MCAS Chico Region: Butte, Colusa, Glenn, Sutter, Yuba Counties 25
5.3.3 MCAS Eureka Region: Del Norte, Humboldt, Lake, Mendocino Counties 26
5.3.4 MCAS Fairfield Region: Solano, Yolo, and Napa Counties 27
5.3.5 MCAS Redding Region: Lassen, Modoc, Shasta, Siskiyou, Tehama, Trinity Counties 28
5.3.6 MCAS Santa Rosa Region: Marin, Sonoma Counties 29
6.0 Overall Health Plan Ranking: DHCS Managed Care Accountability Set (MCAS) 30
7.0 Year-over-year Performance Trends and Initial Assessment of Results 32
7.1 Year-over-year Performance Trends 32

7.2 Plan-Wide Strengths: Measure Performing Above MPL 32
7.3 Opportunities for Improvement 35
7.3.1 MCAS Measures with Regional Performance Opportunities 35
7.3.2 MCAS Measures with Data Completeness and Measure Limitation Issues 38
7.4 Comparing MY2025 MCAS Results to MY2025 PCP QIP Results 39
7.5 Next Steps in Finalizing Assessment of Results 40
8.0 Summary of MCAS Measures in Partnership's Quality Improvement Programs 41
9.0 Measurement Year 2024 Managed Care Accountability Site (MCAS) Measurement Set Descriptions-Accountable Measures 43
10.0 Quality Improvement Initiatives - HEDIS Score Improvement 47
10.1 Behavioral Health Measure Activities 47
10.2 Pediatric Medicine Measure Activities 49
10.3 Chronic Disease Measure Activities 51
10.4 Women's Health and Perinatal Care Measure Activities 51

NCQA’s Notice of Copyright and Disclaimers

The source for certain health plan measure rates and benchmark (averages and percentiles) data ("the Data") is Quality Compass® [2025] and is used with the permission of the National Committee for Quality Assurance ("NCQA"). Any analysis, interpretation or conclusion based on the Data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation or conclusion. Quality Compass is a registered trademark of NCQA.

The Data comprises audited performance rates and associated benchmarks for Healthcare Effectiveness Data and Information Set measures ("HEDIS®") and HEDIS CAHPS® survey measure results. HEDIS measures and specifications were developed by and are owned by NCQA. HEDIS measures and specifications are not clinical guidelines and do not establish standards of medical care. NCQA makes no representations, warranties or endorsement about the quality of any organization or clinician who uses or reports performance measures, or any data or rates calculated using HEDIS measures and specifications, and NCQA has no liability to anyone who relies on such measures or specifications.

NCQA holds a copyright in Quality Compass and the Data, or NCQA has obtained the necessary rights in the Data, and may rescind or alter the Data at any time. The Data may not be modified by anyone other than NCQA. Anyone desiring to use or reproduce the Data without modification for an internal, noncommercial purpose may do so without obtaining approval from NCQA. All other uses, including a commercial use and/or external reproduction, distribution or publication, must be approved by NCQA and are subject to a license at the discretion of NCQA. © [2024] National Committee for Quality Assurance, all rights reserved.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

1.0 Introduction

As a Medi-Cal Managed Care Plan, Partnership provides health care coverage for 24 counties in Northern California – the largest geographic footprint of any Medi-Cal Managed Care Plan in California. The health plan covers over 900,000 members who qualify for coverage based on low household income, and who make up a substantial portion of Northern California's total population. The annual clinical measure performance analysis contained in this Annual Summary of Performance, centered on 18 HEDIS measures selected by DHCS, is intended to give the best possible understanding of the status of quality outcomes for the low-income population served in these counties.

Partnership generates a detailed Annual Summary of Performance and distributes it widely so that stakeholders in Northern California – local governments, county public health, medical and behavioral health providers, hospitals, and community foundations – can use current, local, accurate, and audited data to prioritize activities to meet the health care needs of their communities. The Summary of Performance contains regional and county-level data that show local strengths and opportunities for preventative health care based on national benchmarks. Behind each measure are many community members who were able to access the preventative services they needed to stay healthy, or who faced challenges and struggles to receive care.

In the end, it takes the entire health care delivery system working together to improve the health outcomes contained in this report. Partnership encourages everyone reading this report to review their local data closely, and look for a handful of ways their organization, alone or with others, can drive improvement on one or more measure that is important to them.

Partnership is always happy to connect organizations and community members within our network to resources and activities to help our members, and the communities we serve, be healthy. Please reach out to our Performance Improvement team at ImprovementAcademy@partnershiphp.org if you would like to learn more about activities in your area.

Thank you for your dedication to improving the health of our communities.

2.0 Notable Changes to the Measurement Year (MY) 2025 Annual Summary of Performance Report

MY2025 continued to host two required separate audits:

- DHCS / MCAS required reporting: Health Service Advisory Group (HSAG) Auditor (this report's focus)
- NCQA HEDIS Health Plan Accreditation / HPA: Advent Advisory Auditor

Partnership HEDIS Reporting Populations – MY2025

In MY2025, Partnership observed slight decrease in overall membership by approximately 1.3%, to 895,339 assigned members in December 2025.

Partnership reports one Plan-Wide rate for all 24 counties in its network for the MCAS measure set to its DHCS auditor, HSAG.

Starting in MY2024, Partnership also reports county-wide rates for all MCAS measures and their respective sub-measures to DHCS directly. DHCS uses county-wide rates to calculate outcomes for multiple accountability programs that are described below. County level rates for hybrid measures are calculated using a county-level oversample populations (minimum size of 100 members).

The impact of population shifts in Partnership's network from the 10 new counties joining the Partnership network in January 2024 continues to impact HEDIS measure reporting populations differently, depending on each measure's continuous enrollment requirements as defined in the NCQA HEDIS MY2025 Technical Specifications. One measure, Breast Cancer Screening, ECDS (BCS-E), requires continuous enrollment greater than one year for a member to be included in the measure's eligible population, which meant that very few members from incoming counties met the criteria to be included in the measures' plan-wide rates in MY2025. All other MCAS measures in the 10 incoming counties have eligible populations that reflect the current membership.

DHCS Managed Care Accountability Set (MCAS) Measure Set – MY2025

Table 1 shows the MY2025 DHCS MCAS Measure Set, which are the eighteen (18) NCQA HEDIS and CMS clinical measures that all California Medi-Cal Managed Care Plans are held to the Minimum Performance Level (MPL) of the Quality Compass 50th percentile. The table includes information such as measure domain and Quality Withhold and Incentive program flags, which are relevant to DHCS Accountability programs described below. All eighteen (18) measures in the MCAS measure set are continuous from MY2023-MY2025.

Table 1: MY2025 DHCS Managed Care Accountability Set – Measures Held to MPL (50th Percentile)

Measure Domain	Measure Abbr	Measure Name	DHCS Quality Withhold Program Measure?
Behavioral Health	FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	
Behavioral Health	FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	
Children's Health	WCV	Child and Adolescent Well-Care Visits	Y
Children's Health	CIS-E	Childhood Immunization Status - Combination 10	Y
Children's Health	IMA-E	Immunizations for Adolescents - Combination 2	Y
Children's Health	W30-2	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months	Y
Children's Health	W30-6	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months	Y
Children's Health	DEV	Developmental Screening in the First Three Years of Life	
Children's Health	LSC	Lead Screening in Children	
Children's Health	TFL	Topical Fluoride for Children	
Chronic Disease	CBP	Controlling High Blood Pressure	Y
Chronic Disease	GSD	Glycemic Status Assessment for Patients With Diabetes (>9%)	Y
Chronic Disease	AMR	Asthma Medication Ratio	
Reproductive Health and Cancer Prevention	PPC-Post	Prenatal and Postpartum Care: Postpartum Care	Y
Reproductive Health and Cancer Prevention	PPC-Pre	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Y
Reproductive Health and Cancer Prevention	BCS-E	Breast Cancer Screening	
Reproductive Health and Cancer Prevention	CCS-E	Cervical Cancer Screening	
Reproductive Health and Cancer Prevention	CHL	Chlamydia Screening in Women	

NCQA released changes to several existing clinical measures used in DHCS MCAS for MY2025:

- ECDS measure Childhood Immunization Status Combination 10 (CIS-10-E) replaced the hybrid measure Childhood Immunization Status Combination 10 (CIS-10).

- ECDS measure Immunizations for Adolescents Combination 2 (IMA-2-E) replaced the hybrid measure Immunizations for Adolescents Combination 2 (IMA-2).
- ECDS measure Cervical Cancer Screening (CCS-E) replaced hybrid measure Cervical Cancer Screening (CCS).
- Breast Cancer Screening (BCS-E)'s age band expanded from 52-75 years to include members 42-75 years.

DHCS Accountability Programs

Since 2019, DHCS has introduced multiple MCP accountability programs that align plan MCAS measure performance with DHCS's Comprehensive Quality Strategy and Bold Goals Initiative. **Table 2** outlines DHCS accountability programs that are driven by MY2025 measure performance, and each program is described below. Results for each program are announced late in the Reporting Year, after the publication of the Annual Summary of Performance.

Table 2: DHCS Accountability Programs Driven by MCAS Measure Performance, MY2025

Program	Description	Geographic Impact	Financial Impact	Financial Impact Trigger
Quality Withholds and Incentive Program	MCP's earn back withheld revenue with high regional performance or improvement on subset of MCAS measures Incentive earnback with closing regional disparities on WCV measure	Quality Rating Regions	1% of MCP's annual revenue earned back	<67th percentile performance AND <25% YoY improvement
Clinical Efficiencies	Performance on clinical efficiency measures (mostly inpatient) impact MCP rate setting	Plan Wide	Plan rates	Main driver: low performance Ambulatory Sensitive Admissions
Community Reinvestments Quality	5% annual net income automatically invested in county community projects, Quality Factor is an additional investment amount based on quality measure performance	County	Additional 7.5% of annual net income - prorated by county membership	2+ measures <50th percentile in a measure domain
Quality Sanctions	Fines for performance below 50th percentile on all MCAS measures	County	Measure population not served is main factor	<50th percentile
Quality Factor Score	Composite MCAS measure score used to compare MCP performance state-wide	Plan Wide	None	None

Quality Withholds and Incentives Program

DHCS's Quality Withholds and Incentives accountability program allows Partnership to earn back a percentage of its withheld income from DHCS based on high performance or significantly improved year-over-year performance on a subset of MCAS measures, as well as two CAHPS measures. The Withholds and Incentives accountability program will be applied to Partnership's three (3) Quality Rating Regions based on MY2025 measure performance. DHCS will use county-level measure rates to calculate weighted regional rates for Partnership's three (3) Quality Rating Regions. **Table 1** (above) flags MY2025 MCAS measures that are included in the Quality Withholds program.

DHCS Quality Rating Region	Counties
North Bay	Marin, Napa, Sonoma, Solano, Yolo
Rural Upper North	Del Norte, Humboldt, Lassen, Lake, Mendocino, Modoc, Shasta, Siskiyou, Trinity
Rural Upper Central	Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba

Clinical Efficiency Program

This program focuses on reducing inefficient utilization of healthcare services by eliminating a portion of inefficient spend during MCP rate development. DHCS's program focuses on several aspects of inefficient spend: Potentially Preventable Admissions (PPA) is the largest current factor impacting Partnership. Though PPA is not an NCQA HEDIS measure, a number of drivers of PPA are indicated in MCAS measures, such as Controlling Blood Pressure (CBP) and Asthma Medication Ratio (AMR).

Quality Accountability Community Reinvestment Program

The Community Reinvestment Program is DHCS's newest accountability program for Managed Care Plans. This program requires Partnership to pay counties with multiple measures below the 50th percentile in any of four (4) measure domains 7.5 percent of annual net income, pro-rated by county membership. **Table 1** (above) shows the MY2025 MCAS measures within the four measure domains.

Quality Sanctions Program

DHCS intends to hold all California Managed Care Plans accountable for sanctions for all MCAS Accountable measures that did not reach the 50th percentile benchmark at either the county level or at the level of groups of counties. In MY2025 sanctions will be applied to all 24 counties in Partnership's network.

Quality Factor Score

DHCS uses a scoring methodology to determine an aggregated Quality Factor Score (QFS), which ranks health plan performance relative to California Medicaid reporting health plans. This score is reputational in nature and carries no financial risk for Partnership.

Partnership's Efforts to Improve Data Quality – MY2025

Partnership was able to use a number of new supplemental data sources in the MY2025 HEDIS Annual project.

Electronic Clinical Data Systems (ECDS) Vendor: Partnership expanded its use of Datalink, an NCQA Certified Data Aggregator software, in MY2025, and received auditor approval to include records in the MY2025 HEDIS Project. The use of clinical data towards HEDIS measure rate calculation is an important step towards readiness for NCQA's planned transition of hybrid measures to ECDS measures by 2029, which require structured clinical data for measure rate generation; and towards readiness for CMS's Interoperability Framework.

Records from over 30 practices within Partnership's provider network were included in the MY2025 HEDIS Annual Project. Partnership continues to make progress with leveraging Datalink as a supplemental data source:

- Even without full implementation across the Partnership network, Datalink made a significant positive impact on administrative rates for MCAS Accountable measures. To summarize, the impact of Datalink on measure rates includes:
    - 23% of total care gaps closed for the CBP administrative measure, plan-wide
    - 17% of total care gaps closed for the GSD administrative measure, plan-wide
    - 18% of total care gaps closed for the BCS-E ECDS measure, plan-wide
    - 12% of total care gaps closed for the CCS-E ECDS measure, plan-wide

- Partnership is preparing for the addition of three (3) Depression Screening measures to the MCAS accountable measure set in MY2026: Depression Screening for Adolescents and Adults (DSF-E-SC); Prenatal Depression Screening (PND-E-SC); and Postpartum Depression Screening (PDS-E-SC). Datalink will be the sole source of data for these three measures.

Year Round Medical Record Review for Well-Child Visits in the First 30 Months of Life (W30) and Prenatal and Postpartum Care (PPC) measures: In MY2024, the QI department identified a systems issue with newborns' temporary member ID's that caused underreporting of newborn visit rates for the W30 measure. To address, the HEDIS team completed a supplemental Medical Record Review of the entire W30 measure eligible population in early 2025, which was accepted as a supplemental data source by HSAG's auditor. The supplemental Medical Record Review made a dramatic impact on the rates for both W30 submeasures, and both W30 submeasure rates scored above the 67th percentile for MY2024.

In MY2025, the HEDIS team repeated the Medical Record Review as a year-round effort, which allowed the team more time to collect and review charts for the W30 eligible population. The team also expanded the scope of the year-round Medical Record Review to allow the Prenatal and Postpartum Care (PPC) submeasures to benefit from the extended review period.

Electronic Record on Demand (ERD) Clinical Data retrieval pilot: Partnership piloted an additional clinical data retrieval methodology supported by the plan's HEDIS certified software vendor, Inovalon. The pilot was focused on retrieving clinical records for measures that were not included in the ECDS Datalink scope which resulted in a slight increase in rates across 22 measures in the MCAS and NCQA Health Plan Accreditation measure sets. Further assessment is underway to determine the potential to expand this effort.

Sacramento Valley MedShare (SVMS): SVMS is a Health Information Exchange used by practices and health systems throughout Northern California. In MY2025, Partnership received auditor approval to use Encounter, Lab, and Measurement (i.e., blood pressure readings) records towards the HEDIS Annual Project, which had a significant impact on several MCAS measures in MY2025. SVMS's Immunization records did not receive auditor approval to be included in the MY2025 HEDIS rate generation.

Root cause analysis of fluoride varnish services: Partnership worked with DHCS in 2024 - 2025 to better understand how it receives fluoride varnish claims and encounters that can be counted towards the Topical Fluoride for Children (TFL) MCAS measure, most of which are billed to Denti-Cal from Federally Qualified Health Center (FQHC), Rural Health Center (RHC), and Tribal Health Dental Centers and then sent to Partnership. In 2025 Partnership actively worked with DHCS and Dental Centers throughout its network to standardize and spread dental fluoride varnish coding that would accurately capture completed services towards the MY2025 measure. The plan also created a Dental Liaison role on the Quality Improvement team to promote pediatric dental care and ensure that the Partnership network has high quality dental directory resources and referral pathways for pediatric members. This has resulted in significant improvements to Partnership's ability to accurately report pediatric fluoride varnish application rates.

HEDIS Annual Project Outcomes

Partnership successfully launched our HEDIS® MY2025 / RY2026 data collection and reporting audits incorporating all changes as noted above.

DHCS MCAS Accountable Measures

In MY2025 / RY2026 HEDIS® Annual Final Reporting, DHCS announced that it is planning to hold managed care plans (MCPs) accountable and imposing financial sanctions on 18 selected Hybrid and Administrative measures performing below the minimum performance level (MPL - 50th national Medicaid percentile). The same 18 MCAS accountable measures from MY2024 continued into MY2025. See **Section 2** above for a full description of DHCS accountability programs.

Results of an additional 10 MCAS measures were reported but were not part of the accountability measure set in MY2025 (“reporting only measures”). The full list of MY2025 MCAS measures can be found on the DHCS website: https://www.dhcs.ca.gov/dataandstats/reports/Documents/Medi-Cal-Accountability-Set-Reporting-Year-2026.pdf

Much of the measure performance analysis that follows is based on the performance of the 18 accountable MCAS measures per NCQA Quality Compass 2025 Benchmarks, developed on MY2024 performance.

3.0 Plan-Wide MCAS Performance Relative to Quality Compass® Medicaid Benchmarks

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

Plan Wide Performance			Medicaid National Benchmarks			
Abbr	Measure	Plan Wide	25TH	50TH	75TH	90TH
Behavioral Health Domain						
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	41.35%	30.17%	39.10%	45.80%	53.27%
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	50.26%	50.47%	57.13%	64.91%	74.67%
Children's Health Domain						
CIS-E	Childhood Immunization Status - Combination 10	26.74%	19.77%	23.89%	28.86%	34.79%
DEV	Developmental Screening in the First Three Years of Life 1, 3	39.42%		37.40%		
IMA-E	Immunizations for Adolescents - Combination 2	39.39%	29.42%	34.14%	40.19%	47.16%
LSC	Lead Screening in Children	74.94%	61.31%	69.96%	76.34%	82.86%
TFL	Topical Fluoride for Children 3	21.07%		21.50%		
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months 5	76.64%	68.38%	72.32%	77.50%	82.12%
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months 5	64.64%	58.04%	63.38%	67.49%	71.71%
WCV	Child and Adolescent Well-Care Visits	52.57%	49.68%	55.41%	61.47%	67.63%
Chronic Disease Domain						
AMR	Asthma Medication Ratio	73.33%	57.63%	63.66%	70.39%	76.25%
CBP	Controlling High Blood Pressure 1	67.40%	63.75%	67.88%	71.34%	75.43%
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%) 1, 4	27.74%	35.77%	30.41%	26.52%	23.60%
Reproductive Health and Cancer Prevention Domain						
BCS-E	Breast Cancer Screening 2	53.43%	50.53%	55.87%	61.43%	66.31%
CCS-E	Cervical Cancer Screening	48.08%	47.10%	52.32%	57.83%	64.21%
CHL	Chlamydia Screening in Women	58.98%	48.48%	56.30%	65.47%	70.67%
PPC-Post	Prenatal and Postpartum Care: Postpartum Care 1	90.02%	78.10%	82.48%	85.15%	88.32%
PPC-Pre	Prenatal and Postpartum Care: Timeliness of Prenatal Care 1	87.10%	82.97%	86.37%	89.78%	91.97%

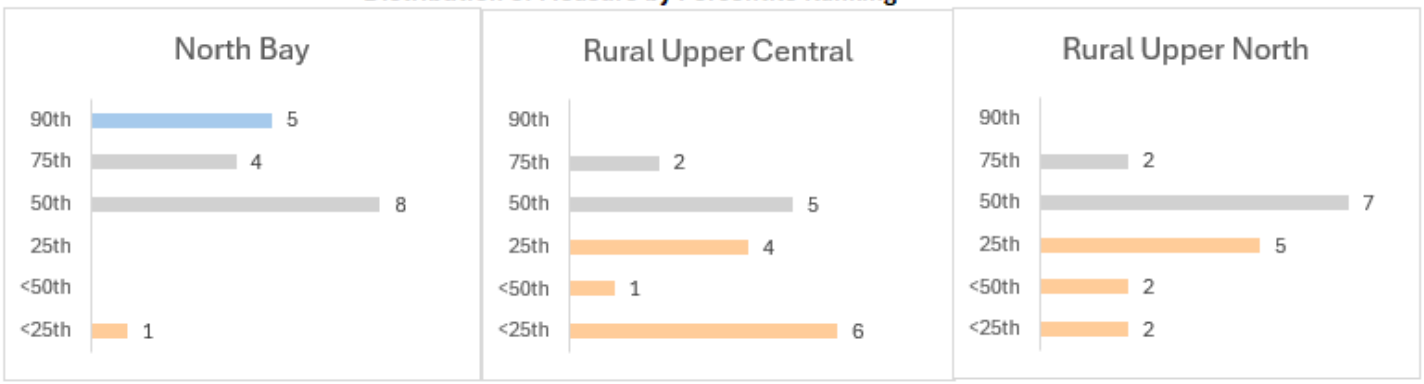
(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

4.0 MCAS Summary of Performance by Region

Regional Distribution of Measures by Percentile Ranking

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MUL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

Distribution of Measure by Percentile Ranking



4.1 MCAS Measures at or Above the High Performance Level (HPL) – 90th Percentile

Measures at or Above the High Performance Level (HPL) – 90th Percentile

Abbr	Measures	North Bay
Children's Health Domain		
CIS-E	Childhood Immunization Status - Combination 10	●
IMA-E	Immunizations for Adolescents - Combination 2	●
Chronic Disease Domain		
AMR	Asthma Medication Ratio	●
Reproductive Health and Cancer Prevention Domain		
PPC-Post	Prenatal and Postpartum Care: Postpartum Care [1]	●
PPC-Pre	Prenatal and Postpartum Care: Timeliness of Prenatal Care [1]	●

4.2 MCAS Measures below the Minimum Performance Level (MPL) - 50th Percentile

Measures below the Minimum Performance Level (MPL) - 50th Percentile

Abbr	Measures	North Bay	Rural Upper Central	Rural Upper North
Behavioral Health Domain				
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness (FUM)-30-Day Follow-Up	●	●	●
Children's Health Domain				
CIS-E	Childhood Immunization Status ECDS (CIS-E)-Combination 10			●
DEV	Developmental Screening in the First Three Years of Life (DEV-CH)-Total, All Ages		●	●
IMA-E	Immunizations for Adolescents ECDS (IMA-E)-Combination 2		●	●
LSC	Lead Screening in Children (LSC)		●	
TFL	Topical Fluoride for Children (TFL-CH)-Numerator 1 Total			●
W30-6	Well Child 30 (W30)-Well Child Visits in the First 15 Months		●	
WCV	Child and Adolescent Well-Care Visits (WCV)-Total		●	●
Chronic Disease Domain				
CBP	Controlling High Blood Pressure (CBP)-Non-Medicare Total		●	
Reproductive Health and Cancer Prevention Domain				
BCS	Breast Cancer Screening ECDS (BCS-E)-Non-Medicare Total		●	●
CCS	Cervical Cancer Screening ECDS (CCS-E)		●	
CHL	Chlamydia Screening in Women (CHL)-Total		●	●
PPC-Pre	Prenatal and Postpartum Care (PPC)-Timeliness of Prenatal Care		●	●

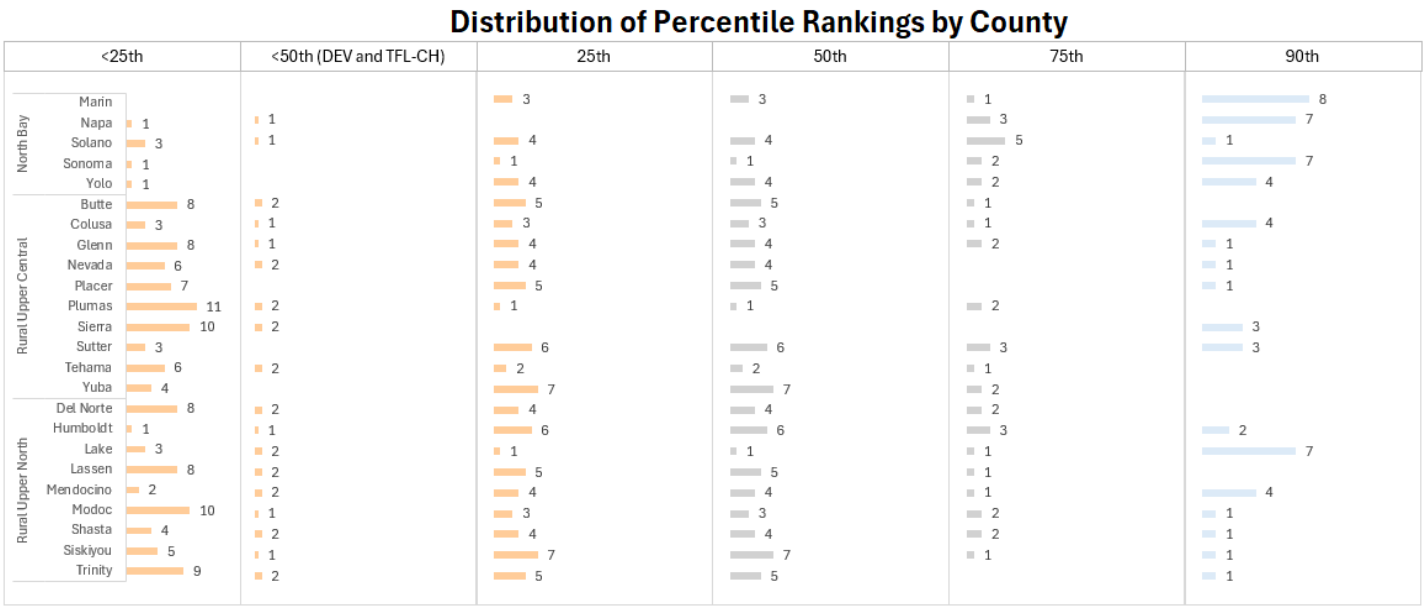
(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.0 MCAS Summary of Performance by County

5.1 MCAS Distribution of Percentile Rankings by County

Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)

Below MVL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)



NOTE: The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. Performance below the 50th percentile is indicated by the <50th column in the graph.

5.2 MCAS Percentile Ranking Change from Prior Year

Where measures remained in the MCAS in MY2025, the next set of tables show that Partnership observed a number of measures that declined or improved in percentile ranking relative to prior year. The NCQA Quality Compass 2025 Benchmarks, which were developed based on MY2024 performance, result in the percentile rankings below.

At the County level, a comparison of county-level performance between MY2024 and MY2025 in Partnership's 24 counties shows:

- 147 county-level measures, or 34% of 432 county-level measures, improved in performance and moved to a higher benchmark in MY2025.
- 204 county-level measures, or 47% of 432 county-level measures, stayed at their same benchmark as MY2024 in MY2025.
- 81 county-level measures, or 19% of 432 county-level measures, declined in performance and moved to a lower benchmark in MY2025.

5.2.1 MCAS Percentile Ranking Change MY2024-2025 – Auburn Region: Nevada, Placer, Plumas, Sierra Counties

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

		NEVADA		PLACER		PLUMAS		SIERRA	
ABBR	MEASURES	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Behavioral Health Domain									
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	50th	25th	25th	50th	25th	50th	90th	90th
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	<25th	25th	<25th	<25th	<25th	50th	<25th	<25th
Children's Health Domain									
CIS-E	Childhood Immunization Status - Combination 10	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th
DEV	Developmental Screening in the First Three Years of Life[1,3]	50th	<50th	50th	50th	<50th	<50th	<50th	<50th
IMA-E	Immunizations for Adolescents - Combination 2	<25th	<25th	50th	<25th	<25th	<25th	<25th	25th
LSC	Lead Screening in Children	75th	25th	50th	50th	75th	<25th	<25th	<25th
TFL	Topical Fluoride for Children[3]	<50th	<50th	50th	50th	<50th	<50th	<50th	<50th
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months[5]	90th	<25th	<25th	25th	<25th	<25th	<25th	<25th
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months[5]	<25th	<25th	<25th	25th	<25th	<25th	<25th	<25th
WCV	Child and Adolescent Well-Care Visits	<25th	<25th	25th	25th	<25th	<25th	<25th	<25th
Chronic Disease Domain									
AMR	Asthma Medication Ratio	<25th	50th	<25th	90th	90th	25th	<25th	90th
CBP	Controlling High Blood Pressure[1]	<25th	50th	<25th	<25th	<25th	<25th	<25th	<25th
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%)[1,4]	25th	25th	25th	25th	<25th	<25th	<25th	25th
Reproductive Health and Cancer Prevention Domain									
BCS-E	Breast Cancer Screening[2]	90th	25th	<25th	<25th	<25th	<25th	<25th	<25th
CCS-E	Cervical Cancer Screening	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th
CHL	Chlamydia Screening in Women	<25th	25th	50th	50th	<25th	<25th	<25th	<25th
PPC-POST	Prenatal and Postpartum Care: Postpartum Care[1]	75th	90th	75th	25th	25th	75th	<25th	90th
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care[1]	25th	50th	<25th	<25th	75th	25th	<25th	25th

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+

and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.2.2 MCAS Percentile Ranking Change MY2024-2025 – Chico Region: Butte, Colusa, Glenn, Sutter, Yuba Counties

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

		BUTTE		COLUSA		GLENN		SUTTER		YUBA	
ABBR	MEASURES	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Behavioral Health Domain											
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	25th	50th	25th	50th	25th	25th	25th	50th	25th	50th
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	<25th	<25th	<25th	25th	<25th	<25th	<25th	50th	<25th	50th
Children's Health Domain											
CIS-E	Childhood Immunization Status - Combination 10	<25th	50th	<25th	50th	50th	75th	75th	75th	75th	75th
DEV	Developmental Screening in the First Three Years of Life[1, 3]	<50th	<50th	50th	<50th	50th	50th	50th	50th	50th	50th
IMA-E	Immunizations for Adolescents - Combination 2	<25th	<25th	90th	<25th	50th	<25th	50th	90th	50th	90th
LSC	Lead Screening in Children	<25th	<25th	90th	50th	75th	50th	90th	75th	90th	75th
TFL	Topical Fluoride for Children[3]	<50th	<50th	50th	50th	<50th	<50th	50th	50th	50th	50th
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months[5]	<25th	50th	90th	75th	<25th	50th	<25th	90th	<25th	90th
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months[5]	<25th	25th	<25th	<25th	<25th	<25th	<25th	25th	<25th	25th
WCV	Child and Adolescent Well-Care Visits	<25th	<25th	50th	90th	50th	50th	50th	50th	50th	50th
Chronic Disease Domain											
AMR	Asthma Medication Ratio	50th	50th	<25th	90th	90th	90th	<25th	50th	<25th	50th
CBP	Controlling High Blood Pressure[1]	50th	<25th	25th	25th	75th	<25th	50th	25th	50th	25th
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%)[1, 4]	25th	50th	50th	25th	50th	<25th	<25th	75th	<25th	75th
Reproductive Health and Cancer Prevention Domain											
BCS-E	Breast Cancer Screening[2]	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th
CCS-E	Cervical Cancer Screening	<25th	<25th	50th	25th	25th	<25th	25th	<25th	25th	<25th
CHL	Chlamydia Screening in Women	25th	25th	25th	25th	25th	25th	50th	25th	50th	25th
PPC-POST	Prenatal and Postpartum Care: Postpartum Care[1]	90th	75th	90th	90th	75th	75th	90th	75th	90th	75th
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care[1]	25th	<25th	<25th	90th	25th	<25th	50th	25th	50th	25th

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.2.3 MCAS Percentile Ranking Change MY2024-2025 – Eureka Region: Del Norte, Humboldt, Lake, Mendocino Counties

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

		DEL NORTE		HUMBOLDT		LAKE		MENDOCINO	
ABBR	MEASURES	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Behavioral Health Domain									
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	25th	50th	75th	75th	<25th	50th	25th	25th
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	<25th	<25th	<25th	25th	<25th	<25th	<25th	<25th
Children's Health Domain									
CIS-E	Childhood Immunization Status - Combination 10	<25th	<25th	<25th	25th	<25th	50th	25th	50th
DEV	Developmental Screening in the First Three Years of Life[1,3]	<50th	<50th	50th	50th	<50th	<50th	<50th	<50th
IMA-E	Immunizations for Adolescents - Combination 2	50th	25th	50th	75th	75th	90th	<25th	50th
LSC	Lead Screening in Children	<25th	25th	90th	50th	50th	90th	75th	90th
TFL	Topical Fluoride for Children[3]	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months[5]	50th	<25th	75th	50th	75th	90th	75th	75th
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months[5]	75th	<25th	75th	25th	90th	90th	90th	90th
WCV	Child and Adolescent Well-Care Visits	25th	50th	25th	25th	25th	25th	25th	25th
Chronic Disease Domain									
AMR	Asthma Medication Ratio	25th	75th	25th	50th	<25th	90th	25th	90th
CBP	Controlling High Blood Pressure[1]	<25th	25th	75th	90th	<25th	75th	25th	<25th
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%)[1,4]	25th	75th	90th	75th	<25th	<25th	50th	50th
Reproductive Health and Cancer Prevention Domain									
BCS-E	Breast Cancer Screening[2]	<25th	<25th	25th	25th	25th	<25th	50th	25th
CCS-E	Cervical Cancer Screening	<25th	<25th	75th	50th	25th	50th	75th	50th
CHL	Chlamydia Screening in Women	<25th	25th	25th	25th	25th	50th	25th	25th
PPC-POST	Prenatal and Postpartum Care: Postpartum Care[1]	25th	<25th	90th	90th	90th	90th	90th	90th
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care[1]	<25th	<25th	<25th	<25th	50th	90th	50th	50th

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+

and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.2.4 MCAS Percentile Ranking Change MY2024-2025 – Fairfield Region: Napa, Solano, Yolo Counties

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

		NAPA		SOLANO		YOLO	
ABBR	MEASURES	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Behavioral Health Domain							
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	<25th	50th	25th	50th	<25th	25th
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	<25th	<25th	<25th	<25th	<25th	<25th
Children's Health Domain							
CIS-E	Childhood Immunization Status - Combination 10	90th	90th	75th	75th	50th	50th
DEV	Developmental Screening in the First Three Years of Life[1,3]	<50th	<50th	<50th	<50th	50th	50th
IMA-E	Immunizations for Adolescents - Combination 2	90th	90th	90th	75th	75th	90th
LSC	Lead Screening in Children	90th	90th	75th	50th	50th	50th
TFL	Topical Fluoride for Children[3]	<50th	50th	<50th	50th	50th	50th
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months[5]	75th	75th	<25th	50th	75th	75th
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months[5]	25th	90th	25th	25th	<25th	50th
WCV	Child and Adolescent Well-Care Visits	50th	75th	<25th	<25th	50th	25th
Chronic Disease Domain							
AMR	Asthma Medication Ratio	90th	90th	25th	75th	50th	90th
CBP	Controlling High Blood Pressure[1]	25th	75th	50th	75th	25th	75th
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%)[1,4]	50th	50th	<25th	25th	25th	50th
Reproductive Health and Cancer Prevention Domain							
BCS-E	Breast Cancer Screening[2]	90th	90th	50th	25th	75th	50th
CCS-E	Cervical Cancer Screening	90th	50th	75th	<25th	25th	25th
CHL	Chlamydia Screening in Women	<25th	50th	50th	75th	25th	25th
PPC-POST	Prenatal and Postpartum Care: Postpartum Care[1]	90th	50th	90th	90th	50th	90th
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care[1]	<25th	90th	25th	25th	<25th	90th

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one

(1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.2.5 MCAS Percentile Ranking Change MY2024-2025 – Redding Region: Lassen, Modoc, Shasta, Siskiyou, Tehama, Trinity Counties

Tehama County is excluded from the Redding Region table, since the County joined Partnership in 2024.

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

		LASSEN		MODOC		SHASTA		SISKIYOU		TEHAMA		TRINITY	
ABBR	MEASURES	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Behavioral Health Domain													
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	<25th	<25th	75th	75th	75th	75th	25th	25th	25th	<25th	25th	25th
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	<25th	<25th	<25th	<25th	<25th	50th	<25th	50th	<25th	<25th	<25th	25th
Children's Health Domain													
CIS-E	Childhood Immunization Status - Combination 10	<25th	<25th	<25th	<25th	<25th	<25th	25th	<25th	<25th	25th	<25th	<25th
DEV	Developmental Screening in the First Three Years of Life[1,3]	<50th	<50th	<50th	50th	<50th	<50th	<50th	50th	<50th	<50th	<50th	<50th
IMA-E	Immunizations for Adolescents - Combination 2	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th
LSC	Lead Screening in Children	75th	25th	90th	25th	50th	50th	25th	25th	75th	25th	75th	25th
TFL	Topical Fluoride for Children[3]	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months[5]	50th	<25th	<25th	<25th	<25th	25th	25th	<25th	75th	50th	<25th	<25th
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months[5]	50th	25th	<25th	<25th	75th	50th	<25th	25th	90th	<25th	25th	<25th
WCV	Child and Adolescent Well-Care Visits	<25th	<25th	25th	<25th	<25th	25th	25th	25th	<25th	25th	25th	<25th
Chronic Disease Domain													
AMR	Asthma Medication Ratio	<25th	75th	25th	90th	<25th	50th	25th	90th	<25th	50th	<25th	<25th
CBP	Controlling High Blood Pressure[1]	50th	25th	<25th	<25th	<25th	50th	50th	75th	25th	25th	<25th	<25th
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%)[1,4]	50th	<25th	75th	75th	50th	90th	90th	50th	<25th	25th	75th	50th
Reproductive Health and Cancer Prevention Domain													
BCS-E	Breast Cancer Screening[2]	<25th	<25th	25th	25th	50th	<25th	25th	25th	<25th	<25th	25th	<25th
CCS-E	Cervical Cancer Screening	25th	<25th	<25th	25th	25th	25th	<25th	25th	<25th	<25th	25th	25th
CHL	Chlamydia Screening in Women	<25th	25th	<25th	<25th	25th	25th	<25th	25th	25th	25th	<25th	<25th
PPC-POST	Prenatal and Postpartum Care: Postpartum Care[1]	25th	50th	25th	<25th	<25th	75th	75th	<25th	25th	75th	<25th	90th
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care[1]	50th	50th	25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	25th

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one
(1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.2.6 MCAS Percentile Ranking Change MY2024-2025 – Santa Rosa Region: Marin, Sonoma Counties

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

		MARIN		SONOMA	
ABBR	MEASURES	MY2024	MY2025	MY2024	MY2025
Behavioral Health Domain					
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	25th	50th	25th	50th
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	<25th	25th	<25th	25th
Children's Health Domain					
CIS-E	Childhood Immunization Status - Combination 10	50th	90th	50th	90th
DEV	Developmental Screening in the First Three Years of Life[1,3]	50th	50th	<50th	50th
IMA-E	Immunizations for Adolescents - Combination 2	90th	90th	75th	90th
LSC	Lead Screening in Children	90th	90th	25th	<25th
TFL	Topical Fluoride for Children[3]	<50th	50th	<50th	50th
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months[5]	90th	90th	50th	75th
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months[5]	90th	90th	90th	90th
WCV	Child and Adolescent Well-Care Visits	50th	50th	50th	50th
Chronic Disease Domain					
AMR	Asthma Medication Ratio	25th	75th	50th	90th
CBP	Controlling High Blood Pressure[1]	50th	25th	75th	75th
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%)[1,4]	25th	25th	90th	90th
Reproductive Health and Cancer Prevention Domain					
BCS-E	Breast Cancer Screening[2]	75th	50th	50th	50th
CCS-E	Cervical Cancer Screening	75th	50th	75th	50th
CHL	Chlamydia Screening in Women	90th	90th	25th	50th
PPC-POST	Prenatal and Postpartum Care: Postpartum Care[1]	90th	90th	90th	90th
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care[1]	50th	90th	25th	90th

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+

and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.3 MY2025 MCAS Annual Performance by County

5.3.1 MCAS Auburn Region: Nevada, Placer, Plumas, Sierra Counties

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

		Partnership Region - Auburn				National Medicaid Benchmarks			
Abbr	**Measure**	**NEVADA**	**PLACER**	**PLUMAS**	**SIERRA**	**25TH**	**50TH**	**75TH**	**90TH**
Behavioral Health Domain									
FUA-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	38.97%	44.96%	45.71%	100.00%	30.17%	39.10%	45.80%	53.27%
FUM-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	52.27%	41.97%	57.50%	12.50%	50.47%	57.13%	64.91%	74.67%
Children's Health Domain									
CIS-E	Childhood Immunization Status - Combination 10	13.61%	16.47%	0.00%	10.00%	19.77%	23.89%	28.86%	34.79%
DEV	Developmental Screening in the First Three Years of Life[1, 3]	23.53%	43.14%	4.90%	17.39%	-	37.40%	-	-
IMA-E	Immunizations for Adolescents - Combination 2	13.01%	29.10%	10.13%	33.33%	29.42%	34.14%	40.19%	47.16%
LSC	Lead Screening in Children	67.00%	75.00%	45.28%	20.00%	61.31%	69.96%	76.34%	82.86%
TFL	Topical Fluoride for Children [3]	13.02%	22.72%	7.38%	9.05%	-	21.50%	-	-
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months [5]	64.09%	70.53%	57.14%	66.67%	68.38%	72.32%	77.50%	82.12%
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months [5]	41.76%	60.71%	30.56%	12.50%	58.04%	63.38%	67.49%	71.71%
WCV	Child and Adolescent Well-Care Visits	44.69%	50.27%	39.48%	32.61%	49.68%	55.41%	61.47%	67.63%
Chronic Disease Domain									
AMR	Asthma Medication Ratio	67.27%	80.43%	63.16%	100.00%	57.63%	63.66%	70.39%	76.25%
CBP	Controlling High Blood Pressure[1]	71.00%	53.00%	62.00%	52.00%	63.75%	67.88%	71.34%	75.43%
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%) [1, 4]	32.00%	31.00%	73.00%	31.58%	35.77%	30.41%	26.52%	23.60%
Reproductive Health and Cancer Prevention Domain									
BCS-E	Breast Cancer Screening [2]	52.94%	50.00%	0.00%	0.00%	50.53%	55.87%	61.43%	66.31%
CCS-E	Cervical Cancer Screening	38.96%	38.27%	16.37%	30.77%	47.10%	52.32%	57.83%	64.21%
CHL	Chlamydia Screening in Women	48.90%	58.83%	27.07%	7.69%	48.48%	56.30%	65.47%	70.67%
PPC-POST	Prenatal and Postpartum Care: Postpartum Care [1]	95.00%	82.00%	86.44%	100.00%	78.10%	82.48%	85.15%	88.32%
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care [1]	87.00%	77.00%	84.75%	83.33%	82.97%	86.37%	89.78%	91.97%

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.3.2 MCAS Chico Region: Butte, Colusa, Glenn, Sutter, Yuba Counties

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

		Partnership Region - Chico					National Medicaid Benchmarks			
Abbr	Measure	BUTTE	COLUSA	GLENN	SUTTER	YUBA	25TH	50TH	75TH	90TH
Behavioral Health Domain										
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	43.34%	39.13%	35.59%	39.47%	37.50%	30.17%	39.10%	45.80%	53.27%
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	45.25%	54.02%	48.21%	59.72%	60.21%	50.47%	57.13%	64.91%	74.67%
Children's Health Domain										
CIS-E	Childhood Immunization Status - Combination 10	27.77%	28.78%	30.41%	33.50%	23.46%	19.77%	23.89%	28.86%	34.79%
DEV	Developmental Screening in the First Three Years of Life[1, 3]	20.59%	23.53%	48.04%	55.88%	49.02%	-	37.40%	-	-
IMA-E	Immunizations for Adolescents - Combination 2	25.62%	29.13%	24.44%	51.93%	43.35%	29.42%	34.14%	40.19%	47.16%
LSC	Lead Screening in Children	55.00%	75.00%	75.00%	80.00%	65.00%	61.31%	69.96%	76.34%	82.86%
TFL	Topical Fluoride for Children[3]	20.23%	31.82%	14.70%	35.18%	26.02%	-	21.50%	-	-
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months[5]	74.16%	81.75%	75.17%	88.04%	76.98%	68.38%	72.32%	77.50%	82.12%
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months[5]	59.95%	55.75%	35.88%	58.51%	54.14%	58.04%	63.38%	67.49%	71.71%
WCV	Child and Adolescent Well-Care Visits	44.32%	68.06%	57.58%	59.83%	50.26%	49.68%	55.41%	61.47%	67.63%
Chronic Disease Domain										
AMR	Asthma Medication Ratio	68.79%	80.00%	78.35%	69.62%	64.93%	57.63%	63.66%	70.39%	76.25%
CBP	Controlling High Blood Pressure[1]	61.00%	64.00%	62.00%	64.00%	55.00%	63.75%	67.88%	71.34%	75.43%
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%)[1, 4]	30.00%	31.00%	36.00%	26.00%	26.00%	35.77%	30.41%	26.52%	23.60%
Reproductive Health and Cancer Prevention Domain										
BCS-E	Breast Cancer Screening[2]	36.96%	11.11%	42.86%	40.00%	44.44%	50.53%	55.87%	61.43%	66.31%
CCS-E	Cervical Cancer Screening	36.16%	49.25%	44.72%	46.08%	40.79%	47.10%	52.32%	57.83%	64.21%
CHL	Chlamydia Screening in Women	54.53%	50.94%	50.75%	55.91%	58.97%	48.48%	56.30%	65.47%	70.67%
PPC-POST	Prenatal and Postpartum Care: Postpartum Care[1]	87.00%	97.00%	87.00%	88.00%	82.00%	78.10%	82.48%	85.15%	88.32%
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care[1]	81.00%	93.00%	69.00%	86.00%	87.00%	82.97%	86.37%	89.78%	91.97%

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.3.3 MCAS Eureka Region: Del Norte, Humboldt, Lake, Mendocino Counties

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

		Partnership Region - Eureka				National Medicaid Benchmarks			
Abbr	**Measures**	**DEL NORTE**	**HUMBOLDT**	**LAKE**	**MENDOCINO**	**25TH**	**50TH**	**75TH**	**90TH**
Behavioral Health Domain									
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	41.73%	46.22%	39.31%	35.44%	30.17%	39.10%	45.80%	53.27%
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	47.18%	53.14%	47.34%	49.04%	50.47%	57.13%	64.91%	74.67%
Children's Health Domain									
CIS-E	Childhood Immunization Status - Combination 10	5.07%	21.66%	26.90%	25.16%	19.77%	23.89%	28.86%	34.79%
DEV	Developmental Screening in the First Three Years of Life[1, 3]	32.35%	53.92%	26.47%	17.65%	-	37.40%	-	-
IMA-E	Immunizations for Adolescents - Combination 2	33.94%	41.59%	50.19%	36.23%	29.42%	34.14%	40.19%	47.16%
LSC	Lead Screening in Children	65.00%	74.00%	84.00%	84.00%	61.31%	69.96%	76.34%	82.86%
TFL	Topical Fluoride for Children [3]	9.86%	9.53%	7.08%	10.69%	-	21.50%	-	-
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months [5]	62.07%	75.81%	86.24%	79.66%	68.38%	72.32%	77.50%	82.12%
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months [5]	56.92%	61.39%	80.12%	77.86%	58.04%	63.38%	67.49%	71.71%
WCV	Child and Adolescent Well-Care Visits	55.90%	51.56%	50.46%	55.28%	49.68%	55.41%	61.47%	67.63%
Chronic Disease Domain									
AMR	Asthma Medication Ratio	74.07%	65.52%	81.37%	80.37%	57.63%	63.66%	70.39%	76.25%
CBP	Controlling High Blood Pressure[1]	66.00%	79.00%	75.00%	58.00%	63.75%	67.88%	71.34%	75.43%
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%) [1, 4]	24.00%	25.00%	39.00%	29.00%	35.77%	30.41%	26.52%	23.60%
Reproductive Health and Cancer Prevention Domain									
BCS-E	Breast Cancer Screening [2]	46.57%	52.24%	47.58%	53.30%	50.53%	55.87%	61.43%	66.31%
CCS-E	Cervical Cancer Screening	46.91%	53.01%	54.00%	55.98%	47.10%	52.32%	57.83%	64.21%
CHL	Chlamydia Screening in Women	52.49%	53.82%	63.70%	56.29%	48.48%	56.30%	65.47%	70.67%
PPC-POST	Prenatal and Postpartum Care: Postpartum Care [1]	76.00%	93.00%	89.00%	94.00%	78.10%	82.48%	85.15%	88.32%
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care [1]	80.00%	79.00%	94.00%	88.00%	82.97%	86.37%	89.78%	91.97%

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.3.4 MCAS Fairfield Region: Solano, Yolo, and Napa Counties

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

		Partnership Region - Fairfield			National Medicaid Benchmarks			
Abbr	**Measures**	**NAPA**	**SOLANO**	**YOLO**	**25TH**	**50TH**	**75TH**	**90TH**
Behavioral Health Domain								
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	40.11%	40.75%	33.33%	30.17%	39.10%	45.80%	53.27%
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	40.49%	47.36%	39.97%	50.47%	57.13%	64.91%	74.67%
Children's Health Domain								
CIS-E	Childhood Immunization Status - Combination 10	38.56%	32.03%	26.68%	19.77%	23.89%	28.86%	34.79%
DEV	Developmental Screening in the First Three Years of Life[1, 3]	11.76%	34.31%	44.12%	-	37.40%	-	-
IMA-E	Immunizations for Adolescents - Combination 2	57.56%	46.98%	48.03%	29.42%	34.14%	40.19%	47.16%
LSC	Lead Screening in Children	86.00%	74.00%	72.00%	61.31%	69.96%	76.34%	82.86%
TFL	Topical Fluoride for Children [3]	27.05%	22.99%	25.19%	-	21.50%	-	-
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months [5]	80.13%	72.82%	78.63%	68.38%	72.32%	77.50%	82.12%
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months [5]	75.36%	62.18%	66.98%	58.04%	63.38%	67.49%	71.71%
WCV	Child and Adolescent Well-Care Visits	64.08%	48.38%	54.46%	49.68%	55.41%	61.47%	67.63%
Chronic Disease Domain								
AMR	Asthma Medication Ratio	84.88%	74.58%	77.20%	57.63%	63.66%	70.39%	76.25%
CBP	Controlling High Blood Pressure[1]	73.00%	73.00%	74.00%	63.75%	67.88%	71.34%	75.43%
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%) [1, 4]	30.00%	34.00%	28.00%	35.77%	30.41%	26.52%	23.60%
Reproductive Health and Cancer Prevention Domain								
BCS-E	Breast Cancer Screening [2]	68.63%	52.50%	56.03%	50.53%	55.87%	61.43%	66.31%
CCS-E	Cervical Cancer Screening	53.29%	45.82%	51.78%	47.10%	52.32%	57.83%	64.21%
CHL	Chlamydia Screening in Women	60.46%	69.97%	55.05%	48.48%	56.30%	65.47%	70.67%
PPC-POST	Prenatal and Postpartum Care: Postpartum Care [1]	84.00%	92.00%	95.00%	78.10%	82.48%	85.15%	88.32%
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care [1]	93.00%	86.00%	94.00%	82.97%	86.37%	89.78%	91.97%

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.3.5 MCAS Redding Region: Lassen, Modoc, Shasta, Siskiyou, Tehama, Trinity Counties

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

		Partnership Region - Redding						National Medicaid Benchmarks			
Abbr	Measures	LASSEN	MODOC	SHASTA	SISKIYOU	TEHAMA	TRINITY	25TH	50TH	75TH	90TH
Behavioral Health Domain											
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	29.63%	48.00%	51.58%	34.92%	28.31%	30.77%	30.17%	39.10%	45.80%	53.27%
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	47.27%	41.67%	59.20%	62.81%	38.10%	52.94%	50.47%	57.13%	64.91%	74.67%
Children's Health Domain											
CIS-E	Childhood Immunization Status - Combination 10	3.23%	11.11%	10.02%	16.49%	20.05%	3.45%	19.77%	23.89%	28.86%	34.79%
DEV	Developmental Screening in the First Three Years of Life[1, 3]	22.55%	45.00%	35.29%	43.14%	36.27%	11.76%	-	37.40%	-	-
IMA-E	Immunizations for Adolescents - Combination 2	11.54%	16.92%	18.75%	19.22%	26.33%	15.49%	29.42%	34.14%	40.19%	47.16%
LSC	Lead Screening in Children	62.77%	66.67%	74.00%	63.00%	68.00%	67.80%	61.31%	69.96%	76.34%	82.86%
TFL	Topical Fluoride for Children[3]	8.54%	5.13%	13.67%	10.63%	14.06%	10.26%	-	21.50%	-	-
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months[5]	54.08%	59.52%	71.36%	67.91%	77.10%	62.71%	68.38%	72.32%	77.50%	82.12%
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months[5]	58.70%	45.71%	64.69%	59.05%	57.81%	46.51%	58.04%	63.38%	67.49%	71.71%
WCV	Child and Adolescent Well-Care Visits	33.68%	47.08%	49.71%	50.13%	51.95%	49.07%	49.68%	55.41%	61.47%	67.63%
Chronic Disease Domain											
AMR	Asthma Medication Ratio	71.43%	100.00%	65.33%	78.26%	69.06%	45.71%	57.63%	63.66%	70.39%	76.25%
CBP	Controlling High Blood Pressure[1]	67.00%	57.00%	71.00%	73.00%	65.00%	54.00%	63.75%	67.88%	71.34%	75.43%
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%)[1, 4]	39.00%	26.00%	23.00%	28.00%	31.00%	28.00%	35.77%	30.41%	26.52%	23.60%
Reproductive Health and Cancer Prevention Domain											
BCS-E	Breast Cancer Screening[2]	39.31%	51.72%	45.02%	50.99%	50.00%	34.53%	50.53%	55.87%	61.43%	66.31%
CCS-E	Cervical Cancer Screening	44.09%	49.74%	51.11%	51.49%	40.93%	49.61%	47.10%	52.32%	57.83%	64.21%
CHL	Chlamydia Screening in Women	53.59%	46.05%	54.35%	51.43%	53.02%	40.00%	48.48%	56.30%	65.47%	70.67%
PPC-POST	Prenatal and Postpartum Care: Postpartum Care[1]	82.76%	64.86%	86.00%	76.00%	86.00%	90.91%	78.10%	82.48%	85.15%	88.32%
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care[1]	88.51%	70.27%	79.00%	81.00%	78.00%	86.36%	82.97%	86.37%	89.78%	91.97%

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.3.6 MCAS Santa Rosa Region: Marin, Sonoma Counties

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

		Partnership Region - Santa Rosa		National Medicaid Benchmarks			
Abbr	Measures	MARIN	SONOMA	25TH	50TH	75TH	90TH
Behavioral Health Domain							
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	43.18%	39.74%	30.17%	39.10%	45.80%	53.27%
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	55.08%	54.83%	50.47%	57.13%	64.91%	74.67%
Children's Health Domain							
CIS-E	Childhood Immunization Status - Combination 10	45.92%	40.14%	19.77%	23.89%	28.86%	34.79%
DEV	Developmental Screening in the First Three Years of Life[1, 3]	81.37%	41.18%		37.40%		
IMA-E	Immunizations for Adolescents - Combination 2	67.47%	55.78%	29.42%	34.14%	40.19%	47.16%
LSC	Lead Screening in Children	86.00%	61.00%	61.31%	69.96%	76.34%	82.86%
TFL	Topical Fluoride for Children[3]	41.72%	27.35%		21.50%		
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months[5]	91.59%	78.86%	68.38%	72.32%	77.50%	82.12%
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months[5]	78.83%	74.53%	58.04%	63.38%	67.49%	71.71%
WCV	Child and Adolescent Well-Care Visits	60.35%	58.16%	49.68%	55.41%	61.47%	67.63%
Chronic Disease Domain							
AMR	Asthma Medication Ratio	73.23%	79.28%	57.63%	63.66%	70.39%	76.25%
CBP	Controlling High Blood Pressure[1]	64.00%	74.00%	63.75%	67.88%	71.34%	75.43%
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%)[1, 4]	34.00%	23.00%	35.77%	30.41%	26.52%	23.60%
Reproductive Health and Cancer Prevention Domain							
BCS-E	Breast Cancer Screening[2]	60.55%	57.12%	50.53%	55.87%	61.43%	66.31%
CCS-E	Cervical Cancer Screening	55.26%	57.41%	47.10%	52.32%	57.83%	64.21%
CHL	Chlamydia Screening in Women	77.57%	60.86%	48.48%	56.30%	65.47%	70.67%
PPC-POST	Prenatal and Postpartum Care: Postpartum Care[1]	98.00%	98.00%	78.10%	82.48%	85.15%	88.32%
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care[1]	93.00%	97.00%	82.97%	86.37%	89.78%	91.97%

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

6.0 Overall Health Plan Ranking: DHCS Managed Care Accountability Set (MCAS)

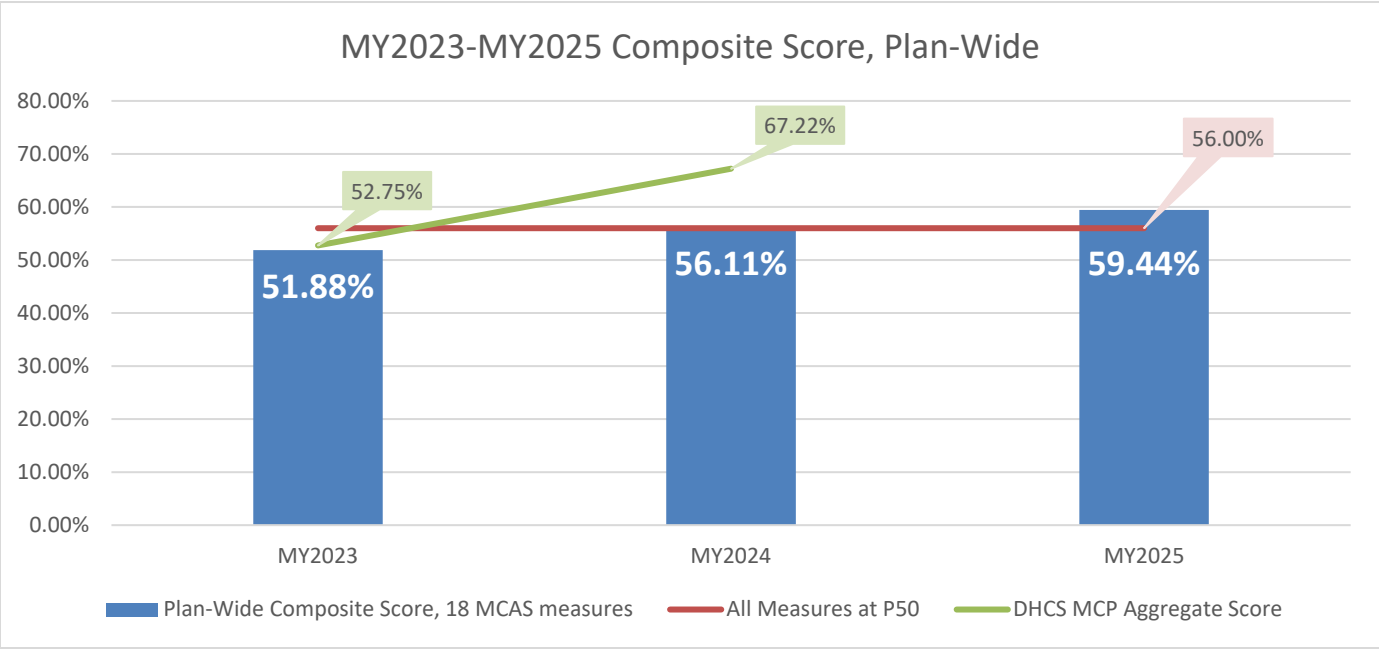
DHCS uses a scoring methodology to determine an aggregated Quality Factor Score (QFS), which ranks health plan performance relative to California Medicaid reporting health plans. Partnership adopts DHCS' scoring methodology to determine Partnership's composite scores year over year. The composite score is based on the plan-wide measure rates for all measures in the MCAS measure set.

To calculate the composite score, each measure is given a score from one to ten based on performance relative to national benchmarks. A composite score is then calculated by dividing total earned points by total possible points.

The Quality Compass 2025 Benchmarks, which were developed based on national MY2024 performance, are the most currently available benchmarks. These benchmarks were used by Partnership to determine percentile rankings and the following composite scoring year over year analysis. Annually each fall, DHCS releases a dashboard displaying the plan's Quality Factor Scores and associated rankings to other health plans, along with the Reporting Year's MCP Aggregate Score. The results of this ranking will be published upon the release of this information later in 2026.

Overall, the MY2025 HEDIS® Composite Performance Year over Year Comparison indicates a 5.93% increase in aggregate plan-wide performance from MY2024 to MY2025.

MY2025 HEDIS® Composite Performance Year over Year Comparison: DHCS Managed Care Accountability Set (MCAS)



Note: MY2025/RY2026: Total Points Earned: 107 Points out of 180 Total Points (18 measures included)

- In MY2025, 18 measures were held accountable to the MPL. The MCAS measure set has included the same 18 measures between MY2023 – MY2025.
- The MY2025 Quality Factor Score will be released by DHCS in Fall 2026, and the MY2025 MCP Aggregate Score will be updated at that time.

7.0 Year-over-year Performance Trends and Initial Assessment of Results

7.1 Year-over-year Performance Trends

Plan-Wide, Partnership saw the following Year over Year changes in Plan-Wide rates between MY2024 and MY2025:

- 6 of 18 measures moved to a higher benchmark in MY2025.
- 7 of 18 measures stayed at their same benchmark as MY2024 in MY2025.
- 5 of 18 measures moved to a lower benchmark in MY2025.

7.2 Plan-Wide Strengths: Measure Performing Above MPL

12 of the 18 measures in the MCAS Accountable set had plan-wide rates that exceeded the Minimum Performance Level in MY2025.

Three measures are newly above the Minimum Performance Level in MY2025, as seen in the Table below.

Table: MCAS Measures Newly Above MPL in MY2025

	Plan-Wide		North Bay Area		Rural Upper Central		Rural Upper North	
Measure Description	MY2024	MY2025 YoY points change	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Follow-Up After Emergency Department Visit for Substance Use - 30-Days (FUA-30)	33rd	50th +8.08%	25th	50th	25th	50th	25th	67th
Asthma Medication Ratio (AMR)	33rd	75th +8.62%	50th	90th	<25th	75th	25th	75th
Chlamydia Screening in Women (CHL)	33rd	50th +3.40%	50th	75th	25th	33rd	25th	33rd

Benchmark
90th
67th or 75th
50th – MPL or >50th (CMS)
25th or 33rd
<25th or <50th (CMS)

Follow-up After Emergency Department (ED) Visit for Substance Use (FUA-30): Partnership's plan-wide rate for FUA-30 is newly over the 50th percentile plan-wide and in all three Rating Regions in MY2025, with a plan-wide increase over 8% in performance. Partnership worked collaboratively with county partners to close care gaps and enhance data collection and reporting of qualifying follow-up services. Additionally, MY2025 was a year of sustained focus on maximizing data capture opportunities from DHCS's data feed. Finally, DHCS released All Plan Letter 26-003 in early 2026 that mandates data sharing for behavioral health visits, including visits for substance use treatment; Partnership believes that this prescribed approach to data sharing will increase access to sensitive data required for accurate rate reporting.

Asthma Medication Ration (AMR): Partnership rates were at the 75th percentile, plan-wide and at or above the 75th percentile in all three Rating Regions, in MY2025. The HEDIS team reviewed updates to its AMR custom code mapping frequently during the MY2025 Annual Project and

requested several custom code mappings from their auditor. In MY2025, Partnership added a Unit of Service (UOS) measure to its PCP QIP, to incentivize practices to host Academic Detailing sessions with Partnership's Pharmacy team. The Pharmacy team reviews pharmacy claims data to improve medication management for asthma and other chronic conditions. The AMR measure was retired at the end of MY2025, and is replaced by a Reporting Only measure, Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E), in MY2026.

Chlamydia Screening in Women (CHL): Partnership added the CHL measure to its PCP QIP in MY2025, which allowed practices to monitor their performance on this measure. As a result Chlamydia Screening rates increased in North Bay Area in MY2025 and the plan-wide rate is over the 50th percentile. DHCS retired CHL from the MCAS measure set at the end of MY2025.

Four additional measures have sustained Plan-Wide performance above the MPL since MY2024.

Table: MCAS Measures With Sustained Performance above the MPL MY2024-2025

	Plan-Wide		North Bay Area		Rural Upper Central		Rural Upper North	
Measure Description	MY2024	MY2025 YoY points change	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Childhood Immunization Status - Combination 10 (CIS-E)	50th	50th +2.16%	67th	90th	<25th	50th	<25th	<25th
Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months (W30-2)	67th	67th +4.42%	67th	75th	<25th	50th	50th	50th
Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD) *	50th	67th -4.87% *	33rd	50th	25th	50th	50th	50th
Prenatal and Postpartum Care: Postpartum Care (PPC-Post)	90th	90th +0.49%	90th	90th	75th	75th	75th	75th

Benchmark
90th
67th or 75th
50th – MPL or >50th (CMS)
25th or 33rd
<25th or <50th (CMS)

* Glycemic Status Assessment is an inverse measure, and a decline in YoY performance indicates improvement.

Childhood Immunizations ECDS (CIS-E): Partnership sustained its Plan-Wide rate above the 50th percentile on this measure in MY2025, despite the measure transitioning from a hybrid measure to an ECDS measure. The sustained performance is partially due to a small plan-wide rate increase, and also due to the continuing decline in the national percentiles between MY2024 and MY2025. North Bay Area and Rural Upper Central counties had significantly stronger measure performance than Rural Upper North counties. Interestingly, Partnership's rate for influenza vaccines, which is the most widely refused vaccine in the measure series, is above the 50th percentile, which is likely the cause of our plan-wide benchmark remaining above the 50th percentile. High rates of parental refusal, especially in Rural Upper North counties, continue to be a major factor in measure performance, which is not a permitted exclusion under the HEDIS measure. Partnership recommends a focus on completing Well Child Visits for children under 2 years as a driver for higher completion rates for this measure.

Well Child Visits in the First 30 Months of Life: 2+ Visits 15-30 Months (W30-2): The W30-2 measure continues its second year at the 67th percentile and is above the 50th percentile in all three Rating Regions. Partnership continues to address the known data completeness issues around the W30 measure by completing a Medical Record Review (MRR) of the entire eligible population for the W30 measure. By requesting charts from PCP's and completing a Medical Record Review, Partnership treats the measure as a hybrid measure and receives auditor approval annually to include the W30 MRR as a supplemental data source.

In addition, the HEDIS team conducted a W30 Kaizen across the organization which primarily identified gaps in incomplete claims submission. Finally, Partnership is working closely with DHCS as an active participant in the DHCS Early Childhood Affinity State Work group to improve newborn visit capture statewide.

Glycemic Status Assessment for Patients with Diabetes (>9%) (GSD): GSD's Plan-Wide rate improved by 4.87% in MY2025 (as an inverse measure, improvement is reflected as a lower rate). GSD is a hybrid measure, and Medical Record Review also shows sustained performance within all three Rating Regions. Partnership's Health Information Exchange, Sacramento Valley MedShare (SVMS) is a clearinghouse for lab data, which helps support the Medical Record Review for this measure. Additionally, Partnership expanded use of an NCQA Data Aggregator, Datalink, in MY2025 – as described in Section 1, Datalink is a promising new source of clinical data, including Hemoglobin A1c results. Finally, the increased use of OCHIN Epic within the PCP network means that more practices have the ability to automate the CPTII coding that is required to support this measure.

Postpartum Care (PPC-Post): Postpartum Care visits continue to be a source of strength for Partnership, with sustained performance over the 90th percentile. Interventions to maintain high postpartum care rates are described in Section 9 and include refinements to the Growing Together Program and equity focused programs centered on communities with lower prenatal and postpartum visit rates.

7.3 Opportunities for Improvement

After analyzing the MY2025 annual results and year over year performance comparisons, measures below the MPL can be categorized across three primary drivers.

1.) Performance – Members qualifying under a measure did not receive the required care per measure specifications and designated timeframes

2.) **Data Completeness** – Data used to generate reported rates has gaps, decreasing confidence that reported rates accurately reflect performance.

3.) Measure Limitations – Measure specifications determine how data is collected through the reporting of rate performance. Measure specifications can detract from a measure's intended purpose. In these cases, specifications can limit accurate representation of performance as well as detection of recent improvements that are in alignment with the measure's purpose and clinical practice.

7.3.1 MCAS Measures with Regional Performance Opportunities

Seven measures are performance improvement opportunities for specific areas of Partnership's network. These measures have sustained performance below the MPL in specific Rating Regions and counties, and data completeness issues are not the primary driver of low measure rates.

Partnership has prioritized **five measures** as its **highest priority for improvement in 2026 onward** at the regional level:

Table: Prioritized MCAS Measures with Performance Opportunities

	Plan-Wide		North Bay Area		Rural Upper Central		Rural Upper North	
Measure Description	MY2024	MY2025 YoY points change	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Child and Adolescent Well-Care Visits (WCV)	33rd	33rd +3.74%	33rd	50th	25th	25th	25th	25th
Immunizations for Adolescents - Combination 2 (IMA-E)	50th	67th +1.46%	75th	90th	25th	33rd	<25th	33rd
Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months (W30-6)	75th	50th -2.41%	75th	75th	<25th	<25th	75th	67th
Controlling High Blood Pressure (CBP)	75th	33rd -2.19%	50th	75th	25th	<25th	25th	50th
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre)	50th	50th +1.70%	<25th	90th	25th	<25th	<25th	25th

Benchmark
90th
67th or 75th
50th – MPL or >50th (CMS)
25th or 33rd
<25th or <50th (CMS)

Child and Adolescent Well Care Visits (WCV): This measure requires an annual well care visit for children and adolescents between the ages of 3-21. While plan-wide performance improved slightly in MY2025, it was not sufficient to meet the MPL benchmark, which increased in MY2025.

Given this measure's demand, performance is largely impacted by access constraints. Young adults ages 18-21 years have by far the lowest rate of well care visit completion within the measure; for several reasons, one of which is to preserve access for younger age bands, the young adult age band is not included in Partnership's PCP QIP WCV measure. Therefore, Partnership requires very high completion rates for children ages 3-17 years (partial payment at 75th percentile and full payment at 90th percentile) in its PCP QIP.

Immunizations for Adolescents (IMA-E): Though Partnership's Plan-Wide rate was at the 67th percentile, regional rates that are approaching the 50th percentile are prioritized as an improvement opportunity for Rural Upper North and Rural Upper Central regions. Because some of the vaccinations included in this measure are required for public school enrollment, this is historically a higher performing childhood vaccination measure than Childhood Immunization Series (CIS-E). Encouragingly, MY2025 shows several counties in Rural Upper North and Rural Upper Central regions exceeding the MPL for this measure along with all North Bay Area counties, and Partnership sees high performance on IMA-E across its network as an achievable goal. The predominant causes of low rates are missing or late secondary doses of the HPV immunization series and high rates of parental refusal.

Well Child Visits in the First 30 Months of Life: 6+ Visits Birth-15 Months (W30-6): The W30-6 measure continues its strong performance in North Bay Area and Rural Upper North Rating Regions. The decline in performance was driven by low performance in the Rural Upper Central Region. MY2025 is the first year that significant numbers of children were in the eligible population for W30-6 in Rural Upper Central counties, and MY2025 should be considered a baseline year for the region. As with W30-2, Partnership completes a Medical Record Review (MRR) of the entire eligible population for the W30 measure, so low performance indicates a low service completion rate, not a data completeness issue.

Controlling Blood Pressure (CBP): This measure was one of the few measures that declined in performance in MY2025, falling from the 75th percentile to the 25th percentile. The decline in performance was driven by low performance in the Rural Upper Central Region and will be a high priority area of focus in MY2026 onward.

Timeliness of Prenatal Care (PPC-Pre): Once again, Partnership just met the MPL for the Plan-Wide rate for this measure in MY2025. While North Bay Area's regional performance improved dramatically in MY2025, PPC-Pre remains an important improvement opportunity for Rural Upper North and Rural Upper Central counties. The HEDIS team observed several performance issues around prenatal visits, noting that many members receive their first prenatal visit outside of the measure timeline, and that visits do not include all of the required components of a prenatal visit. Prenatal visits will continue to be a measure of regional focus in MY2026 onwards to overcome the challenges for birthing populations in the rural North (ie: prenatal care deserts, loss of L&D units and critical access hospitals).

An additional **four measures** are improvement opportunities in 2026 onward at the regional level:

Table: Additional MCAS Measures with Performance Opportunities

	Plan-Wide		North Bay Area		Rural Upper Central		Rural Upper North	
Measure Description	**MY2024**	**MY2025 YoY points change**	**MY2024**	**MY2025**	**MY2024**	**MY2025**	**MY2024**	**MY2025**
Developmental Screening in the First Three Years of Life (DEV)	<50th	50th +9.77%	<50th	50th	50th	<50th	<50th	<50th
Lead Screening in Children (LSC)	75th	67th +3.16%	50th	50th	50th	33rd	75th	67th
Topical Fluoride for Children (TFL)	<50th	<50th +8.67%	<50th	50th	50th	50th	<50th	<50th
Cervical Cancer Screening (CCS-E)	50th (Hybrid)	25th -11.04%	75th (Hybrid)	50th	<25th (Hybrid)	<25th	25th (Hybrid)	50th

Benchmark
90th
67th or 75th
50th – MPL or >50th (CMS)
25th or 33rd
<25th or <50th (CMS)

Developmental Screening (DEV): In MY2025, DHCS transitioned the Developmental Screening measure from administrative to hybrid, which is recommended by CMS, the measure steward. As a hybrid measure, Partnership had the opportunity to complete a Medical Record Review on this measure in MY2025, which helped to overcome measure coding limitations seen in past years' HEDIS rates.

While only one Rating Region (North Bay Area) achieved the MPL for this measure, the other two regions were very close to the 50th percentile in MY2025. Partnership recommends a focus on completing Well Child Visits for children ages 1-3 years as a driver for higher completion rates for this measure.

Lead Screening for Children (LSC): Partnership sustained performance over the 50th percentile on the LSC measure in MY2025 in North Bay Area and Rural Upper North. Sustained high performance is related to the inclusion of the measure in the PCP QIP, which allows practices to measure their improvement throughout the measurement year, as well as interventions to maintain high lead screening rates described in Section 9. This measure is at the 33rd percentile in Rural Upper Central region and represents a regional improvement opportunity. Partnership recommends a focus on completing Well Child Visits for children ages 1-3 years as a driver for higher completion rates for this measure.

Topical Fluoride for Children (TFL-CH): The largest driver of performance on this measure is Denti-Cal claims data provided by DHCS. Partnership engaged very closely with DHCS's Data Team around improving the completeness of data around this measure, with significant success in MY2025. The use of an ICD-10 code (Z29.3) indicating fluoride varnish application is now mandated on Denti-Cal claims, to allow complete data capture. For the second year in a row, Partnership showed significant year-over-year improvement in TFL-CH rates, and is less than 1 percentage point from meeting the MPL for the measure in MY2025. (There are no additional

benchmarks for this measure.) The Rural Upper North has an improvement opportunity for TFL-CH. Partnership recommends a focus on completing Well Child Visits for children ages 1-20 years as a driver for higher completion rates for this measure.

Cervical Cancer Screening (CCS-E): Cervical Cancer Screening transitioned from a hybrid to an ECDS measure in MY2025. Plan-wide performance at the 25th percentile was driven by low performance in the Rural Upper Central region. While CCS-E represents an improvement opportunity for Rural Upper Central counties, expansion of Datalink will also address data capture of historical screens that occurred prior to the network joining Partnership.

As noted in Section 9, Partnership is promoting self-swab testing to members through PCPs, now that this method has received FDA approval and can be counted towards this HEDIS measure in MY2026 and onward.

7.3.2 MCAS Measures with Data Completeness and Measure Limitation Issues

Finally, two measures performed below the MPL in MY2025 primarily because of data completeness and measure limitation issues. Partnership has documented and escalated data completeness issues around both measures directly to DHCS and is engaged in interventions and activities meant to improve the quality and completeness of data, where relevant.

Table: MCAS Measures with Data Completeness and Measure Limitation Issues

	Plan-Wide		North Bay Area		Rural Upper Central		Rural Upper North		
Measure Description	MY2024	MY2025 YoY points change	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	Benchmark
									90th
									67th or 75th
									50th – MPL or >50th (CMS)
									25th or 33rd
									<25th or <50th (CMS)
Follow-Up After Emergency Department Visit for Mental Illness - 30-Days (FUM-30)	<25th	<25th +21.25%	<25th	<25th	<25th	<25th	<25th	33rd	
Breast Cancer Screening (BCS-E)	50th	33rd -2.86%	50th	50th	<25th	<25th	25th	<25th	

Follow-up After Emergency Department (ED) Visit for Mental Illness (FUM-30): Partnership's plan-wide rate for FUM-30 increased over 20 percentage points in MY2025. Partnership benefitted from a revised NCQA measure definition that expanded the scope of services counting as a follow-up visit, as well as sustained focus on maximizing data capture opportunities from DHCS's data feed. While the plan made significant gains in data capture from DHCS data feeds, Partnership is still not receiving a full year's worth of data from County DBH's to apply to this measure during the HEDIS project timeline. Partnership is actively working with DHCS to improve the quality of our data feed, and exploring other opportunities to receive clinical data from County DBH EMR's to improve the completeness of our data.
Breast Cancer Screening (BCS-E): The Breast Cancer Screening measure transitioned its age range from 52-74 years to 42-74 years. This has resulted in a misalignment of the MY2025 measure (42-74 years), with the NCQA benchmark applied, that was based on MY2024 national

outcomes (52-74 years). Once NCQA creates a national benchmark based on the new age range (later in 2026), this measure limitation issue will no longer exist.

Partnership has recommended to DHCS that Medi-Cal MCP's be held accountable for the 52-74 years sub-measure, which does align with the MY2024 NCQA benchmark. In the majority of counties, Partnership's performance would be above the 50th percentile in MY2025 for DHCS accountability programs if this recommendation is acted upon by DHCS.

Because the measure has long continuous enrollment requirements for members to be included in the measure, MY2025's measure still included very few members from the Rural Upper Central Rating Region.

7.4 Comparing MY2025 MCAS Results to MY2025 PCP QIP Results

The clinical measures included in the Primary Care Provider Quality Incentive Program (PCP QIP) are designed to reflect HEDIS measure priorities. Most PCP QIP clinical measures have very similar definitions to their HEDIS measure counterparts, and strong performance on PCP QIP measures should be reflected in strong HEDIS measure performance. Differences between PCP QIP and HEDIS measures are designed to improve providers' ability to impact the population in the measure. Some examples include:

- Partnership relaxes the strict continuous enrollment requirements in PCP QIP measures that are present in many HEDIS measures. Several measures (AMR, BCS-E, and W30) require members be continuously enrolled with a MCP for 11 months to be included in the HEDIS measure; Partnership relaxed this requirement so that incoming members could be included in their PCP QIP cohorts.
- Partnership allows PCPs to upload supplemental data for all PCP QIP measures. HEDIS administrative and ECDS measures only allow claims and encounter data, as well as auditor approved supplemental data, to be applied to a HEDIS measure.
- Two PCP QIP measures have smaller age bands than their aligned HEDIS measures to prioritize focus on the highest priority age bands in the eligible populations: Child and Adolescent Well-Care Visits and Topical Fluoride for Children. An additional PCP QIP measure had a larger eligible population than the HEDIS measure: Chlamydia Screening in Women.

Overall, plan-wide performance improved significantly (>=5 percent) on the following continuous measures on the PCP QIP that are aligned with MCAS measures between MY2024 and MY2025:

- Cervical Cancer Screening
- Diabetes – HbA1c Good Control

Several measures were added to the PCP QIP measure set in MY2025 to align with the MCAS measure set:

- Breast Cancer Screening, 40-51 years (monitoring measure)

- Chlamydia Screening
- Topical Fluoride for Children – 1-5 years (monitoring measure)
- Well Child Visits 15-30 Months (monitoring measures)

The MY2025 MCAS measure plan-wide performance trends were consistent with corresponding MY2025 PCP QIP results in most cases.

Unsurprisingly, the two PCP QIP measures with smaller age bands (Child and Adolescent Well-Care Visits and Topical Fluoride for Children) had higher performance than their HEDIS measure counterpart, and the one PCP QIP measure with a larger eligible population (Chlamydia Screening in Women) had lower performance than its HEDIS measure counterpart.

The PCP QIP Cervical Cancer Screening measure performed significantly higher than its HEDIS counterpart. This is due to the HEDIS measure transitioning to an ECDS measure in MY2025, which exposed significant data completeness issues with the measure. Partnership will be addressing these issues in 2026 onward by focusing on best practices in coding and clinical data exchange via Health Information Exchanges and Datalink.

All other HEDIS measures that are aligned with PCP QIP measures showed slightly higher plan wide performance in the HEDIS measure than in the plan wide PCP QIP.

7.5 Next Steps in Finalizing Assessment of Results

- DHCS will finalize Quality Factor Scoring of all managed care plans, based on composite scoring, in fall 2026.
- DHCS has not yet announced the outcomes of MY2025 accountability programs described in Section 1. DHCS will share sanctions and the results of other accountability programs with plans including Partnership.
- Final assessment of results will be used to adapt quality measure score improvement strategies and tactics in 2026-2027.

8.0 Summary of MCAS Measures in Partnership's Quality Improvement Programs

The table below provides a summary of included in the Measures Managed Care Accountability Sets (MCAS) Measures included in Partnership's Quality Improvement Programs, Measurement Year 2025.

HEDIS® Measures	MCAS Accountable/Reporting	MY2024 QIP Measure	MY2025 QIP Measure	QIP Program
Asthma Medication Ration (AMR)*	Accountable			None
Breast Cancer Screening (BCS-E)*	Accountable	X	X	PCP QIP Ages 52-74 years – Clinical Ages 40-51 years – Monitoring
Cervical Cancer Screening (CCS-E)	Accountable	X	X	PCP QIP
Childhood Immunization Status (CIS-E) – Combo 10	Accountable	X	X	PCP QIP
Chlamydia Screening (CHL)	Accountable		X	PCP QIP Monitoring
Colorectal Cancer Screening (COL-E)	Reporting	X	X	PCP QIP
Controlling High Blood Pressure (CBP)	Accountable	X	X	PCP QIP
Developmental Screening in the First Three Years of Life (DEV)	Accountable			None
Eye Exam for Patients with Diabetes (EED)	Reporting	X	X	PCP QIP
Glycemic Status Assessment for Patients with Diabetes—Glycemic Status (>9%), Poor Control (GSD)	Accountable	X	X	PCP QIP QIP uses the inverse of this measure: Good Control, HbA1c Good Control <9%
Immunizations for Adolescents (IMA-E) – Combo 2	Accountable	X	X	PCP QIP
Lead Screening in Children (LSC)	Accountable	X	X	PCP QIP
Postpartum Depression Screening (PDS-E)	Reporting	X	X	Perinatal QIP
Prenatal Depression Screening (PND-E)	Reporting	X	X	Perinatal QIP
Prenatal and Postpartum Care (PPC) – Postpartum Care	Accountable	X	X	Perinatal QIP
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	Accountable	X	X	Perinatal QIP
Prenatal Immunization Status – combo (PRS-E)	Reporting	X	X	Perinatal QIP
Topical Fluoride for Children (TFL)	Accountable		X	PCP QIP Ages 1-5 years - Monitoring
Well-Child Visits in the First 30 Months of Life—15 to 30 Months—Two or More Well-Child Visits (W30-2)	Accountable		X	PCP QIP

HEDIS® Measures	MCAS Accountable/Reporting	MY2024 QIP Measure	MY2025 QIP Measure	QIP Program
Well-Child Visits in the First 30 Months of Life—0 to 15 Months—Six or More Well-Child Visits (W30-6)	Accountable	X	X	PCP QIP
Child and Adolescent Well-Care Visits (WCV)	Accountable	X	X	PCP QIP

PCP QIP Measurement Set: http://www.partnershiphp.org/Providers/Quality/Pages/PCPQIPLandingPage.aspx

9.0 Measurement Year 2024 Managed Care Accountability Site (MCAS) Measurement Set Descriptions-Accountable Measures

HEDIS Measure	Measure Indicator	Measure Definition
Asthma Medication Ratio (AMR)	• Total	• The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
Breast Cancer Screening (BCS-E)	• Non-Medicare Total	• The percentage of women 42–74 years of age who had a mammogram to screen for breast cancer as of December 31 of the measurement year.
Cervical Cancer Screening (CCS-E)	• Total	• The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: o Women 21–64 years of age who had cervical cytology performed within the last 3 years o Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years • Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years
Child and Adolescent Well-Care Visits (WCV)	• Total	• The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. • Total. The sum of the age stratifications (ages 3–21) as of December 31 of the measurement year.

HEDIS Measure	Measure Indicator	Measure Definition
Childhood Immunization Status (CIS-E)	• Combination 10	• The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates.
Chlamydia Screening in Women (CHL)	• Total	• The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. o Total: the sum of the age stratifications.
Controlling High Blood Pressure (CBP) *	• Total	• The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
Developmental Screening in the First Three Years of Life (DEV_CH) *	• Total All Ages	• Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday. • This measure is a CMS FFY 2023 Child Core Set Measure, held to the DHCS designated MPL.
Follow-Up After ED Visit for Mental Illness – 30 days (FUM)	• Total	• The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. • The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

HEDIS Measure	Measure Indicator	Measure Definition
Follow-Up After ED Visit for Substance Abuse – 30 days (FUA)	• Total	• The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. • The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
Immunizations for Adolescents (IMA-E)	• Combination 2	• The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates. • Combination 2. Adolescents who have had all three indicators (meningococcal, Tdap and HPV).
Hemoglobin A1c Control for Patients With Diabetes (GSD)*	• HbA1c poor control (>9.0%)	• The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the Measure Indicators performed. o HbA1c poor control (>9.0%). The most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year.
Lead Screening in Children (LSC) *	• Total	• The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday. • At least one lead capillary or venous blood test (Lead Tests Value Set) on or before the child's second birthday.

HEDIS Measure	Measure Indicator	Measure Definition
Prenatal and Postpartum Care (PPC) *	• Timeliness of Prenatal Care • Postpartum Care	• The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. o Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. o Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.
Topical Fluoride for Children (TFL-CH)	• Total ages 1 through 20	• Percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications as: (1) dental or oral health services, (2) dental services, and (3) oral health services within the measurement year. • This measure is a CMS FFY 2023 Child Core Set Measure, held to the DHCS designated MPL.
Well-Child Visits in the First 30 Months of Life (W30)	• Well-Child Visits in the First 15 Months • Well-Child Visits for Age 15 Months–30 Months.	• The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: • Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. • Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.

** Hybrid Measures. A random sample of the eligible population is used in calculating performance, as opposed to the entire eligible population.*

10.0 Quality Improvement Initiatives - HEDIS Score Improvement

Partnership's Quality Improvement organization-wide goals for 2025-2026 focused on four measure domains similar to those defined under the DHCS Managed Care Accountability Set (MCAS) measures:

1. **Behavioral Health**
2. **Pediatrics**
3. **Chronic Diseases**
4. **Women's Health and Perinatal**

The Quality Measure Score Improvement (QMSI) effort continues to better coordinate service and performance across the organization and to raise Partnership's overall performance in quality measures, as defined under DHCS MCAS and NCQA Health Plan Accreditation (HPA). This effort involved team formation under QMSI to encompass all current and potentially future accountable measures by measure family within each workgroup team: Pediatric, Chronic Diseases, Behavioral Health, Women's Health and Perinatal Care. Each workgroup monitored and reviewed all measure performance where data was available, assessed current improvement efforts, identified gaps and initiated new performance improvement activities.

QMSI workgroups consisted of cross-functional teams led by Quality and included representation from across the organization, such as: Care Coordination, Claims, Health Education, Office of the CMO, Pharmacy, Population Health, Provider Relations, Quality and/or regional leadership. The following summaries include what each measure-family QMSI Workgroup Team achieved in 2025-2026.

10.1 Behavioral Health Measure Activities

Sac Valley MedShare Data Exchange: Partnership HealthPlan of California and SacValley MedShare (SVMS): To improve data sharing capabilities between Behavioral Health Plans (BHPs) and Partnership, the partnership with SacValley MedShare (SVMS) was expanded to include county participation. By the end of 2025, Partnership and SVMS successfully onboarded all participating counties into a unified data exchange, significantly strengthening regional data-sharing infrastructure. Partnership's auditor, HSAG, approved use of the SVMS Encounters file, which contained County DBH follow-up service data, as a supplemental data source for MY2025 HEDIS rate generation.

Key Learnings:

- The collaboration facilitated the provision of medical data, including real-time admissions, discharges, and transfers, from participating hospitals.
- Some counties implemented opt-in procedures for data sharing, which have limited the number

of beneficiaries included in the data.
- Substance use disorder data has not yet been included in the exchange due to varying levels of regulatory uncertainty across counties.

DHCS Mandated Non-Clinical PIP: Improving Provider Notifications and Follow-Up for Members with Serious Mental Health Diagnoses: The Department of Health Care Services (DHCS) has mandated a non-clinical Performance Improvement Project (PIP) focused on enhancing the timeliness and consistency of provider notifications for members with Serious Mental Health (SMH) diagnoses following emergency department (ED) visits. The primary goal of this initiative is to improve the percentage of notifications sent to providers within seven days of an ED visit, thereby increasing the likelihood of timely follow-up care for affected members.

In 2024, the QI team at Partnership identified a tool with the potential to significantly improve provider notification processes: PointClickCare. Partnership subscribes to this platform, which serves as a centralized hub for real-time Admission, Discharge, and Transfer (ADT) messages from EDs and hospitals across California. To operationalize this data, Partnership launched a targeted intervention in the Eureka Region, routing daily PointClickCare reports to a large provider organization. These reports flag assigned members with recent ED visits for SMH diagnoses. In response, the provider organization is developing integrated clinical and operational workflows across its sites to proactively conduct outreach, schedule appointments, and ensure follow-up care is completed within 30 days of the ED event. This approach supports engagement for members less likely to seek care due to stigma or other barriers. The pilot will continue through 2026, with expansion planned based on promising results.

Key Learnings:
- Regular data exchange to promote shared learning, pattern recognition, and continuous quality improvement.
- Real-time data analysis to support agile adjustments and maintain program responsiveness.
- Focused efforts on increasing the rate of timely notifications and achieving compliance with follow-up targets.

DHCS 2025–27 DMC ODS Clinical and Non-Clinical Performance Improvement Projects (PIPs):
The California Department of Health Care Services (DHCS) requires all Drug Medi-Cal Organized Delivery System (DMC-ODS) plans to conduct two Performance Improvement Projects (PIPs) per contract period—one clinical and one non-clinical. The current PIP cycle began in 2025, with annual submissions due each July, and will conclude in 2027 (final submission due July 2028). Participating counties include Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano.

Within this framework, Partnership is implementing PIPs focused on improving follow-up after Emergency Department (ED) visits for substance use and increasing the number of members receiving Peer Support Services. Together, these efforts aim to strengthen engagement and continuity of care for members with behavioral health and substance use needs.

The Clinical PIP focuses on improving follow-up rates after ED visits for substance use. Root cause analysis is underway to identify barriers to timely follow-up, and targeted interventions are being implemented and monitored for effectiveness. Findings from this work will inform process improvements for upcoming reporting periods.

The Non-Clinical PIP focuses on expanding access to Peer Support Services. To support this, counties have been offered up to $10,000 per individual through HCAI funding to train and develop Peer Support Specialists, increasing workforce capacity.

Key Learning:

- Accurate and up-to-date member contact information is critical to enhance outreach effectiveness and increase successful linkage to care.

Community Health Worker (CHW) & Emergency Department: Partnership HealthPlan of California:

To bridge the gap between existing Substance Use Navigation (SUN) grants and the implementation of community health workers (CHWs), Partnership offered a grant of up to $100,000 to promote the use of CHWs in emergency departments. A total of 24 hospitals expressed interest, and 17 followed through during the grant year.

Key Learnings:

- The project achieved its primary objective of expanding CHW presence in acute care settings and concluded at the end of calendar year 2025. It also advanced the foundation for longer-term sustainability by aligning services with CHW billing pathways.
- Strengthening documentation will support accurate billing, enable reimbursement for CHW services, and ensure the long-term sustainability of this model of care.

10.2 Pediatric Medicine Measure Activities

State-Mandated Performance Improvement Project (PIP) Focused on Early Well-Care in Black/African American Members in Solano County: This PIP's initial intervention addressed delays in Medi-Cal enrollment, which have a significant impact on all families, including African American families. In 2024, the team launched a six-week phone outreach pilot project in collaboration with NorthBay Health, with

outstanding reach rates and outcomes. In 2025, the pilot expanded to Fairchild Medical Center, the primary labor and delivery hospital in Siskiyou County. The initial reach rate was lower than expected.

Key Learning:

- Overall, findings suggest that while the intervention model has potential, its effectiveness is highly dependent on consistent operational execution, data-sharing infrastructure, and strong partner accountability.

Educating Practices about Developmental Screening in the First Three Years of Life: This initiative focused on improving completion of three developmental screenings in the first three years of life by conducting one-on-one training for PCP practices with scores significantly below the MPL. The Pediatric QSMI workgroup reviewed MY2025 HEDIS rates and worked with an Associate Medical Director to set up one-on-one interventions for select practices with especially low scores and larger denominators. Practices that receive coaching will be monitored and offered additional training if their scores do not improve after 3 months.

Key Learnings:

- The current data set relies on claims submitted with code 96110. Six of the lowest performing practices were compared against a list of site audits by the Medical Record Review team and two of those sites had fully compliant charts during their last site visit so it appears at least some practices are conducting screenings but not billing correctly for them.
- Some practices discuss elements of the screenings during the actual visit and document those discussions in the EHR but may not complete the actual screening tool or correctly bill for the screening.
- Even among pediatric-only practices, some are performing well and others are far below the MPL. Proper billing and documentation appears to be an issue regardless of practice type.

Improve Data Capture of Topical Fluoride Application: Partnership launched a multi-pronged messaging campaign to providers to evangelize the use of the Z29.3 ICD code to indicate fluoride varnish application in FQHC, RHC, and Tribal Health Dental Centers. Following the messaging campaign, QI coaches and Partnership's new Dental Liaison followed up with practices during coaching calls to see if the codes had been implemented. In November 2025, DHCS released guidance to the Denti-Cal network that use of the Z29.3 ICD is now mandated for payment on claims that include fluoride varnish services.

Key Learning:

- Sustained focus on data exchange pathways, data validation exercises with provider partners, and partnership with external stakeholders including DHCS is crucial for success on measures

with less straightforward coding and claims pathways

10.3 Chronic Disease Measure Activities

Colorectal Cancer Screening: Cologuard: In 2023 Partnership conducted a pilot project with Exact Sciences who produces the Cologuard Fit DNA colorectal cancer screening product. During the pilot Partnership observed notable improvements in colorectal cancer screening rates with participating providers. Partnership has turned this effort into an ongoing program and has worked closely with Exact Sciences to spread awareness and access to the bulk ordering program. Partnership has created a Cologuard Care-gap Orders page with information and resources. Exact Sciences has a minimum number of patients required for bulk orders since it is resource intensive for them to do outreach and messaging for patients with an order. Partnership has offered to help facilitate bulk orders for smaller practices who do not have large enough denominators to do bulk orders on their own, with orders going out twice annually.

Key Learning:

- Tracking screening rates by screening type helped the team find opportunities where Cologuard bulk order might be appropriate based on availability of other screening methods.

Diabetes Management Offerings From Telemed2U: In 2025-26, Partnership monitored, evaluated, and enhanced utilization of the TeleMed2U diabetes management program through analysis of utilization and engagement data, with the goals of assessing program effectiveness, identifying participation gaps, and informing decisions regarding the continued prioritization of this intervention relative to other strategies. The workgroup partnered with Provider Relations and supported outreach and member education efforts by promoting available nutrition services as an integral component of diabetes management, developing and disseminating fax communications to the provider network to increase program awareness and encourage referrals The collaboration also extended to engagement with Care Coordination to further expand awareness of the program among members and providers who may benefit from additional diabetes support services.

Key Learning:

- Collaboration between Quality Improvement, Care Coordination, and Provider Relations was crucial for building awareness of available diabetes support services.

10.4 Women's Health and Perinatal Care Measure Activities

PPC Pre Timeliness of Prenatal Care Alignment: A multidisciplinary team review identified opportunities to improve consistency of PPC-Pre measurement support across the organization. The initiative focused on reducing variation in coding and documentation practices, standardizing best practices for qualifying perinatal encounters, and identifying allowable care models (telehealth

pathways) that support timely access to prenatal care. This was a multifaceted quality improvement effort that included targeted research, root-cause analysis, claims review, cross-departmental meetings, workflow and policy document review, and implementation of standardized guidance to improve organizational alignment and measure performance.

Key Learnings:

- Adding validated HEDIS codes to the P-QIP Value Set Directory improves clarity, reduces variation in prenatal care coding and documentation, and supports more reliable HEDIS performance monitoring.
- The PPC-Pre measure best practice resource provides a standardized, evidence-based framework for improving perinatal care delivery and operational performance. Translating measure requirements into actionable workflows can improve quality of care and patient outcomes without organizations reinventing the wheel.
- PPC-Pre Telehealth visits in both administrative and hybrid data collection methods are eligible for use in HEDIS reporting. The visit must be with an appropriate provider, within the applicable timeframe, and include a confirmation/diagnosis of pregnancy, and a visit component such as discussion of screening or lab results or last menstrual period with Obstetric (OB) history.
- Primary care, FQHC, rural, and Tribal health providers play a critical role in early pregnancy and should be included in performance visibility and improvement strategies.
- Integrating provider education efforts into existing structures strengthens the program allowing wider visibility, the prioritizing of providers based on performance data, and inclusion of improvement advisors.

Increase PPC-Pre Timeliness of Prenatal Care Awareness: This initiative focused on improving performance for the Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre) measure by partnering with improvement advisors who had established relationships with providers in effort to strengthen awareness of measure timing requirements and identify barriers to timely first prenatal visits.

Key Learnings:

- Clear, repeated messaging on PPC-Pre requirements is needed to build and sustain staff awareness.
- Site-specific performance and access data supports more focused coaching and helps prioritize outreach to practices with the greatest opportunity for improvement.
- Medi-Cal Managed Care plans require first prenatal visits within 10 business days.
- Documentation of initial prenatal visit completed within four weeks of entry to prenatal care. Optimally within the first trimester.

- First prenatal visit access is a site review standard for PCPs who provide obstetric care and missed appointments and referrals require documented outreach and follow-up. Failure to follow up on missed specialty referrals results in a zero score under coordination criteria.
- If prenatal visit periodicity does not meet current ACOG standards, OB providers must document missed visits and outreach efforts.
- Established relationships through Improvement Advisors offers a valuable entry point and provides knowledge of clinics, counties, and regions, as well as insight into local barriers. This can improve provider's engagement and aid in identifying and addressing both site specific and local performance barriers.

Tribal Perinatal Program: This initiative focused on supporting Tribal entities in developing and expanding Tribal Perinatal Programs to improve access to timely prenatal and postpartum care. The Tribal Perinatal Program Tribal Birth Equity Initiative was designed to build culturally informed perinatal care capacity through training, case management, peer support, doula development, and implementation of reimbursement pathways that support sustainable services in Tribal communities. The program goal is to support Tribal communities achieve the best possible outcomes for pregnant American Indians in Northern California.

Key Learnings:

- Culturally grounded training and program design are central to building Tribal perinatal care capacity.
- Trusted entry points and sustained subject matter support, including outreach from the Tribal Liaison and education from a Medical Director champion, can strengthen engagement, improve understanding of program requirements, and support movement from interest to implementation.
- Aligning training, ECM, and PHPS within a shared implementation approach can strengthen care coordination and support long-term sustainability of Tribal perinatal services.
- Baseline performance suggests Tribal providers may be better positioned to support postpartum follow-up than timely first prenatal care, highlighting a need for continued focus on earlier pregnancy identification, access to initial prenatal visits, and stronger prenatal workflow support to improve PPC-Pre performance.

High-risk Human Papillomavirus Self-Collect Support and Education: This initiative focused on improving performance in the Cervical Cancer Screening measure by expanding and standardizing use of the high-risk HPV (hrHPV) self-collect option in healthcare settings. Work centered on strengthening network-wide awareness, updating best-practice guidance, and ensuring clinics had consistent instructions and education materials to support appropriate implementation.

Key Learnings:

- Provider and patient education materials are foundational for scaling hrHPV self-collect consistently across the network.
- Equity-centered material review is important to ensure patient instructions are accessible across threshold languages and usable by patients with different literacy levels and care access needs.
- Targeted provider education informed by site level performance data and improvement advisor insights was an efficient way to prioritize education.
- hrHPV self-collect can be integrated successfully when clinics have clear instructions, laboratory access, and practical examples of staffing, outreach, and visit workflows.

Healthcare Effectiveness Data and Information Set (HEDIS®)

Measurement Year 2025 / Reporting Year 2026

NCQA HealthPlan Accreditation (HPA) Summary of Performance

Partnership – HPA Star Rating

June 2026

Table of Contents

NCQA's Notice of Copyright and Disclaimers 3

1.0 Introduction 4
2.0 Overview of the MY2025 Annual Summary of Performance Report 5
3.0 HPA Summary of Performance Plan-wide Relative to National All Lines of Business Benchmarks 7
3.1 HPA Plan-wide Performance Child CAHPS Results – Patient Experience: 7
3.2 HPA HEDIS Plan-wide Performance – Prevention and Population 7
3.2 HPA HEDIS Plan-wide Performance – Prevention and Population 9
3.2 HPA HEDIS Plan-wide Performance – Prevention and Population 10
3.3 HPA HEDIS Plan-wide Performance – Treatment: Respiratory, Diabetes, Heart Disease 11
3.4 HPA HEDIS Plan-wide Performance – Behavioral Health 13
3.5 HPA HEDIS Plan-wide Performance – Risk Adjusted / Other 14
4.0 MY 2025 HPA HEDIS Rate Performance by County 15
4.1 HPA HEDIS Rate Performance by County, Auburn Region: Nevada, Placer, Plumas, Sierra Counties 16
4.2 HPA HEDIS Rate Performance by County, Chico Region: Butte, Colusa, Glenn, Sutter, Yuba Counties 22
4.3 HPA HEDIS Rate Performance by County, Eureka Region: Del Norte, Humboldt, Lake, Mendocino Counties 28
4.4 HPA HEDIS Rate Performance by County, Fairfield Region: Solano, Yolo, and Napa Counties 34
4.5 HPA HEDIS Rate Performance by County, Redding Region: Lassen, Modoc, Shasta, Siskiyou, Tehama, Trinity Counties 40
4.6 HPA HEDIS Rate Performance by County, Santa Rosa Region: Marin, Sonoma Counties 46
5.0 HEDIS HealthPlan Accreditation (HPA) – Health plan Rating Methodology 52
6.0 HEDIS/CAHPS Measures Required for HP Accreditation—Medicaid 53
7.0 HEDIS/CAHPS MY2025 / RY2026 HPA Overall Star Rating Results: with Child CAHPS Survey Results (Projected) 56
7.1 Factors in MY2025 HPA Star Rating 56
7.2 MY2025 HEDIS HealthPlan Accreditation (HPA) – HealthPlan Rating Score Child CAHPS - Change from Prior Year 58
7.3 MY2025 HEDIS HealthPlan Accreditation (HPA) – HealthPlan Rating Score Adults CAHPS - Change from Prior Year 59
8.0 MY2025 HEDIS HealthPlan Accreditation (HPA) – Measurement Set Descriptions 60

NCQA’s Notice of Copyright and Disclaimers

The source for certain health plan measure rates and benchmark (averages and percentiles) data ("the Data") is Quality Compass® [2025] and is used with the permission of the National Committee for Quality Assurance ("NCQA"). Any analysis, interpretation or conclusion based on the Data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation or conclusion. Quality Compass is a registered trademark of NCQA.

The Data comprises audited performance rates and associated benchmarks for Healthcare Effectiveness Data and Information Set measures ("HEDIS®") and HEDIS CAHPS® survey measure results. HEDIS measures and specifications were developed by and are owned by NCQA. HEDIS measures and specifications are not clinical guidelines and do not establish standards of medical care. NCQA makes no representations, warranties or endorsement about the quality of any organization or clinician who uses or reports performance measures, or any data or rates calculated using HEDIS measures and specifications, and NCQA has no liability to anyone who relies on such measures or specifications.

NCQA holds a copyright in Quality Compass and the Data, or NCQA has obtained the necessary rights in the Data and may rescind or alter the Data at any time. The Data may not be modified by anyone other than NCQA. Anyone desiring to use or reproduce the Data without modification for an internal, noncommercial purpose may do so without obtaining approval from NCQA. All other uses, including commercial use and/or external reproduction, distribution or publication, must be approved by NCQA and are subject to a license at the discretion of NCQA. © [2025] National Committee for Quality Assurance, all rights reserved.

CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

1.0 Introduction

As a Medi-Cal Managed Care Plan, Partnership provides health care coverage for 24 counties in Northern California – the largest geographic footprint of any Medi-Cal Managed Care Plan in California. The health plan covers over 900,000 members who qualify for coverage based on low household income, and who make up a substantial portion of Northern California's total population. The annual measure performance analysis contained in this Annual Summary of Performance, centered on Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures selected by the National Committee for Quality Assurance (NCQA), supports Partnership's Health Plan Accreditation and is intended to give the best possible understanding of the status of quality outcomes for the low-income population served in these counties.

Partnership generates a detailed Annual Summary of Performance and distributes it widely so that stakeholders in Northern California – local governments, county public health, medical and behavioral health providers, hospitals, and community foundations - can use current, local, accurate, and audited data to prioritize activities to meet the health care needs of their communities. The Summary of Performance contains regional and county-level data that show local strengths and opportunities for preventative health care, based on national benchmarks. Behind each measure are many community members who were able to access the preventative services they needed to stay healthy, or who faced challenges or struggles to receive care.

In the end, it takes the entire health care delivery system working together to improve the health outcomes contained in this report. Partnership encourages everyone reading this report to review their local data closely, and look for a handful of ways their organization, alone or with others, can drive improvement on one or more measure that is important to them.

Partnership is always happy to connect organizations and community members within our network to resources and activities to help our members, and the communities we serve, be healthy. Please reach out to our Performance Improvement team at ImprovementAcademy@partnershiphp.org if you would like to learn more about activities in your area.

Thank you for your dedication to improving the health of our communities.

2.0 Overview of the MY2025 Annual Summary of Performance Report

As an NCQA Accredited plan, Partnership is required to report HEDIS and CAHPS annually. The overall Health Plan Rating (HPR) is the weighted average of a plan's HEDIS and CAHPS measure ratings, plus bonus points for plans with current Accreditation status. In MY2025 Partnership chose to be formally scored utilizing the Child CAHPS results.

Measure benchmarks achieved that are described in this report are preliminary and will change later in the Reporting Year. As in previous years, the HPA Annual Summary of Performance, which is published in June of the Reporting Year, estimates performance relative to the latest set of Quality Compass benchmarks published (in this year's case, for MY2024). The actual benchmarks for MY2025 will be published by Quality Compass in Fall 2026, based on national measure rates, and will then be applied to MY2025 rates. Therefore, all MY2025 performance percentiles, NCQA scores, and NCQA Star Rating in this report should be considered preliminary and not final.

MY2025 continued to host two required separate audits:

- DHCS / MCAS required reporting: Health Service Advisory Group (HSAG) Auditor
- NCQA HEDIS Health Plan Accreditation / HPA: Advent Advisory Auditor (this report's focus)

Partnership HEDIS Reporting Populations – MY2025
In MY2025, Partnership observed slight decrease in overall membership by approximately 1.3%, to 895,339 assigned members in December 2025.

The impact of population shifts in Partnership's network from the 10 new counties joining the Partnership network in January 2024 continues to impact HEDIS measure reporting populations differently, depending on each measure's continuous enrollment requirements as defined in the NCQA HEDIS MY2025 Technical Specifications. One measure, Breast Cancer Screening, ECDS (BCS-E), requires continuous enrollment greater than one year for a member to be included in the measure's eligible population, which meant that very few members from incoming counties met the criteria to be included in the measures' plan-wide rates in MY2025. All other MCAS measures in the 10 incoming counties have eligible populations that reflect the current membership.

Partnership reports one Plan-Wide rate for all 24 counties in its network for the MCAS measure set to its DHCS auditor, Advent Advisory.

Changes to NCQA HEDIS Measures – MY2025

NCQA released changes to several existing clinical measures used in NCQA HPA for MY2025:

Measure Changes for MY2025 HPA Required Reporting:

- New Measures:
  - Well-Child Visits in the First 30 Months of Life – Well-Child Visits Birth – 15 Months (W30-6+)
  - Well-Child Visits in the First 30 Months of Life – Well-Child Visits 15-30 Months (W30-2+)
  - Child and Adolescent Well-Care Visits
- Changed Measures:
  - Cervical Cancer Screening (CCS-E) is now an Electronic Clinical Data Systems (ECDS) measure.
  - Childhood Immunization Status – Combination 10 (CIS-E) is now an Electronic Clinical Data Systems (ECDS) measure.
  - Immunizations for Adolescents – Combination 2 (IMA-E) is now an Electronic Clinical Data Systems (ECDS) measure.
  - Language Diversity of Membership (LDM) increased its weight in Health Plan Rating calculations from 0.5 to 1
- Removed Measures:
  - Rating of Personal Doctor (CAHPS)
  - Appropriate Testing for Pharyngitis (CWP)
  - Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid (PCE)
  - Pharmacotherapy Management of COPD Exacerbation – Bronchodilator (PCE)
  - Antidepressant Medication Management – Effective Continuation Phase Treatment (AMM)
  - Use of Imaging Studies for Low Back Pain (LBP)

Partnership successfully launched our HEDIS® MY2025/RY2026 data collection and reporting audits incorporating all changes as noted above.

3.0 HPA Summary of Performance Plan-wide Relative to National All Lines of Business Benchmarks

3.1 HPA Plan-wide Performance Child CAHPS Results – Patient Experience:

This table shows the results of the MY2024 - MY2025 performance on the Patient Experience NCQA Accreditation measures relative to the MY2023 and MY2024 National All Lines of Business 10th, 33.33rd, 66.67th and 90th benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points

NCQA Accreditation Measures: Child CAHPS Survey Results MY2024-MY2025

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Patient Experience						
Getting Care						
MY 2024	***Getting Needed Care (Usually + Always)	77.87%	76.79%	81.10%	85.70%	89.41%
MY 2025		84.44%	77.87%	82.32%	86.44%	89.48%
MY 2024	Getting Care Quickly (Usually + Always)	80.04%	78.92%	84.62%	89.35%	92.10%
MY 2025		82.13%	79.11%	85.02%	88.64%	91.98%

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

3.2 HPA HEDIS Plan-wide Performance – Prevention and Population

This table shows the MY2024 – MY2025 baseline performance on the **Prevention and Population** NCQA Accreditation measures relative to the MY2023 and MY2024 National All Lines of Business10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures)

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Prevention and Population						
Children and Adolescent Well-Care						
MY 2024	***CIS - Childhood Immunization Status (Combination 10)	28.22%	18.25%	24.39%	31.32%	42.34%
MY 2025	***CIS-E - Childhood Immunization Status (Combination 10) ECDS Measure	26.74%	14.67%	21.34%	26.93%	34.79%
MY 2024	***IMA - Immunizations for Adolescents (Combination 2)	40.39%	25.41%	31.39%	38.69%	48.66%
MY 2025	***IMA-E - Immunizations for Adolescents (Combination 2) ECDS Measure	39.39%	25.00%	30.70%	37.78%	47.16%
MY 2024	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	76.16%	66.91%	76.89%	86.20%	91.24%
MY 2025		83.21%	65.21%	80.54%	87.69%	91.97%
MY 2025	W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits in the First 15 months)	64.64%	49.46%	60.39%	66.35%	71.71%
MY 2025	W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits for Age 15 Months - 30	76.64%	64.14%	70.06%	75.87%	82.12%
MY 2025	WCV - Child and Adolescent Well-Care Visits—Total	52.57%	44.96%	51.48%	58.37%	67.63%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

3.2 HPA HEDIS Plan-wide Performance – Prevention and Population

This table shows the MY2024 – MY2025 baseline performance on the **Prevention and Population** NCQA Accreditation measures relative to the MY2023 and MY2024 National All Lines of Business10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures)

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Prevention and Population						
Women's Reproductive Health						
MY 2024	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	85.40%	73.48%	81.94%	86.89%	91.85%
MY 2025		87.10%	76.16%	84.40%	88.56%	91.97%
MY 2024	***PPC - Prenatal and Postpartum Care—Postpartum Care	89.54%	68.63%	77.37%	82.48%	86.62%
MY 2025		90.02%	72.26%	79.73%	83.94%	88.32%
MY 2024	PRS-E - Prenatal Immunization Status - Combination Rate	29.36%	8.42%	15.96%	24.92%	35.60%
MY 2025		33.52%	8.23%	16.07%	25.25%	34.91%
Cancer Screening						
MY 2024	BCS-E - Breast Cancer Screening	56.29%	42.86%	49.24%	56.66%	63.48%
MY 2025		53.43%	45.09%	52.22%	58.93%	66.31%
MY 2024	CCS - Cervical Cancer Screening	59.12%	43.31%	52.07%	60.10%	67.46%
MY 2025	CCS-E - Cervical Cancer Screening - ECDS Measure	48.08%	40.21%	48.91%	55.86%	64.21%
MY 2024	COL-E - Colorectal Cancer Screening	32.99%	27.27%	34.30%	41.59%	49.35%
MY 2025		35.45%	29.99%	38.05%	45.84%	53.31%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

3.2 HPA HEDIS Plan-wide Performance – Prevention and Population

This table shows the MY2024 – MY2025 baseline performance on the **Prevention and Population** NCQA Accreditation measures relative to the MY2023 and MY2024 National All Lines of Business10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures)

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Prevention and Population						
Description of Membership						
MY 2024	RDM - Race/Ethnicity Diversity of Membership (Reportin	100.00%	100.00%	100.00%	100.00%	100.00%
MY 2025		100.00%	100.00%	100.00%	100.00%	100.00%
MY 2024	LDM - Language Diversity of Membership	100.00%	0.00%	0.00%	13.07%	100.00%
MY 2025		100.00%	0.01%	0.31%	5.88%	71.15%
Other Preventive Services						
MY 2024	**CHL - Chlamydia Screening in Women—Total**	55.58%	43.53%	52.40%	61.46%	69.07%
MY 2025		58.98%	41.71%	51.22%	62.81%	70.67%
MY 2024	AIS-E - Adult Immunization Status -- Influenza Immunizations for Adults	14.33%	7.39%	12.55%	17.91%	26.40%
MY 2025		15.81%	8.73%	13.56%	18.61%	26.60%
MY 2024	AIS-E - Adult Immunization Status—Pneumococcal	44.03%	21.04%	38.73%	55.03%	68.07%
MY 2025		48.20%	28.84%	43.72%	58.40%	71.90%
MY 2024	AIS-E - Adult Immunization Status—Td/Tdap Immunizations for Adults	32.96%	21.26%	33.40%	47.30%	57.67%
MY 2025		38.34%	26.23%	36.85%	50.60%	61.22%
MY 2024	AIS-E - Adult Immunization Status—Zoster Immunizations for Adults	14.47%	2.23%	7.15%	13.49%	20.56%
MY 2025		17.03%	3.62%	9.28%	16.63%	24.04%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

3.3 HPA HEDIS Plan-wide Performance – Treatment: Respiratory, Diabetes, Heart Disease

This table shows the MY2025 baseline performance on the **Treatment** NCQA Accreditation measures relative to the MY2023 and MY2024 National All Lines of Business10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Treatment						
Respiratory						
MY 2024	**AMR - Asthma Medication Ratio- Total**	64.71%	54.56%	62.35%	70.56%	76.65%
MY 2025		73.33%	52.00%	59.38%	68.13%	76.25%
MY 2024	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	44.00%	49.48%	56.76%	67.03%	77.66%
MY 2025		53.84%	48.00%	56.37%	65.97%	75.42%
Diabetes						
MY 2024	EED - Eye Exams for Patients with Diabetes	52.31%	40.39%	49.15%	57.09%	64.06%
MY 2025		52.94%	42.09%	52.55%	60.83%	68.61%
MY 2024	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	70.56%	58.15%	65.32%	71.78%	77.37%
MY 2025		69.83%	60.34%	69.34%	74.21%	78.83%
MY 2024	HBD -Hemoglobin A1c Control for Patients with Diabetes-- HbA1c Control (<8%)	54.26%	44.25%	54.50%	59.64%	63.50%
MY 2025	**GSD -Glycemic Status Assessment for Patients with Diabetes-- HbA1c Control (<8%)**	63.75%	49.30%	57.41%	63.04%	67.40%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	64.93%	51.96%	62.66%	67.01%	71.41%
MY 2025		63.24%	56.26%	64.27%	69.01%	73.76%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	67.90%	53.23%	64.18%	70.91%	79.73%
MY 2025		65.12%	57.38%	65.75%	72.29%	80.89%
MY 2024	KED - Kidney Health Evaluation for Patients with Diabetes	40.88%	26.79%	33.00%	42.10%	49.72%
MY 2025		41.66%	30.61%	38.74%	46.17%	54.15%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Treatment						
Heart Disease						
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	81.06%	66.64%	79.82%	83.00%	85.89%
MY 2025		82.43%	69.48%	79.83%	82.94%	86.40%
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	70.33%	59.20%	66.84%	73.75%	81.25%
MY 2025		68.74%	61.58%	68.28%	75.45%	82.65%
MY 2024	***CBP - Controlling High Blood Pressure	69.59%	54.61%	61.43%	67.40%	72.75%
MY 2025		67.40%	56.93%	65.21%	70.35%	75.43%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

3.4 HPA HEDIS Plan-wide Performance – Behavioral Health

This table shows the MY2025 baseline performance on the **Behavioral Health** NCQA Accreditation measures relative to the MY2023 and MY2024 National All Lines of Business10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Treatment						
Behavioral Health--Care Coordination						
MY 2024	FUH - Follow-Up After Hospitalization for Mental Illness-7 days	NB	23.55%	32.71%	42.86%	57.69%
MY 2025		21.54%	26.07%	35.29%	45.08%	57.76%
MY 2024	FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total	13.39%	21.19%	33.01%	44.33%	59.95%
MY 2025		26.32%	26.32%	36.34%	46.71%	62.06%
MY 2024	FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total	22.88%	12.73%	18.76%	27.62%	37.47%
MY 2025		28.37%	15.49%	21.62%	30.53%	39.38%
MY 2024	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	29.83%	15.91%	26.90%	37.64%	50.80%
MY 2025		30.81%	18.61%	28.46%	40.55%	53.73%
Behavioral Health--Medication Adherence						
MY 2024	POD - Pharmacotherapy for Opioid Use Disorder—Total	15.84%	12.05%	21.36%	29.01%	36.71%
MY 2025		15.30%	14.52%	20.92%	30.43%	36.44%
MY 2024	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	68.58%	44.65%	58.60%	66.15%	74.83%
MY 2025		67.20%	49.57%	62.98%	69.67%	77.21%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

3.5 HPA HEDIS Plan-wide Performance – Risk Adjusted / Other

This table shows the MY2025 baseline performance on the **Risk Adjusted** / Other NCQA Accreditation measures relative to the MY2023 and MY2024 National All Lines of Business10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points ○ 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Treatment						
Behavioral Health-- Access, Monitoring and Safety						
MY 2024	APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	32.18%	25.86%	30.92%	41.41%	52.57%
MY 2025	APM-E - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (ECDS)	32.49%	26.70%	33.26%	41.52%	55.96%
MY 2024	ADD -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	40.36%	37.19%	48.94%	56.83%	63.49%
MY 2025	ADD-E -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase (ECDS)	45.36%	39.95%	51.20%	58.69%	65.18%
MY 2024	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.85%	75.46%	79.51%	83.51%	87.27%
MY 2025		83.97%	77.16%	81.03%	84.36%	87.47%
MY 2024	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	41.38%	41.57%	54.55%	64.10%	74.14%
MY 2025		53.41%	46.48%	58.39%	66.54%	75.82%
MY 2024	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	7.63%	6.08%	10.51%	16.78%	26.72%
MY 2025		12.05%	7.33%	11.35%	17.80%	27.95%
Risk-Adjusted Utilization						
MY 2024	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	0.9944	1.1783	1.0290	0.9124	0.8188
MY 2025		0.9706	1.3971	1.2155	1.0696	0.9598

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA. NCQA calculates the Confidence Limits (CLs) for all health plans.

4.0 MY 2025 HPA HEDIS Rate Performance by County

The following tables show MY2025 county-level performance on HPA HEDIS measures in Partnership's six (6) Regions. MY2025 county-level performance is also included, showing year-over-year performance trends by county.

HPA measures not included in the county-level performance tables are:

- CAHPS Measures, which only have plan-wide rates;
- Description of Membership measures, which only have plan-wide rates

All tables show the MY2025 baseline performance on NCQA Accreditation measures relative to the MY2023 and MY2024 National All Lines of Business 10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4.1 HPA HEDIS Rate Performance by County, Auburn Region: Nevada, Placer, Plumas, Sierra Counties

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).

Year	Measure	County Performance				National Medicaid Benchmarks			
		Nevada	Placer	Plumas	Sierra	10th	33.33rd	66.67th	90th
Prevention and Population									
Children and Adolescent Well-Care									
MY 2024	***CIS - Childhood Immunization Status (Combination 10)	100.00%	0.00%	0.00%	0.00%	18.25%	24.39%	31.32%	42.34%
MY 2025	***CIS-E - Childhood Immunization Status (Combination 10) ECDS Measure	13.61%	16.47%	0.00%	10.00%	14.67%	21.34%	26.93%	34.79%
MY 2024	***IMA - Immunizations for Adolescents (Combination 2)	0.00%	12.50%	0.00%	0.00%	25.41%	31.39%	38.69%	48.66%
MY 2025	***IMA-E - Immunizations for Adolescents (Combination 2) ECDS Measure	13.01%	29.10%	10.13%	33.33%	25.00%	30.70%	37.78%	47.16%
MY 2024	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	73.33%	90.48%	0.00%	0.00%	66.91%	76.89%	86.20%	91.24%
MY 2025		80.00%	87.50%	0.00%	0.00%	65.21%	80.54%	87.69%	91.97%
MY 2025	W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits in the First 15 months)	41.76%	60.71%	30.56%	12.50%	49.46%	60.39%	66.35%	71.71%
MY 2025	W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits for Age 15 Months - 30 Months)	64.09%	70.53%	57.14%	66.67%	64.14%	70.06%	75.87%	82.12%
MY 2025	WCV - Child and Adolescent Well-Care Visits—Total	44.69%	50.27%	39.48%	32.61%	44.96%	51.48%	58.37%	67.63%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance				National Medicaid Benchmarks			
		Nevada	Placer	Plumas	Sierra	10th	33.33rd	66.67th	90th
Prevention and Population									
Women's Reproductive Health									
MY 2024	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	100.00%	75.00%	100.00%	73.33%	73.48%	81.94%	86.89%	91.85%
MY 2025		83.33%	81.48%	100.00%	0.00%	76.16%	84.40%	88.56%	91.97%
MY 2024	***PPC - Prenatal and Postpartum Care—Postpartum Care	100.00%	83.33%	100.00%	86.67%	68.63%	77.37%	82.48%	86.62%
MY 2025		100.00%	88.89%	100.00%	0.00%	72.26%	79.73%	83.94%	88.32%
MY 2024	PRS-E - Prenatal Immunization Status - Combination Rate	11.28%	21.29%	31.11%	25.00%	8.42%	15.96%	24.92%	35.60%
MY 2025		18.99%	26.68%	29.41%	66.67%	8.23%	16.07%	25.25%	34.91%
Cancer Screening									
MY 2024	BCS-E- Breast Cancer Screening	66.67%	0.00%	0.00%	0.00%	42.86%	49.24%	56.66%	63.48%
MY 2025		52.94%	50.00%	0.00%	0.00%	45.09%	52.22%	58.93%	66.31%
MY 2024	CCS - Cervical Cancer Screening	62.50%	50.00%	33.33%	50.00%	43.31%	52.07%	60.10%	67.46%
MY 2025	CCS-E - Cervical Cancer Screening - ECDS Measure	38.96%	38.27%	16.37%	30.77%	40.21%	48.91%	55.86%	64.21%
MY 2024	COL-E - Colorectal cancer Screening	18.18%	0.00%	33.33%	0.00%	27.27%	34.30%	41.59%	49.35%
MY 2025		27.71%	28.87%	19.77%	27.91%	29.99%	38.05%	45.84%	53.31%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance				National Medicaid Benchmarks			
		Nevada	Placer	Plumas	Sierra	10th	33.33rd	66.67th	90th
Prevention and Population									
Other preventive services									
MY 2024	**CHL - Chlamydia Screening in Women—Total**	48.06%	60.67%	23.26%	27.27%	43.53%	52.40%	61.46%	69.07%
MY 2025		48.90%	58.83%	27.07%	7.69%	41.71%	51.22%	62.81%	70.67%
MY 2024	AIS-E-Adult Immunization Status—Influenza - Total	8.48%	11.84%	10.38%	12.12%	7.39%	12.55%	17.91%	26.40%
MY 2025		9.44%	13.91%	12.47%	11.20%	8.73%	13.56%	18.61%	26.60%
MY 2024	AIS-E-Adult Immunization Status—Pneumococcal - 66+	35.21%	30.02%	31.25%	0.00%	21.04%	38.73%	55.03%	68.07%
MY 2025		38.61%	33.12%	45.83%	0.00%	28.84%	43.72%	58.40%	71.90%
MY 2024	AIS-E-Adult Immunization Status—Td/Tdap - Total	26.37%	24.48%	30.03%	37.12%	21.26%	33.40%	47.30%	57.67%
MY 2025		28.74%	29.53%	32.79%	36.68%	26.23%	36.85%	50.60%	61.22%
MY 2024	AIS-E-Adult Immunization Status—Zoster - Total	13.02%	14.60%	6.87%	8.60%	2.23%	7.15%	13.49%	20.56%
MY 2025		9.91%	15.04%	8.44%	5.13%	3.62%	9.28%	16.63%	24.04%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance				National Medicaid Benchmarks			
		Nevada	Placer	Plumas	Sierra	10th	33.33rd	66.67th	90th
Treatment									
Respiratory									
MY 2024	**AMR - Asthma Medication Ratio- Total**	0.00%	0.00%	100.00%	0.00%	54.56%	62.35%	70.56%	76.65%
MY 2025		67.27%	80.43%	63.16%	100.00%	52.00%	59.38%	68.13%	76.25%
MY 2024	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	23.33%	34.78%	42.31%	0.00%	49.48%	50.98%	67.03%	77.66%
MY 2025		29.38%	29.60%	28.33%	0.00%	48.00%	56.37%	65.97%	75.42%
Diabetes									
MY 2024	EED - Eye Exams for Patients with Diabetes	20.00%	44.44%	0.00%	0.00%	40.39%	49.15%	57.09%	64.06%
MY 2025		40.14%	32.73%	20.29%	31.58%	42.09%	52.55%	60.83%	68.61%
MY 2024	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	70.00%	72.22%	0.00%	0.00%	58.15%	65.32%	71.78%	77.37%
MY 2025		66.67%	56.25%	0.00%	0.00%	60.34%	69.34%	74.21%	78.83%
MY 2024	HBD -Hemoglobin A1c Control for Patients with Diabetes-HbA1c Control (<8%)	50.00%	44.44%	0.00%	0.00%	44.25%	54.50%	59.64%	63.50%
MY 2025	GSD -Glycemic Status Assessment for Patients with Diabetes--HbA1c Control (<8%)	66.67%	62.50%	100.00%	0.00%	49.30%	57.41%	63.04%	67.40%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	100.00%	0.00%	50.00%	0.00%	51.96%	62.66%	67.01%	71.41%
MY 2025		54.49%	64.79%	52.17%	66.67%	56.26%	64.27%	69.01%	73.76%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	0.00%	0.00%	100.00%	0.00%	53.23%	64.18%	70.91%	79.73%
MY 2025		70.33%	70.30%	68.75%	50.00%	57.38%	65.75%	72.29%	80.89%
MY 2024	KED - Kidney Health Evaluation for Patients with Diabetes	45.34%	49.73%	14.62%	0.00%	26.79%	33.00%	42.10%	49.72%
MY 2025		39.00%	41.47%	10.37%	22.22%	30.61%	38.74%	46.17%	54.15%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance				National Medicaid Benchmarks			
		Nevada	Placer	Plumas	Sierra	10th	33.33rd	66.67th	90th
Treatment									
Heart Disease									
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	100.00%	0.00%	0.00%	0.00%	66.64%	79.82%	83.00%	85.89%
MY 2025		87.21%	83.45%	86.67%	50.00%	69.48%	79.83%	82.94%	86.40%
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	100.00%	0.00%	0.00%	0.00%	59.95%	67.42%	74.07%	81.79%
MY 2025		69.33%	69.42%	46.15%	0.00%	61.58%	68.28%	75.45%	82.65%
MY 2024	***CBP - Controlling High Blood Pressure	71.43%	50.00%	0.00%	0.00%	54.61%	61.43%	67.40%	72.75%
MY 2025		42.86%	50.00%	50.00%	0.00%	56.93%	65.21%	70.35%	75.43%
Behavioral Health - Care Coordination									
MY 2024	FUH - Follow-Up After Hospitalization for Mental Illness-7 days	NB	NB	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2025		4.35%	18.60%	50.00%	0.00%	26.07%	35.29%	45.08%	57.76%
MY 2024	FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total	17.58%	9.04%	10.71%	0.00%	21.19%	33.01%	44.33%	59.95%
MY 2025		25.33%	17.40%	30.00%	12.50%	26.32%	36.34%	46.71%	62.06%
MY 2024	FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total	22.25%	22.72%	17.31%	87.50%	12.73%	18.76%	27.62%	37.47%
MY 2025		24.63%	32.04%	34.29%	100.00%	15.49%	21.62%	30.53%	39.38%
MY 2024	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	13.46%	12.05%	33.33%	50.00%	15.91%	26.90%	37.64%	50.80%
MY 2025		17.46%	13.21%	0.00%	40.00%	18.61%	28.46%	40.55%	53.73%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance				National Medicaid Benchmarks			
		Nevada	Placer	Plumas	Sierra	10th	33.33rd	66.67th	90th
Behavioral Health - Medication Adherence									
MY 2024	POD - Pharmacotherapy for Opioid Use Disorder—Total	9.76%	12.50%	0.00%	0.00%	12.05%	21.36%	29.01%	36.71%
MY 2025		10.84%	11.39%	6.25%	16.67%	14.52%	20.92%	30.43%	36.44%
MY 2024	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	65.45%	79.66%	72.73%	100.00%	44.65%	58.60%	66.15%	74.83%
MY 2025		58.33%	74.83%	76.00%	100.00%	49.57%	62.98%	69.67%	77.21%
Behavioral Health - Access, Monitoring and Safety									
MY 2024	APM-E - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (ECDS)	39.29%	35.92%	38.46%	0.00%	25.86%	30.92%	41.41%	52.57%
MY 2025		40.30%	42.86%	37.50%	0.00%	26.70%	33.26%	41.52%	55.96%
MY 2024	ADD-E -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase (ECDS)	0.00%	0.00%	0.00%	0.00%	37.19%	48.94%	56.83%	63.49%
MY 2025		35.00%	42.86%	0.00%	0.00%	39.95%	51.20%	58.69%	65.18%
MY 2024	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	85.08%	85.07%	89.29%	80.00%	75.46%	79.51%	83.51%	87.27%
MY 2025		81.68%	81.67%	78.38%	100.00%	77.16%	81.03%	84.36%	87.47%
MY 2024	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	80.00%	6.25%	0.00%	0.00%	41.57%	54.55%	64.10%	74.14%
MY 2025		50.00%	40.43%	83.33%	0.00%	46.48%	58.39%	66.54%	75.82%
MY 2024	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	3.82%	5.83%	3.08%	14.29%	6.08%	10.51%	16.78%	26.72%
MY 2025		9.60%	11.04%	8.70%	5.88%	7.33%	11.35%	17.80%	27.95%
Risk-Adjusted Utilization									
MY 2024	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	2.0801	1.7290	0.0000	12.8852	1.1783	1.029	0.9124	0.8188
MY 2025		0.8315	1.1128	1.0359	0.0000	1.3971	1.2155	1.0696	0.9598
Administrative measures:The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).									

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA.
NCQA calculates the Confidence Limits (CLs) for all health plans.

4.2 HPA HEDIS Rate Performance by County, Chico Region: Butte, Colusa, Glenn, Sutter, Yuba Counties

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).

Year	Measure	County Performance					National Medicaid Benchmarks			
		Butte	Colusa	Glenn	Sutter	Yuba	10th	33.33rd	66.67th	90th
Prevention and Population										
Children and Adolescent Well-Care										
MY 2024	***CIS - Childhood Immunization Status (Combination 10)	0.00%	0.00%	0.00%	0.00%	0.00%	18.25%	24.39%	31.32%	42.34%
MY 2025	***CIS-E - Childhood Immunization Status (Combination 10) ECDS Measure	27.77%	28.78%	30.41%	33.50%	23.46%	14.67%	21.34%	26.93%	34.79%
MY 2024	***IMA - Immunizations for Adolescents (Combination 2)	0.00%	0.00%	100.00%	40.00%	37.50%	25.41%	31.39%	38.69%	48.66%
MY 2025	***IMA-E - Immunizations for Adolescents (Combination 2) ECDS Measure	25.62%	29.13%	24.44%	51.93%	43.35%	25.00%	30.70%	37.78%	47.16%
MY 2024	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	64.52%	100.00%	77.78%	63.33%	58.82%	66.91%	76.89%	86.20%	91.24%
MY 2025		62.07%	100.00%	86.67%	76.92%	66.67%	65.21%	80.54%	87.69%	91.97%
MY 2025	W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits in the First 15 months)	59.95%	55.75%	35.88%	58.51%	54.14%	49.46%	60.39%	66.35%	71.71%
MY 2025	W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits for Age 15 Months - 30 Months)	74.16%	81.75%	75.17%	88.04%	76.98%	64.14%	70.06%	75.87%	82.12%
MY 2025	WCV - Child and Adolescent Well-Care Visits—Total	44.32%	68.06%	57.58%	59.83%	50.26%	44.96%	51.48%	58.37%	67.63%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance					National Medicaid Benchmarks			
		Butte	Colusa	Glenn	Sutter	Yuba	10th	33.33rd	66.67th	90th
Prevention and Population										
Women's Reproductive Health										
MY 2024	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	93.33%	33.33%	83.33%	92.00%	90.00%	73.48%	81.94%	86.89%	91.85%
MY 2025		87.18%	100.00%	100.00%	72.73%	90.91%	76.16%	84.40%	88.56%	91.97%
MY 2024	***PPC - Prenatal and Postpartum Care—Postpartum Care	96.67%	100.00%	100.00%	88.00%	80.00%	68.63%	77.37%	82.48%	86.62%
MY 2025		84.62%	77.78%	75.00%	86.36%	77.27%	72.26%	79.73%	83.94%	88.32%
MY 2024	PRS-E - Prenatal Immunization Status - Combination Rate	19.02%	24.19%	25.82%	18.15%	17.99%	8.42%	15.96%	24.92%	35.60%
MY 2025		26.95%	24.81%	34.97%	24.07%	24.52%	8.23%	16.07%	25.25%	34.91%
Cancer Screening										
MY 2024	BCS-E- Breast Cancer Screening	26.32%	20.00%	0.00%	0.00%	100.00%	42.86%	49.24%	56.66%	63.48%
MY 2025		36.96%	11.11%	42.86%	40.00%	44.44%	45.09%	52.22%	58.93%	66.31%
MY 2024	CCS - Cervical Cancer Screening	53.19%	75.00%	30.00%	55.56%	60.00%	43.31%	52.07%	60.10%	67.46%
MY 2025	CCS-E - Cervical Cancer Screening - ECDS Measure	36.16%	49.25%	44.72%	46.08%	40.79%	40.21%	48.91%	55.86%	64.21%
MY 2024	COL-E - Colorectal cancer Screening	26.67%	20.00%	25.00%	50.00%	50.00%	27.27%	34.30%	41.59%	49.35%
MY 2025		29.30%	33.30%	31.14%	34.81%	28.35%	29.99%	38.05%	45.84%	53.31%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance					National Medicaid Benchmarks			
		Butte	Colusa	Glenn	Sutter	Yuba	10th	33.33rd	66.67th	90th
Prevention and Population										
Other preventive services										
MY 2024	**CHL - Chlamydia Screening in Women—Total**	55.64%	53.02%	51.47%	57.24%	57.89%	43.53%	52.40%	61.46%	69.07%
MY 2025		54.53%	50.94%	50.75%	55.91%	58.97%	41.71%	51.22%	62.81%	70.67%
MY 2024	AIS-E-Adult Immunization Status—Influenza - Total	11.00%	17.54%	13.04%	12.57%	9.16%	7.39%	12.55%	17.91%	26.40%
MY 2025		11.33%	16.95%	14.09%	14.84%	10.79%	8.73%	13.56%	18.61%	26.60%
MY 2024	AIS-E-Adult Immunization Status—Pneumococcal - 66+	39.50%	43.21%	32.31%	51.35%	36.51%	21.04%	38.73%	55.03%	68.07%
MY 2025		43.26%	54.26%	40.91%	59.35%	42.55%	28.84%	43.72%	58.40%	71.90%
MY 2024	AIS-E-Adult Immunization Status—Td/Tdap - Total	28.86%	30.82%	32.27%	30.26%	27.31%	21.26%	33.40%	47.30%	57.67%
MY 2025		33.40%	40.05%	40.81%	40.59%	33.43%	26.23%	36.85%	50.60%	61.22%
MY 2024	AIS-E-Adult Immunization Status—Zoster - Total	13.42%	15.10%	17.50%	14.44%	9.08%	2.23%	7.15%	13.49%	20.56%
MY 2025		15.36%	20.82%	21.83%	19.23%	10.98%	3.62%	9.28%	16.63%	24.04%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance					National Medicaid Benchmarks			
		Butte	Colusa	Glenn	Sutter	Yuba	10th	33.33rd	66.67th	90th
Treatment										
Respiratory										
MY 2024	**AMR - Asthma Medication Ratio- Total**	66.67%	0.00%	100.00%	0.00%	0.00%	54.56%	62.35%	70.56%	76.65%
MY 2025		68.79%	80.00%	78.35%	69.62%	64.93%	52.00%	59.38%	68.13%	76.25%
MY 2024	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	79.77%	53.33%	75.71%	57.62%	68.41%	49.48%	50.98%	67.03%	77.66%
MY 2025		77.02%	53.10%	71.55%	64.50%	65.81%	48.00%	56.37%	65.97%	75.42%
Diabetes										
MY 2024	EED - Eye Exams for Patients with Diabetes	59.09%	100.00%	60.00%	39.13%	52.94%	40.39%	49.15%	57.09%	64.06%
MY 2025		48.62%	30.17%	43.47%	50.19%	49.04%	42.09%	52.55%	60.83%	68.61%
MY 2024	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	79.55%	100.00%	60.00%	65.22%	70.59%	58.15%	65.32%	71.78%	77.37%
MY 2025		50.00%	87.50%	44.44%	66.67%	66.67%	60.34%	69.34%	74.21%	78.83%
MY 2024	HBD -Hemoglobin A1c Control for Patients with Diabetes-HbA1c Control (<8%)	68.18%	50.00%	60.00%	56.52%	52.94%	44.25%	54.50%	59.64%	63.50%
MY 2025	GSD -Glycemic Status Assessment for Patients with Diabetes--HbA1c Control (<8%)	60.00%	75.00%	55.56%	70.37%	57.14%	49.30%	57.41%	63.04%	67.40%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	63.64%	75.00%	50.00%	0.00%	0.00%	51.96%	62.66%	67.01%	71.41%
MY 2025		59.44%	69.14%	53.66%	70.18%	63.71%	56.26%	64.27%	69.01%	73.76%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	57.14%	0.00%	100.00%	0.00%	0.00%	53.23%	64.18%	70.91%	79.73%
MY 2025		64.29%	44.64%	64.26%	62.62%	69.60%	57.38%	65.75%	72.29%	80.89%
MY 2024	KED - Kidney Health Evaluation for Patients with Diabetes	33.96%	37.39%	28.71%	32.35%	29.28%	26.79%	33.00%	42.10%	49.72%
MY 2025		34.90%	37.57%	24.30%	33.37%	32.97%	30.61%	38.74%	46.17%	54.15%
Heart Disease										
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	100.00%	100.00%	100.00%	0.00%	0.00%	66.64%	79.82%	83.00%	85.89%
MY 2025		77.88%	90.48%	85.00%	91.14%	88.10%	69.48%	79.83%	82.94%	86.40%
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	100.00%	100.00%	100.00%	0.00%	0.00%	59.95%	67.42%	74.07%	81.79%
MY 2025		66.80%	63.16%	70.59%	78.47%	62.16%	61.58%	68.28%	75.45%	82.65%
MY 2024	***CBP - Controlling High Blood Pressure	72.00%	75.00%	66.67%	61.11%	37.50%	54.61%	61.43%	67.40%	72.75%
MY 2025		73.47%	57.14%	77.78%	50.00%	47.62%	56.93%	65.21%	70.35%	75.43%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance					National Medicaid Benchmarks			
		Butte	Colusa	Glenn	Sutter	Yuba	10th	33.33rd	66.67th	90th
Treatment										
Behavioral Health - Care Coordination										
MY 2024	FUH - Follow-Up After Hospitalization for Mental Illness-7 days	NB	NB	NB	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2025		31.76%	0.00%	66.67%	18.18%	25.00%	26.07%	35.29%	45.08%	57.76%
MY 2024	FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total	10.45%	22.22%	10.71%	12.32%	10.11%	21.19%	33.01%	44.33%	59.95%
MY 2025		26.02%	24.14%	22.32%	32.68%	39.57%	26.32%	36.34%	46.71%	62.06%
MY 2024	FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total	26.69%	15.38%	28.26%	23.38%	22.71%	12.73%	18.76%	27.62%	37.47%
MY 2025		34.33%	26.09%	28.81%	30.92%	27.84%	15.49%	21.62%	30.53%	39.38%
MY 2024	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	15.91%	30.00%	33.33%	17.65%	16.67%	15.91%	26.90%	37.64%	50.80%
MY 2025		16.90%	28.57%	0.00%	8.33%	20.00%	18.61%	28.46%	40.55%	53.73%
Behavioral Health - Medication Adherence										
MY 2024	POD - Pharmacotherapy for Opioid Use Disorder—Total	14.88%	0.00%	28.57%	25.00%	11.63%	12.05%	21.36%	29.01%	36.71%
MY 2025		18.08%	12.50%	8.57%	16.49%	15.00%	14.52%	20.92%	30.43%	36.44%
MY 2024	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	67.83%	83.33%	87.50%	86.96%	69.81%	44.65%	58.60%	66.15%	74.83%
MY 2025		67.94%	50.00%	75.86%	76.54%	63.64%	49.57%	62.98%	69.67%	77.21%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance					National Medicaid Benchmarks			
		Butte	Colusa	Glenn	Sutter	Yuba	10th	33.33rd	66.67th	90th
Treatment										
Behavioral Health - Access, Monitoring and Safety										
MY 2024	APM-E - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (ECDS)	35.56%	50.00%	25.81%	28.26%	34.44%	25.86%	30.92%	41.41%	52.57%
MY 2025		36.57%	30.00%	20.69%	38.30%	35.00%	26.70%	33.26%	41.52%	55.96%
MY 2024	ADD-E -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase (ECDS)	0.00%	0.00%	0.00%	0.00%	0.00%	37.19%	48.94%	56.83%	63.49%
MY 2025		41.89%	16.67%	28.57%	55.56%	45.00%	39.95%	51.20%	58.69%	65.18%
MY 2024	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	86.90%	90.91%	86.36%	89.57%	85.26%	75.46%	79.51%	83.51%	87.27%
MY 2025		85.10%	100.00%	88.10%	81.58%	85.26%	77.16%	81.03%	84.36%	87.47%
MY 2024	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	45.16%	100.00%	44.44%	33.33%	29.63%	41.57%	54.55%	64.10%	74.14%
MY 2025		50.67%	57.14%	83.33%	50.00%	65.22%	46.48%	58.39%	66.54%	75.82%
MY 2024	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	4.59%	5.77%	3.28%	6.01%	5.12%	6.08%	10.51%	16.78%	26.72%
MY 2025		7.90%	14.85%	10.00%	13.77%	13.43%	7.33%	11.35%	17.80%	27.95%
Risk-Adjusted Utilization										
MY 2024	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	2.6863	1.3132	0.0000	1.5553	2.337	1.1783	1.029	0.9124	0.8188
MY 2025		1.1826	0.3715	0.5332	0.8275	0.7274	1.3971	1.2155	1.0696	0.9598
Administrative measures:The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).										

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Note: *PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA.*
NCQA calculates the Confidence Limits (CLs) for all health plans.

4.3 HPA HEDIS Rate Performance by County, Eureka Region: Del Norte, Humboldt, Lake, Mendocino Counties

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). Denominators less than 20 at the county level are suppressed.

Year	Measure	County Performance				National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Mendocino	10th	33.33rd	66.67th	90th
Prevention and Population									
Children and Adolescent Well-Care									
MY 2024	***CIS - Childhood Immunization Status (Combination 10)	0.00%	26.47%	26.09%	31.43%	18.25%	24.39%	31.32%	42.34%
MY 2025	***CIS-E - Childhood Immunization Status (Combination 10) ECDS Measure	5.07%	21.66%	26.90%	25.16%	14.67%	21.34%	26.93%	34.79%
MY 2024	***IMA - Immunizations for Adolescents (Combination 2)	16.67%	36.36%	50.00%	35.71%	25.41%	31.39%	38.69%	48.66%
MY 2025	***IMA-E - Immunizations for Adolescents (Combination 2) ECDS Measure	33.94%	41.59%	50.19%	36.23%	25.00%	30.70%	37.78%	47.16%
MY 2024	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	85.71%	88.00%	100.00%	80.00%	66.91%	76.89%	86.20%	91.24%
MY 2025		71.43%	88.00%	100.00%	88.46%	65.21%	80.54%	87.69%	91.97%
MY 2025	W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits in the First 15 months)	56.92%	61.39%	80.12%	77.86%	49.46%	60.39%	66.35%	71.71%
MY 2025	W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits for Age 15 Months - 30 Months)	62.07%	75.81%	86.24%	79.66%	64.14%	70.06%	75.87%	82.12%
MY 2025	WCV - Child and Adolescent Well-Care Visits—Total	55.90%	51.56%	50.46%	55.28%	44.96%	51.48%	58.37%	67.63%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance				National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Mendocino	10th	33.33rd	66.67th	90th
Prevention and Population									
Women's Reproductive Health									
MY 2024	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	55.56%	76.00%	86.67%	90.91%	73.48%	81.94%	86.89%	91.85%
MY 2025		83.33%	72.22%	94.12%	78.26%	76.16%	84.40%	88.56%	91.97%
MY 2024	***PPC - Prenatal and Postpartum Care—Postpartum Care	44.44%	88.00%	93.33%	90.91%	68.63%	77.37%	82.48%	86.62%
MY 2025		100.00%	100.00%	100.00%	86.96%	72.26%	79.73%	83.94%	88.32%
MY 2024	PRS-E - Prenatal Immunization Status - Combination Rate	14.05%	20.24%	28.69%	37.32%	8.42%	15.96%	24.92%	35.60%
MY 2025		9.60%	20.34%	42.37%	37.59%	8.23%	16.07%	25.25%	34.91%
Cancer Screening									
MY 2024	BCS-E- Breast Cancer Screening	46.83%	51.35%	48.55%	56.75%	42.86%	49.24%	56.66%	63.48%
MY 2025		46.57%	52.24%	47.58%	53.30%	45.09%	52.22%	58.93%	66.31%
MY 2024	CCS - Cervical Cancer Screening	50.00%	75.00%	30.00%	50.00%	43.31%	52.07%	60.10%	67.46%
MY 2025	CCS-E - Cervical Cancer Screening - ECDS Measure	46.91%	53.01%	54.00%	55.98%	40.21%	48.91%	55.86%	64.21%
MY 2024	COL-E - Colorectal cancer Screening	25.14%	28.05%	33.41%	31.50%	27.27%	34.30%	41.59%	49.35%
MY 2025		31.49%	33.09%	38.15%	38.20%	29.99%	38.05%	45.84%	53.31%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance				National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Mendocino	10th	33.33rd	66.67th	90th
Prevention and Population									
Other preventive services									
MY 2024	**CHL - Chlamydia Screening in Women—Total**	47.33%	54.61%	53.93%	52.00%	43.53%	52.40%	61.46%	69.07%
MY 2025		52.49%	53.82%	63.70%	56.29%	41.71%	51.22%	62.81%	70.67%
MY 2024	AIS-E-Adult Immunization Status—Influenza - Total	10.32%	13.81%	13.21%	13.76%	7.39%	12.55%	17.91%	26.40%
MY 2025		11.11%	14.01%	15.28%	14.08%	8.73%	13.56%	18.61%	26.60%
MY 2024	AIS-E-Adult Immunization Status—Pneumococcal - 66+	41.03%	50.90%	44.74%	43.85%	21.04%	38.73%	55.03%	68.07%
MY 2025		40.00%	55.60%	45.86%	50.57%	28.84%	43.72%	58.40%	71.90%
MY 2024	AIS-E-Adult Immunization Status—Td/Tdap - Total	36.08%	35.95%	39.66%	36.92%	21.26%	33.40%	47.30%	57.67%
MY 2025		43.87%	44.26%	47.65%	46.35%	26.23%	36.85%	50.60%	61.22%
MY 2024	AIS-E-Adult Immunization Status—Zoster - Total	10.10%	10.46%	13.05%	10.64%	2.23%	7.15%	13.49%	20.56%
MY 2025		11.41%	12.33%	15.93%	13.01%	3.62%	9.28%	16.63%	24.04%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance				National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Mendocino	10th	33.33rd	66.67th	90th
Treatment									
Respiratory									
MY 2024	**AMR - Asthma Medication Ratio- Total**	60.83%	63.41%	57.84%	62.50%	54.56%	62.35%	70.56%	76.65%
MY 2025		74.07%	65.52%	81.37%	80.37%	52.00%	59.38%	68.13%	76.25%
MY 2024	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	43.75%	43.14%	44.48%	37.92%	49.48%	50.98%	67.03%	77.66%
MY 2025		56.00%	40.45%	39.22%	33.72%	48.00%	56.37%	65.97%	75.42%
Diabetes									
MY 2024	EED - Eye Exams for Patients with Diabetes	0.00%	33.33%	50.00%	70.00%	40.39%	49.15%	57.09%	64.06%
MY 2025		43.72%	45.92%	54.56%	47.99%	42.09%	52.55%	60.83%	68.61%
MY 2024	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	66.67%	66.67%	92.86%	60.00%	58.15%	65.32%	71.78%	77.37%
MY 2025		66.67%	64.71%	87.50%	70.59%	60.34%	69.34%	74.21%	78.83%
MY 2024	HBD -Hemoglobin A1c Control for Patients with Diabetes-HbA1c Control (<8%)	33.33%	59.26%	78.57%	60.00%	44.25%	54.50%	59.64%	63.50%
MY 2025	GSD -Glycemic Status Assessment for Patients with Diabetes--HbA1c Control (<8%)	66.67%	70.59%	56.25%	64.71%	49.30%	57.41%	63.04%	67.40%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	59.47%	59.20%	61.94%	55.91%	51.96%	62.66%	67.01%	71.41%
MY 2025		60.58%	58.50%	59.54%	55.87%	56.26%	64.27%	69.01%	73.76%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	73.25%	70.16%	61.03%	65.32%	53.23%	64.18%	70.91%	79.73%
MY 2025		65.06%	67.16%	62.07%	62.87%	57.38%	65.75%	72.29%	80.89%
MY 2024	KED - Kidney Health Evaluation for Patients with Diabetes	29.02%	37.62%	35.38%	31.95%	26.79%	33.00%	42.10%	49.72%
MY 2025		31.91%	40.66%	35.03%	38.30%	30.61%	38.74%	46.17%	54.15%
Heart Disease									
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	64.00%	74.73%	71.67%	61.04%	66.64%	79.82%	83.00%	85.89%
MY 2025		73.91%	78.15%	84.29%	77.32%	69.48%	79.83%	82.94%	86.40%
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	69.44%	75.83%	85.71%	77.78%	59.95%	67.42%	74.07%	81.79%
MY 2025		58.82%	74.19%	62.71%	70.67%	61.58%	68.28%	75.45%	82.65%
MY 2024	***CBP - Controlling High Blood Pressure	83.33%	48.00%	68.18%	78.95%	54.61%	61.43%	67.40%	72.75%
MY 2025		100.00%	83.87%	100.00%	56.67%	56.93%	65.21%	70.35%	75.43%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance				National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Mendocino	10th	33.33rd	66.67th	90th
Treatment									
Behavioral Health - Care Coordination									
MY 2024	FUH - Follow-Up After Hospitalization for Mental Illness-7 days	NB	NB	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2025		50.00%	22.22%	0.00%	23.08%	26.07%	35.29%	45.08%	57.76%
MY 2024	FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total	11.61%	17.14%	10.36%	12.77%	21.19%	33.01%	44.33%	59.95%
MY 2025		25.64%	27.30%	21.01%	22.86%	26.32%	36.34%	46.71%	62.06%
MY 2024	FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total	18.24%	31.70%	13.33%	21.08%	12.73%	18.76%	27.62%	37.47%
MY 2025		28.35%	31.65%	21.03%	24.18%	15.49%	21.62%	30.53%	39.38%
MY 2024	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	15.79%	37.24%	6.67%	52.52%	15.91%	26.90%	37.64%	50.80%
MY 2025		50.00%	42.94%	7.32%	43.08%	18.61%	28.46%	40.55%	53.73%
Behavioral Health - Medication Adherence									
MY 2024	POD - Pharmacotherapy for Opioid Use Disorder—Total	16.95%	20.75%	13.82%	17.47%	12.05%	21.36%	29.01%	36.71%
MY 2025		14.47%	16.86%	15.38%	15.08%	14.52%	20.92%	30.43%	36.44%
MY 2024	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	67.57%	68.39%	68.12%	62.81%	44.65%	58.60%	66.15%	74.83%
MY 2025		68.57%	63.89%	74.78%	69.84%	49.57%	62.98%	69.67%	77.21%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance				National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Mendocino	10th	33.33rd	66.67th	90th
Treatment									
Behavioral Health - Access, Monitoring and Safety									
MY 2024	APM-E - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (ECDS)	45.95%	21.14%	26.47%	29.09%	25.86%	30.92%	41.41%	52.57%
MY 2025		30.23%	19.27%	29.03%	32.20%	26.70%	33.26%	41.52%	55.96%
MY 2024	ADD-E -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase (ECDS)	18.18%	43.24%	50.00%	33.33%	37.19%	48.94%	56.83%	63.49%
MY 2025		38.46%	59.62%	76.92%	50.00%	39.95%	51.20%	58.69%	65.18%
MY 2024	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.11%	79.15%	80.07%	88.03%	75.46%	79.51%	83.51%	87.27%
MY 2025		91.15%	80.38%	80.08%	86.90%	77.16%	81.03%	84.36%	87.47%
MY 2024	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	0.00%	48.98%	33.33%	75.00%	41.57%	54.55%	64.10%	74.14%
MY 2025		33.33%	48.48%	51.92%	54.55%	46.48%	58.39%	66.54%	75.82%
MY 2024	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	5.94%	8.06%	3.82%	8.25%	6.08%	10.51%	16.78%	26.72%
MY 2025		10.42%	15.50%	7.97%	14.81%	7.33%	11.35%	17.80%	27.95%
Risk-Adjusted Utilization									
MY 2024	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	0.6596	0.9967	0.9747	0.9901	1.1783	1.029	0.9124	0.8188
MY 2025		1.0269	0.8488	1.0048	1.0164	1.3971	1.2155	1.0696	0.9598
Administrative measures:The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).									

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA.
NCQA calculates the Confidence Limits (CLs) for all health plans.

4.4 HPA HEDIS Rate Performance by County, Fairfield Region: Solano, Yolo, and Napa Counties

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). Denominators less than 20 at the county level are suppressed.

Year	Measure	County Performance			National Medicaid Benchmarks			
		Napa	Solano	Yolo	10th	33.33rd	66.67th	90th
Prevention and Population								
Children and Adolescent Well-Care								
MY 2024	***CIS - Childhood Immunization Status (Combination 10)	47.06%	34.85%	21.62%	18.25%	24.39%	31.32%	42.34%
MY 2025	***CIS-E - Childhood Immunization Status (Combination 10) ECDS Measure	38.56%	32.03%	26.68%	14.67%	21.34%	26.93%	34.79%
MY 2024	***IMA - Immunizations for Adolescents (Combination 2)	50.00%	38.03%	55.56%	25.41%	31.39%	38.69%	48.66%
MY 2025	***IMA-E - Immunizations for Adolescents (Combination 2) ECDS Measure	57.56%	46.98%	48.03%	25.00%	30.70%	37.78%	47.16%
MY 2024	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	100.00%	80.65%	45.00%	66.91%	76.89%	86.20%	91.24%
MY 2025		100.00%	89.19%	57.69%	65.21%	80.54%	87.69%	91.97%
MY 2025	W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits in the First 15 months)	75.36%	62.18%	66.98%	49.46%	60.39%	66.35%	71.71%
MY 2025	W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits for Age 15 Months - 30 Months)	80.13%	72.82%	78.63%	64.14%	70.06%	75.87%	82.12%
MY 2025	WCV - Child and Adolescent Well-Care Visits—Total	64.08%	48.38%	54.46%	44.96%	51.48%	58.37%	67.63%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance			National Medicaid Benchmarks			
		Napa	Solano	Yolo	10th	33.33rd	66.67th	90th
Prevention and Population								
Women's Reproductive Health								
MY 2024	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.24%	87.76%	76.00%	73.48%	81.94%	86.89%	91.85%
MY 2025		100.00%	86.67%	100.00%	76.16%	84.40%	88.56%	91.97%
MY 2024	***PPC - Prenatal and Postpartum Care—Postpartum Care	100.00%	85.71%	68.00%	68.63%	77.37%	82.48%	86.62%
MY 2025		80.00%	91.11%	100.00%	72.26%	79.73%	83.94%	88.32%
MY 2024	PRS-E - Prenatal Immunization Status - Combination Rate	38.62%	37.70%	40.00%	8.42%	15.96%	24.92%	35.60%
MY 2025		31.19%	43.39%	40.19%	8.23%	16.07%	25.25%	34.91%
Cancer Screening								
MY 2024	BCS-E- Breast Cancer Screening	66.84%	54.14%	60.29%	42.86%	49.24%	56.66%	63.48%
MY 2025		68.63%	52.50%	56.03%	45.09%	52.22%	58.93%	66.31%
MY 2024	CCS - Cervical Cancer Screening	75.00%	64.71%	47.62%	43.31%	52.07%	60.10%	67.46%
MY 2025	CCS-E - Cervical Cancer Screening - ECDS Measure	53.29%	45.82%	51.78%	40.21%	48.91%	55.86%	64.21%
MY 2024	COL-E - Colorectal cancer Screening	38.24%	31.74%	32.50%	27.27%	34.30%	41.59%	49.35%
MY 2025		45.04%	36.08%	38.29%	29.99%	38.05%	45.84%	53.31%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance			National Medicaid Benchmarks			
		Napa	Solano	Yolo	10th	33.33rd	66.67th	90th
Prevention and Population								
Other preventive services								
MY 2024	**CHL - Chlamydia Screening in Women—Total**	49.58%	62.14%	51.37%	43.53%	52.40%	61.46%	69.07%
MY 2025		60.46%	69.97%	55.05%	41.71%	51.22%	62.81%	70.67%
MY 2024	AIS-E-Adult Immunization Status—Influenza - Total	21.99%	16.50%	21.83%	7.39%	12.55%	17.91%	26.40%
MY 2025		22.40%	18.06%	21.98%	8.73%	13.56%	18.61%	26.60%
MY 2024	AIS-E-Adult Immunization Status—Pneumococcal - 66+	51.67%	51.11%	47.74%	21.04%	38.73%	55.03%	68.07%
MY 2025		54.48%	52.84%	51.56%	28.84%	43.72%	58.40%	71.90%
MY 2024	AIS-E-Adult Immunization Status—Td/Tdap - Total	35.69%	34.58%	39.96%	21.26%	33.40%	47.30%	57.67%
MY 2025		40.39%	40.02%	42.63%	26.23%	36.85%	50.60%	61.22%
MY 2024	AIS-E-Adult Immunization Status—Zoster - Total	24.27%	17.30%	19.20%	2.23%	7.15%	13.49%	20.56%
MY 2025		31.03%	20.64%	22.49%	3.62%	9.28%	16.63%	24.04%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance			National Medicaid Benchmarks			
		Napa	Solano	Yolo	10th	33.33rd	66.67th	90th
Treatment								
Respiratory								
MY 2024	**AMR - Asthma Medication Ratio- Total**	79.82%	65.79%	67.84%	54.56%	62.35%	70.56%	76.65%
MY 2025		84.88%	74.58%	77.20%	52.00%	59.38%	68.13%	76.25%
MY 2024	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	31.21%	19.66%	19.23%	49.48%	50.98%	67.03%	77.66%
MY 2025		46.15%	21.24%	24.47%	48.00%	56.37%	65.97%	75.42%
Diabetes								
MY 2024	EED - Eye Exams for Patients with Diabetes	46.67%	59.65%	44.83%	40.39%	49.15%	57.09%	64.06%
MY 2025		69.69%	55.68%	56.68%	42.09%	52.55%	60.83%	68.61%
MY 2024	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	86.67%	84.21%	68.97%	58.15%	65.32%	71.78%	77.37%
MY 2025		80.00%	71.67%	91.30%	60.34%	69.34%	74.21%	78.83%
MY 2024	HBD -Hemoglobin A1c Control for Patients with Diabetes-HbA1c Control (<8%)	66.67%	52.63%	55.17%	44.25%	54.50%	59.64%	63.50%
MY 2025	GSD -Glycemic Status Assessment for Patients with Diabetes--HbA1c Control (<8%)	70.00%	60.00%	69.57%	49.30%	57.41%	63.04%	67.40%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	67.58%	68.90%	69.47%	51.96%	62.66%	67.01%	71.41%
MY 2025		72.21%	67.20%	67.02%	56.26%	64.27%	69.01%	73.76%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	65.16%	70.86%	71.09%	53.23%	64.18%	70.91%	79.73%
MY 2025		60.11%	71.39%	67.64%	57.38%	65.75%	72.29%	80.89%
MY 2024	KED - Kidney Health Evaluation for Patients with Diabetes	48.46%	50.53%	39.00%	26.79%	33.00%	42.10%	49.72%
MY 2025		55.58%	51.56%	41.50%	30.61%	38.74%	46.17%	54.15%
Heart Disease								
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	64.62%	69.87%	81.42%	66.64%	79.82%	83.00%	85.89%
MY 2025		84.00%	79.55%	87.84%	69.48%	79.83%	82.94%	86.40%
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	87.84%	77.89%	82.48%	59.95%	67.42%	74.07%	81.79%
MY 2025		70.24%	72.65%	71.54%	61.58%	68.28%	75.45%	82.65%
MY 2024	***CBP - Controlling High Blood Pressure	52.38%	62.75%	78.13%	54.61%	61.43%	67.40%	72.75%
MY 2025		84.62%	77.78%	60.71%	56.93%	65.21%	70.35%	75.43%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance			National Medicaid Benchmarks			
		Napa	Solano	Yolo	10th	33.33rd	66.67th	90th
Treatment								
Behavioral Health - Care Coordination								
MY 2024	FUH - Follow-Up After Hospitalization for Mental Illness-7 days	NB	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2025		11.11%	20.00%	20.69%	26.07%	35.29%	45.08%	57.76%
MY 2024	FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total	13.04%	9.98%	10.69%	21.19%	33.01%	44.33%	59.95%
MY 2025		17.07%	24.21%	21.07%	26.32%	36.34%	46.71%	62.06%
MY 2024	FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total	10.83%	20.83%	17.30%	12.73%	18.76%	27.62%	37.47%
MY 2025		23.16%	32.46%	21.57%	15.49%	21.62%	30.53%	39.38%
MY 2024	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	12.90%	32.17%	15.07%	15.91%	26.90%	37.64%	50.80%
MY 2025		20.00%	34.57%	16.67%	18.61%	28.46%	40.55%	53.73%
Behavioral Health - Medication Adherence								
MY 2024	POD - Pharmacotherapy for Opioid Use Disorder—Total	3.57%	13.07%	3.85%	12.05%	21.36%	29.01%	36.71%
MY 2025		15.25%	18.43%	8.74%	14.52%	20.92%	30.43%	36.44%
MY 2024	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	65.67%	65.96%	64.89%	44.65%	58.60%	66.15%	74.83%
MY 2025		72.46%	68.47%	64.29%	49.57%	62.98%	69.67%	77.21%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance			National Medicaid Benchmarks			
		Napa	Solano	Yolo	10th	33.33rd	66.67th	90th
Treatment								
Behavioral Health - Access, Monitoring and Safety								
MY 2024	APM-E - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (ECDS)	40.00%	41.57%	23.88%	25.86%	30.92%	41.41%	52.57%
MY 2025		27.78%	31.37%	19.35%	26.70%	33.26%	41.52%	55.96%
MY 2024	ADD-E -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase (ECDS)	28.57%	25.00%	48.84%	37.19%	48.94%	56.83%	63.49%
MY 2025		58.82%	43.90%	48.65%	39.95%	51.20%	58.69%	65.18%
MY 2024	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.85%	87.32%	80.00%	75.46%	79.51%	83.51%	87.27%
MY 2025		82.11%	85.57%	87.68%	77.16%	81.03%	84.36%	87.47%
MY 2024	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	9.09%	58.33%	28.00%	41.57%	54.55%	64.10%	74.14%
MY 2025		50.00%	73.08%	57.58%	46.48%	58.39%	66.54%	75.82%
MY 2024	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	4.79%	8.85%	3.50%	6.08%	10.51%	16.78%	26.72%
MY 2025		16.31%	11.58%	8.97%	7.33%	11.35%	17.80%	27.95%
Risk-Adjusted Utilization								
MY 2024	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	0.8874	1.1087	1.0775	1.1783	1.029	0.9124	0.8188
MY 2025		1.2404	0.9766	0.8632	1.3971	1.2155	1.0696	0.9598
Administrative measures:The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).								

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA.
NCQA calculates the Confidence Limits (CLs) for all health plans.

4.5 HPA HEDIS Rate Performance by County, Redding Region: Lassen, Modoc, Shasta, Siskiyou, Tehama, Trinity Counties

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). Denominators less than 20 at the county level are suppressed.

Year	Measure	County Performance						National Medicaid Benchmarks			
		Lassen	Modoc	Shasta	Siskiyou	Tehama	Trinity	10th	33.33rd	66.67th	90th
Prevention and Population											
Children and Adolescent Well-Care											
MY 2024	***CIS - Childhood Immunization Status (Combination 10)	50.00%	0.00%	16.00%	18.18%	0.00%	25.00%	18.25%	24.39%	31.32%	42.34%
MY 2025	***CIS-E - Childhood Immunization Status (Combination 10) ECDS Measure	3.23%	11.11%	10.02%	16.49%	20.05%	3.45%	14.67%	21.34%	26.93%	34.79%
MY 2024	***IMA - Immunizations for Adolescents (Combination 2)	12.50%	0.00%	21.57%	10.00%	0.00%	33.33%	25.41%	31.39%	38.69%	48.66%
MY 2025	***IMA-E - Immunizations for Adolescents (Combination 2) ECDS Measure	11.54%	16.92%	18.75%	19.22%	26.33%	15.49%	25.00%	30.70%	37.78%	47.16%
MY 2024	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	100.00%	100.00%	95.12%	66.67%	56.25%	0.00%	66.91%	76.89%	86.20%	91.24%
MY 2025		100.00%	100.00%	100.00%	50.00%	84.62%	100.00%	65.21%	80.54%	87.69%	91.97%
MY 2025	W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits in the First 15 months)	58.70%	45.71%	64.69%	59.05%	57.81%	46.51%	49.46%	60.39%	66.35%	71.71%
MY 2025	W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits for Age 15 Months - 30 Months)	54.08%	59.52%	71.36%	67.91%	77.10%	62.71%	64.14%	70.06%	75.87%	82.12%
MY 2025	WCV - Child and Adolescent Well-Care Visits—Total	33.68%	47.08%	49.71%	50.13%	51.95%	49.07%	44.96%	51.48%	58.37%	67.63%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance						National Medicaid Benchmarks			
		Lassen	Modoc	Shasta	Siskiyou	Tehama	Trinity	10th	33.33rd	66.67th	90th
Prevention and Population											
Women's Reproductive Health											
MY 2024	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	100.00%	100.00%	84.38%	100.00%	61.54%	50.00%	73.48%	81.94%	86.89%	91.85%
MY 2025		88.89%	100.00%	78.57%	100.00%	80.00%	100.00%	76.16%	84.40%	88.56%	91.97%
MY 2024	***PPC - Prenatal and Postpartum Care—Postpartum Care	100.00%	50.00%	0.00%	100.00%	92.31%	75.00%	68.63%	77.37%	82.48%	86.62%
MY 2025		66.67%	100.00%	82.14%	100.00%	86.67%	100.00%	72.26%	79.73%	83.94%	88.32%
MY 2024	PRS-E - Prenatal Immunization Status - Combination Rate	26.67%	17.14%	24.12%	27.33%	22.51%	15.38%	8.42%	15.96%	24.92%	35.60%
MY 2025		19.10%	18.60%	20.20%	34.97%	26.38%	7.14%	8.23%	16.07%	25.25%	34.91%
Cancer Screening											
MY 2024	BCS-E- Breast Cancer Screening	43.08%	48.52%	54.90%	52.64%	38.46%	49.39%	42.86%	49.24%	56.66%	63.48%
MY 2025		39.31%	51.72%	45.02%	50.99%	50.00%	34.53%	45.09%	52.22%	58.93%	66.31%
MY 2024	CCS - Cervical Cancer Screening	50.00%	100.00%	53.85%	72.73%	36.84%	100.00%	43.31%	52.07%	60.10%	67.46%
MY 2025	CCS-E - Cervical Cancer Screening - ECDS Measure	44.09%	49.74%	51.11%	51.49%	40.93%	49.61%	40.21%	48.91%	55.86%	64.21%
MY 2024	COL-E - Colorectal cancer Screening	23.17%	31.51%	32.16%	27.63%	25.00%	27.13%	27.27%	34.30%	41.59%	49.35%
MY 2025		25.06%	34.67%	35.93%	30.69%	26.89%	30.62%	29.99%	38.05%	45.84%	53.31%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance						National Medicaid Benchmarks			
		Lassen	Modoc	Shasta	Siskiyou	Tehama	Trinity	10th	33.33rd	66.67th	90th
Prevention and Population											
Other preventive services											
MY 2024	**CHL - Chlamydia Screening in Women—Total**	41.55%	32.89%	52.12%	45.38%	54.34%	34.72%	43.53%	52.40%	61.46%	69.07%
MY 2025		53.59%	46.05%	54.35%	51.43%	53.02%	40.00%	41.71%	51.22%	62.81%	70.67%
MY 2024	AIS-E-Adult Immunization Status—Influenza - Total	12.02%	10.14%	8.49%	10.20%	9.42%	8.18%	7.39%	12.55%	17.91%	26.40%
MY 2025		10.47%	10.13%	10.34%	10.08%	11.12%	9.21%	8.73%	13.56%	18.61%	26.60%
MY 2024	AIS-E-Adult Immunization Status—Pneumococcal - 66+	30.00%	46.15%	36.81%	32.43%	27.00%	9.09%	21.04%	38.73%	55.03%	68.07%
MY 2025		36.84%	47.83%	32.90%	24.56%	35.66%	31.25%	28.84%	43.72%	58.40%	71.90%
MY 2024	AIS-E-Adult Immunization Status—Td/Tdap - Total	28.42%	31.51%	33.87%	31.68%	29.20%	31.10%	21.26%	33.40%	47.30%	57.67%
MY 2025		32.18%	30.94%	33.68%	33.65%	36.08%	31.27%	26.23%	36.85%	50.60%	61.22%
MY 2024	AIS-E-Adult Immunization Status—Zoster - Total	4.50%	10.87%	10.49%	5.84%	9.87%	6.96%	2.23%	7.15%	13.49%	20.56%
MY 2025		4.18%	11.44%	11.02%	6.11%	11.74%	6.18%	3.62%	9.28%	16.63%	24.04%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance						National Medicaid Benchmarks			
		Lassen	Modoc	Shasta	Siskiyou	Tehama	Trinity	10th	33.33rd	66.67th	90th
Treatment											
Respiratory											
MY 2024	**AMR - Asthma Medication Ratio- Total**	58.70%	63.16%	57.28%	59.62%	0.00%	50.00%	54.56%	62.35%	70.56%	76.65%
MY 2025		71.43%	100.00%	65.33%	78.26%	69.06%	45.71%	52.00%	59.38%	68.13%	76.25%
MY 2024	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	40.38%	40.00%	38.22%	34.34%	46.95%	35.29%	49.48%	50.98%	67.03%	77.66%
MY 2025		40.63%	17.39%	43.50%	34.65%	50.71%	52.00%	48.00%	56.37%	65.97%	75.42%
Diabetes											
MY 2024	EED - Eye Exams for Patients with Diabetes	20.00%	100.00%	58.33%	71.43%	30.77%	0.00%	40.39%	49.15%	57.09%	64.06%
MY 2025		27.94%	35.67%	58.08%	50.09%	41.61%	40.49%	42.09%	52.55%	60.83%	68.61%
MY 2024	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	20.00%	0.00%	62.50%	57.14%	30.77%	0.00%	58.15%	65.32%	71.78%	77.37%
MY 2025		0.00%	100.00%	75.00%	100.00%	84.21%	33.33%	60.34%	69.34%	74.21%	78.83%
MY 2024	HBD -Hemoglobin A1c Control for Patients with Diabetes-HbA1c Control (<8%)	60.00%	50.00%	54.17%	42.86%	38.46%	0.00%	44.25%	54.50%	59.64%	63.50%
MY 2025	GSD -Glycemic Status Assessment for Patients with Diabetes--HbA1c Control (<8%)	50.00%	100.00%	66.67%	66.67%	68.42%	66.67%	49.30%	57.41%	63.04%	67.40%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	53.90%	60.61%	57.12%	61.60%	46.15%	51.09%	51.96%	62.66%	67.01%	71.41%
MY 2025		54.65%	57.14%	53.18%	55.16%	52.24%	53.06%	56.26%	64.27%	69.01%	73.76%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	67.47%	73.33%	71.68%	67.71%	66.67%	82.98%	53.23%	64.18%	70.91%	79.73%
MY 2025		62.77%	60.00%	68.79%	58.29%	69.53%	65.38%	57.38%	65.75%	72.29%	80.89%
MY 2024	KED - Kidney Health Evaluation for Patients with Diabetes	17.08%	24.22%	42.26%	38.86%	37.70%	31.72%	26.79%	33.00%	42.10%	49.72%
MY 2025		21.19%	33.33%	39.71%	38.13%	32.63%	28.57%	30.61%	38.74%	46.17%	54.15%
Heart Disease											
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	60.00%	57.14%	68.00%	60.87%	50.00%	73.33%	66.64%	79.82%	83.00%	85.89%
MY 2025		76.47%	80.00%	76.50%	80.77%	79.12%	76.47%	69.48%	79.83%	82.94%	86.40%
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	78.95%	100.00%	80.65%	76.67%	66.67%	78.95%	59.95%	67.42%	74.07%	81.79%
MY 2025		76.92%	62.50%	65.36%	47.62%	69.44%	69.23%	61.58%	68.28%	75.45%	82.65%
MY 2024	***CBP - Controlling High Blood Pressure	54.55%	0.00%	51.52%	50.00%	33.33%	0.00%	54.61%	61.43%	67.40%	72.75%
MY 2025		33.33%	33.33%	76.19%	50.00%	45.45%	33.33%	56.93%	65.21%	70.35%	75.43%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance						National Medicaid Benchmarks			
		Lassen	Modoc	Shasta	Siskiyou	Tehama	Trinity	10th	33.33rd	66.67th	90th
Treatment											
Behavioral Health - Care Coordination											
MY 2024	FUH - Follow-Up After Hospitalization for Mental Illness-7 days	NB	NB	NB	NB	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2025		0.00%	0.00%	20.00%	66.67%	7.14%	50.00%	26.07%	35.29%	45.08%	57.76%
MY 2024	FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total	9.38%	5.88%	18.90%	23.61%	6.67%	6.25%	21.19%	33.01%	44.33%	59.95%
MY 2025		33.64%	18.75%	34.82%	31.66%	22.79%	29.41%	26.32%	36.34%	46.71%	62.06%
MY 2024	FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total	14.52%	27.27%	34.01%	22.29%	22.94%	20.93%	12.73%	18.76%	27.62%	37.47%
MY 2025		16.67%	40.00%	39.82%	26.19%	20.48%	19.23%	15.49%	21.62%	30.53%	39.38%
MY 2024	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	37.04%	31.25%	36.40%	39.29%	25.00%	0.00%	15.91%	26.90%	37.64%	50.80%
MY 2025		38.46%	58.82%	39.38%	44.07%	15.00%	0.00%	18.61%	28.46%	40.55%	53.73%
Behavioral Health - Medication Adherence											
MY 2024	POD - Pharmacotherapy for Opioid Use Disorder—Total	5.56%	55.56%	16.40%	27.83%	4.00%	10.00%	12.05%	21.36%	29.01%	36.71%
MY 2025		10.34%	25.00%	17.52%	13.48%	15.71%	11.11%	14.52%	20.92%	30.43%	36.44%
MY 2024	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	73.91%	46.15%	66.19%	57.58%	60.53%	70.00%	44.65%	58.60%	66.15%	74.83%
MY 2025		69.57%	60.00%	63.61%	51.06%	65.67%	36.36%	49.57%	62.98%	69.67%	77.21%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance						National Medicaid Benchmarks			
		Lassen	Modoc	Shasta	Siskiyou	Tehama	Trinity	10th	33.33rd	66.67th	90th
Treatment											
Behavioral Health - Access, Monitoring and Safety											
MY 2024	APM-E - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (ECDS)	31.03%	0.00%	29.56%	29.73%	29.52%	50.00%	25.86%	30.92%	41.41%	52.57%
MY 2025		12.00%	22.22%	29.54%	35.00%	30.08%	60.00%	26.70%	33.26%	41.52%	55.96%
MY 2024	ADD-E -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase (ECDS)	20.00%	50.00%	48.53%	53.85%	0.00%	40.00%	37.19%	48.94%	56.83%	63.49%
MY 2025		38.46%	0.00%	36.47%	26.67%	41.94%	33.33%	39.95%	51.20%	58.69%	65.18%
MY 2024	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.43%	90.48%	81.42%	82.76%	84.08%	88.89%	75.46%	79.51%	83.51%	87.27%
MY 2025		81.63%	93.75%	81.74%	87.80%	82.69%	83.87%	77.16%	81.03%	84.36%	87.47%
MY 2024	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	6.25%	33.33%	54.55%	50.00%	20.69%	50.00%	41.57%	54.55%	64.10%	74.14%
MY 2025		44.44%	75.00%	60.26%	55.56%	27.66%	20.00%	46.48%	58.39%	66.54%	75.82%
MY 2024	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	9.57%	8.94%	12.24%	11.41%	4.96%	2.87%	6.08%	10.51%	16.78%	26.72%
MY 2025		9.52%	10.92%	14.89%	17.65%	10.36%	8.45%	7.33%	11.35%	17.80%	27.95%
Risk-Adjusted Utilization											
MY 2024	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	0.9224	0.9456	0.8900	0.4606	2.7723	0.6961	1.1783	1.029	0.9124	0.8188
MY 2025		0.9683	0.7650	1.0554	1.0053	0.7756	0.6492	1.3971	1.2155	1.0696	0.9598
Administrative measures:The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).											

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA.
NCQA calculates the Confidence Limits (CLs) for all health plans.

4.6 HPA HEDIS Rate Performance by County, Santa Rosa Region: Marin, Sonoma Counties

Note: CAHPS is not captured by County

4-5 points ○ 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). Denominators less than 20 at the county level are suppressed.

Year	Measure	County Performance		National Medicaid Benchmarks			
		Marin	Sonoma	10th	33.33rd	66.67th	90th
Prevention and Population							
Children and Adolescent Well-Care							
MY 2024	***CIS - Childhood Immunization Status (Combination 10)	35.14%	34.25%	18.25%	24.39%	31.32%	42.34%
MY 2025	***CIS-E - Childhood Immunization Status (Combination 10) ECDS Measure	45.92%	40.14%	14.67%	21.34%	26.93%	34.79%
MY 2024	***IMA - Immunizations for Adolescents (Combination 2)	57.14%	53.85%	25.41%	31.39%	38.69%	48.66%
MY 2025	***IMA-E - Immunizations for Adolescents (Combination 2) ECDS Measure	67.47%	55.78%	25.00%	30.70%	37.78%	47.16%
MY 2024	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	90.91%	69.49%	66.91%	76.89%	86.20%	91.24%
MY 2025		88.89%	88.46%	65.21%	80.54%	87.69%	91.97%
MY 2025	W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits in the First 15 months)	78.83%	74.53%	49.46%	60.39%	66.35%	71.71%
MY 2025	W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits for Age 15 Months - 30 Months)	91.59%	78.86%	64.14%	70.06%	75.87%	82.12%
MY 2025	WCV - Child and Adolescent Well-Care Visits—Total	60.35%	58.16%	44.96%	51.48%	58.37%	67.63%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance		National Medicaid Benchmarks			
		Marin	Sonoma	10th	33.33rd	66.67th	90th
Prevention and Population							
Women's Reproductive Health							
MY 2024	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	100.00%	90.00%	73.48%	81.94%	86.89%	91.85%
MY 2025		77.78%	98.36%	76.16%	84.40%	88.56%	91.97%
MY 2024	***PPC - Prenatal and Postpartum Care—Postpartum Care	100.00%	96.67%	68.63%	77.37%	82.48%	86.62%
MY 2025		100.00%	96.72%	72.26%	79.73%	83.94%	88.32%
MY 2024	PRS-E - Prenatal Immunization Status - Combination Rate	46.87%	39.15%	8.42%	15.96%	24.92%	35.60%
MY 2025		57.09%	49.95%	8.23%	16.07%	25.25%	34.91%
Cancer Screening							
MY 2024	BCS-E- Breast Cancer Screening	63.44%	59.17%	42.86%	49.24%	56.66%	63.48%
MY 2025		60.55%	57.12%	45.09%	52.22%	58.93%	66.31%
MY 2024	CCS - Cervical Cancer Screening	71.43%	68.00%	43.31%	52.07%	60.10%	67.46%
MY 2025	CCS-E - Cervical Cancer Screening - ECDS Measure	55.26%	57.41%	40.21%	48.91%	55.86%	64.21%
MY 2024	COL-E - Colorectal cancer Screening	34.44%	38.68%	27.27%	34.30%	41.59%	49.35%
MY 2025		38.90%	45.42%	29.99%	38.05%	45.84%	53.31%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance		National Medicaid Benchmarks			
		Marin	Sonoma	10th	33.33rd	66.67th	90th
Prevention and Population							
Other preventive services							
MY 2024	**CHL - Chlamydia Screening in Women—Total**	77.63%	51.89%	43.53%	52.40%	61.46%	69.07%
MY 2025		77.57%	60.86%	41.71%	51.22%	62.81%	70.67%
MY 2024	AIS-E-Adult Immunization Status—Influenza - Total	21.41%	18.25%	7.39%	12.55%	17.91%	26.40%
MY 2025		24.03%	21.78%	8.73%	13.56%	18.61%	26.60%
MY 2024	AIS-E-Adult Immunization Status—Pneumococcal - 66+	49.58%	40.21%	21.04%	38.73%	55.03%	68.07%
MY 2025		56.43%	45.73%	28.84%	43.72%	58.40%	71.90%
MY 2024	AIS-E-Adult Immunization Status—Td/Tdap - Total	40.27%	31.66%	21.26%	33.40%	47.30%	57.67%
MY 2025		43.29%	38.18%	26.23%	36.85%	50.60%	61.22%
MY 2024	AIS-E-Adult Immunization Status—Zoster - Total	27.44%	13.98%	2.23%	7.15%	13.49%	20.56%
MY 2025		32.92%	16.69%	3.62%	9.28%	16.63%	24.04%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance		National Medicaid Benchmarks			
		Marin	Sonoma	10th	33.33rd	66.67th	90th
Treatment							
Respiratory							
MY 2024	**AMR - Asthma Medication Ratio- Total**	61.27%	70.42%	54.56%	62.35%	70.56%	76.65%
MY 2025		73.23%	79.28%	52.00%	59.38%	68.13%	76.25%
MY 2024	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	11.98%	22.67%	49.48%	50.98%	67.03%	77.66%
MY 2025		19.78%	23.61%	48.00%	56.37%	65.97%	75.42%
Diabetes							
MY 2024	EED - Eye Exams for Patients with Diabetes	63.16%	65.52%	40.39%	49.15%	57.09%	64.06%
MY 2025		66.05%	65.12%	42.09%	52.55%	60.83%	68.61%
MY 2024	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	89.47%	67.24%	58.15%	65.32%	71.78%	77.37%
MY 2025		82.61%	65.15%	60.34%	69.34%	74.21%	78.83%
MY 2024	HBD -Hemoglobin A1c Control for Patients with Diabetes-HbA1c Control (<8%)	52.63%	44.83%	44.25%	54.50%	59.64%	63.50%
MY 2025	GSD -Glycemic Status Assessment for Patients with Diabetes--HbA1c Control (<8%)	56.52%	63.64%	49.30%	57.41%	63.04%	67.40%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	67.69%	68.61%	51.96%	62.66%	67.01%	71.41%
MY 2025		71.73%	66.67%	56.26%	64.27%	69.01%	73.76%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	69.25%	62.65%	53.23%	64.18%	70.91%	79.73%
MY 2025		66.45%	58.50%	57.38%	65.75%	72.29%	80.89%
MY 2024	KED - Kidney Health Evaluation for Patients with Diabetes	50.23%	47.24%	26.79%	33.00%	42.10%	49.72%
MY 2025		50.34%	50.23%	30.61%	38.74%	46.17%	54.15%
Heart Disease							
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	72.84%	70.46%	66.64%	79.82%	83.00%	85.89%
MY 2025		87.70%	84.82%	69.48%	79.83%	82.94%	86.40%
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	89.01%	82.29%	59.95%	67.42%	74.07%	81.79%
MY 2025		75.70%	65.37%	61.58%	68.28%	75.45%	82.65%
MY 2024	***CBP - Controlling High Blood Pressure	62.07%	62.67%	54.61%	61.43%	67.40%	72.75%
MY 2025		63.64%	74.00%	56.93%	65.21%	70.35%	75.43%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance		National Medicaid Benchmarks			
		Marin	Sonoma	10th	33.33rd	66.67th	90th
Treatment							
Behavioral Health - Care Coordination							
MY 2024	FUH - Follow-Up After Hospitalization for Mental Illness-7 days	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2025		13.04%	22.45%	26.07%	35.29%	45.08%	57.76%
MY 2024	FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total	20.50%	16.83%	21.19%	33.01%	44.33%	59.95%
MY 2025		28.92%	27.56%	26.32%	36.34%	46.71%	62.06%
MY 2024	FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total	21.33%	18.89%	12.73%	18.76%	27.62%	37.47%
MY 2025		25.00%	21.69%	15.49%	21.62%	30.53%	39.38%
MY 2024	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	10.53%	22.86%	15.91%	26.90%	37.64%	50.80%
MY 2025		15.00%	19.18%	18.61%	28.46%	40.55%	53.73%
Behavioral Health - Medication Adherence							
MY 2024	POD - Pharmacotherapy for Opioid Use Disorder—Total	5.19%	12.62%	12.05%	21.36%	29.01%	36.71%
MY 2025		11.24%	10.57%	14.52%	20.92%	30.43%	36.44%
MY 2024	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	77.88%	68.80%	44.65%	58.60%	66.15%	74.83%
MY 2025		71.30%	66.01%	49.57%	62.98%	69.67%	77.21%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Year	Measure	County Performance		National Medicaid Benchmarks			
		Marin	Sonoma	10th	33.33rd	66.67th	90th
Treatment							
Behavioral Health - Access, Monitoring and Safety							
MY 2024	APM-E - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (ECDS)	51.72%	35.29%	25.86%	30.92%	41.41%	52.57%
MY 2025		44.12%	42.61%	26.70%	33.26%	41.52%	55.96%
MY 2024	ADD-E -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase (ECDS)	50.00%	31.82%	37.19%	48.94%	56.83%	63.49%
MY 2025		33.33%	53.19%	39.95%	51.20%	58.69%	65.18%
MY 2024	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	78.61%	85.90%	75.46%	79.51%	83.51%	87.27%
MY 2025		88.77%	85.51%	77.16%	81.03%	84.36%	87.47%
MY 2024	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	77.78%	31.48%	41.57%	54.55%	64.10%	74.14%
MY 2025		75.00%	59.57%	46.48%	58.39%	66.54%	75.82%
MY 2024	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	5.39%	8.69%	6.08%	10.51%	16.78%	26.72%
MY 2025		10.74%	13.59%	7.33%	11.35%	17.80%	27.95%
Risk-Adjusted Utilization							
MY 2024	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	0.9704	0.8308	1.1783	1.029	0.9124	0.8188
MY 2025		0.9309	0.9443	1.3971	1.2155	1.0696	0.9598
Administrative measures:The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).							

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA.
NCQA calculates the Confidence Limits (CLs) for all health plans.

5.0 HEDIS HealthPlan Accreditation (HPA) – Health plan Rating Methodology

Health plans are rated in three categories: private/commercial plans in which people enroll through employers or on their own; plans that serve Medicare beneficiaries in the Medicare Advantage program (not supplemental plans); and plans that serve Medicaid beneficiaries.

NCQA ratings are based on three types of quality measures: 1) measures of clinical quality from NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®) and Health Outcomes Survey (HOS); 2) measures of patient experience using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®); and 3) results from NCQA's review of a health plan's health quality processes (NCQA Accreditation). NCQA rates health plans that choose to report measures publicly.

The overall rating is the weighted average of a plan's HEDIS, HOS, and CAHPS measure ratings, plus Accreditation bonus points (if the plan is Accredited by NCQA), rounded to the nearest half point displayed as stars.

The overall rating is based on performance on dozens of measures of care and is calculated on a 0–5 scale in half points (5 is highest). Performance includes three subcategories:

1. **Patient Experience:** Patient-reported experience of care, including experience with doctors, services and customer service (measures in the Patient Experience category).

2. **Rates for Clinical Measures:** The proportion of eligible members who received preventive services (prevention measures) and the proportion of eligible members who received recommended care for certain conditions (treatment measures).

3. **NCQA Health Plan Accreditation:** For a plan with an Accredited or Provisional status, 0.5 bonus points are added to the overall rating before rounding to the nearest half point and displayed as stars.

6.0 HEDIS/CAHPS Measures Required for HP Accreditation—Medicaid

HEDIS MY 2025 & CAHPS MY 2025 (Reporting Year 2026)

Measure Name		Display Name	Weight
PATIENT EXPERIENCE			
Getting Care			
Getting Needed Care (Usually + Always)		Getting care easily	1.5
Getting Care Quickly (Usually + Always)		Getting care quickly	1.5
Satisfaction With Plan and Plan Services			
Rating of Health Plan (9 + 10)		Rating of health plan	1.5
Rating of All Health Care (9 + 10)		Rating of care	1.5
PREVENTION AND POPULATION			
Children and Adolescent Well-Care			
CIS-E	Childhood Immunization Status—Combination 10 ***(NEW REPORTING METHOD)***	Childhood immunizations	3
IMA-E	Immunizations for Adolescents—Combination 2 ***(NEW REPORTING METHOD)***	Adolescent immunizations	3
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	BMI percentile assessment	1
W30	Well-Child Visits in the First 30 Months of Life—*Well-Child Visits in the First 15 Months* ***(NEW MEASURE)***	Well care for children in the first 15 months of life	1
	Well-Child Visits in the First 30 Months of Life—*Well-Child Visits for Age 15 Months–30 Months* ***(NEW MEASURE)***	Well care for children ages 15-30 months	1
WCV	Child and Adolescent Well-Care Visits—Total ***(NEW MEASURE)***	Well care for children and adolescents	1
Women's Reproductive Health			
PPC	Prenatal and Postpartum Care—Timeliness of Prenatal Care	Prenatal checkups	1
	Prenatal and Postpartum Care—Postpartum Care	Postpartum care	1
PRS-E	Prenatal Immunization Status—Combination Rate	Prenatal immunizations	1
Cancer Screening			
BCS-E	Breast Cancer Screening—Total	Breast cancer screening	1
COL-E	Colorectal Cancer Screening—Total	Colorectal cancer screening	1
CCS-E	Cervical Cancer Screening ***(NEW REPORTING METHOD)***	Cervical cancer screening	1

Measure Name		Display Name	Weight
Description of Membership			
RDM	Race/Ethnicity Diversity of Membership	Race and ethnicity of members	1
LDM	Language Diversity of Membership	Language preferences of members	1
Other Preventive Services			
CHL	Chlamydia Screening—Total	Chlamydia screening	1
AIS-E	Adult Immunization Status—Influenza—Total	Influenza immunizations for adults	1
	Adult Immunization Status—Td/Tdap—Total	Td/Tdap immunizations for adults	1
	Adult Immunization Status—Zoster—Total	Zoster immunizations for adults	1
	Adult Immunization Status—Pneumococcal—65+	Pneumococcal immunizations for adults	1
TREATMENT			
Respiratory			
AMR	Asthma Medication Ratio—Total	Asthma control	1
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	Appropriate antibiotic use for acute bronchitis/bronchiolitis	1
Diabetes			
BPD	Blood Pressure Control for Patients With Diabetes	Patients with diabetes—blood pressure control (140/90)	3
EED	Eye Exam for Patients With Diabetes	Patients with diabetes—eye exams	1
GSD	Glycemic Status Assessment for Patients With Diabetes—Glycemic Status (<8%)	Patients with diabetes—glycemic status	3
SPD	Statin Therapy for Patients With Diabetes—Received Statin Therapy	Patients with diabetes—received statin therapy	1
	Statin Therapy for Patients With Diabetes—Statin Adherence 80%	Patients with diabetes—statin adherence 80%	1
KED	Kidney Health Evaluation for Patients With Diabetes—Total	Patients with diabetes—kidney health evaluation	1
Heart Disease			
SPC	Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	Patients with cardiovascular disease—received statin therapy	1
	Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	Patients with cardiovascular disease—statin adherence 80%	1
CBP	Controlling High Blood Pressure	Controlling high blood pressure	3

Measure Name		Display Name	Weight
Behavioral Health—Care Coordination			
FUH	Follow-Up After Hospitalization for Mental Illness—7 days—Total	Follow-up after hospitalization for mental illness	1
FUM	Follow-Up After Emergency Department Visit for Mental Illness—7 days—Total	Follow-up after ED for mental illness	1
FUA	Follow-Up After Emergency Department Visit for Substance Use—7 days—Total	Follow-up after ED for substance use disorder	1
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	Follow-up after high-intensity care for substance use disorder	1
Behavioral Health—Medication Adherence			
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Adherence to antipsychotic medications for individuals with schizophrenia	1
POD	Pharmacotherapy for Opioid Use Disorder—Total	Patients with opioid use disorder—medication adherence for 6 months	1
Behavioral Health—Access, Monitoring and Safety			
APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	Cholesterol and blood sugar testing for youth on antipsychotic medications	1
ADD-E	Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	Continued follow-up after ADHD diagnosis	1
SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Diabetes screening for individuals with schizophrenia or bipolar disorder	1
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	First-line psychosocial care for youth on antipsychotic medications	1
IET	Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total	Substance use disorder treatment engagement	1
Risk-Adjusted Utilization			
PCR	Plan All-Cause Readmissions—Observed-to-Expected Ratio—18-64	Plan all-cause readmissions	1

7.0 HEDIS/CAHPS MY2025 / RY2026 HPA Overall Star Rating Results: with Child CAHPS Survey Results (Projected)

Partnership's projected MY2025 HPA Star Rating is 3.5 Stars. This rating is calculated based on the MY2025 Child CAHPS® (regulated) survey results and plan-wide HEDIS rates per the NCQA Health Plan scoring methodology. Final scores will be published by NCQA in Fall of 2026. Because NCQA's scoring methodology uses rates that are proprietary to NCQA and will not be published until Fall 2026, Partnership's scoring calculations are not published in the MY2026 Annual Summary of Performance at this time.

Rounding Rules	
0.000–0.249 → 0.0	2.750–3.249 → 3.0
0.250–0.749 → 0.5	3.250–3.749 →3.5
0.750–1.249 → 1.0	3.750–4.249 → 4.0
1.250–1.749 → 1.5	4.250–4.749 → 4.5
1.750–2.249 → 2.0	≥4.750 → 5.0
2.250–2.749 → 2.5	

Overall Rating Source	
Field	**Calculation**
Measure points	181
Overall Rating Not Rounded	3.120689655
Final Overall Rating +.5 Bonus	3.621
Final Score Rounded	3.5

7.1 Factors in MY2025 HPA Star Rating

The following factors were important drivers of Partnership's performance on the MY2025 HPA measures:

Changes to MY2025 HPA Measure Set: Several measures were added to the HPA measure set in MY2025 that align with Partnership's Managed Care Accountability Set (MCAS): Well Child Visits in the First 30 Months of Life (W30) and Child and Adolescent Well-Care Visits (WCV). These measures have been prioritized and incentivized throughout Partnership's provider network for

many years and all have Plan-Wide rates above the 33rd percentile. This resulted in the Prevention and Population section of the Star Rating scoring 3.5 Stars, a year-over-year improvement of 0.5 Stars.

In addition, several medication management measures were retired from the Treatment section that historically performed below the 67th percentile.

Improvements in Year-over-Year Performance: Ten clinical measures improved significantly in Plan-Wide performance in MY2025.

- Immunizations for Adolescents (IMA-2), a heavily weighted clinical measure, performed above the 90th percentile in MY2025
- Glycemic Status Assessment for Patients With Diabetes (<8%) (GSD), a heavily weighted clinical measure, performed above the 90th percentile.
- Asthma Medication Ratio moved above the 90th percentile
- Prenatal Immunization Status moved above the 90th percentile
- Adult Immunization Status – Zoster moved above the 90th percentile
- Adult Immunization Status – Td/Tdap moved to the 33rd – 66th percentile
- Controlling Blood Pressure moved to the 33rd – 66th percentile
- Eye Exams for Patients with Diabetes moved to the 33rd – 66th percentile
- Weight Assessment and Counseling for Children/Adolescents—BMI Percentile moved to the 33rd – 66th percentile
- Follow-Up After Emergency Department Visit for Mental Illness – 7 Days moved to the 10th – 32nd percentile

In addition, one Child CAHPS measure, Getting Needed Care (Usually+ Always), improved in MY2025.

7.2 MY2025 HEDIS HealthPlan Accreditation (HPA) – HealthPlan Rating Score Child CAHPS - Change from Prior Year

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Rounding Rules	
0.000–0.249 → 0.0	2.750–3.249 → 3.0
0.250–0.749 → 0.5	3.250–3.749 →3.5
0.750–1.249 → 1.0	3.750–4.249 → 4.0
1.250–1.749 → 1.5	4.250–4.749 → 4.5
1.750–2.249 → 2.0	≥4.750 → 5.0
2.250–2.749 → 2.5	

MY2025 Star Rating w/Child CAHPS survey results (submitted for HPA):

Preliminary Overall Rating +.5 Bonus	3.62068966

HEDIS HealthPlan Accreditation Star Rating Scoring MY2025 With Child CAHPS Survey Results	TOTAL ACCRD Score MY2025	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points overall
Overall Rating (CAHPS + Accreditation Measures)	140	181	3.120689655	3.5
Patient Experience	10	15	2.500	2.5
Prevention and Population	66	82	3.565	3.5
Treatment	64	84	2.897	3.0

MY2024 Star Rating w/Child CAHPS survey results:

Final Overall Rating +.5 Bonus	3.24166667

HEDIS HealthPlan Accreditation Star Rating Scoring MY2024 With Child CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2024	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points overall
Overall Rating (CAHPS + Accreditation Measures)	60	135	164.5	2.741666667	3.0
Patient Experience	7.5	12	18	2.400	2.5
Prevention and Population	19.5	52	61.5	3.154	3.0
Treatment	33	71	85	2.576	2.5

7.3 MY2025 HEDIS HealthPlan Accreditation (HPA) – HealthPlan Rating Score Adults CAHPS - Change from Prior Year

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Rounding Rules	
0.000–0.249 → 0.0	2.750–3.249 → 3.0
0.250–0.749 → 0.5	3.250–3.749 →3.5
0.750–1.249 → 1.0	3.750–4.249 → 4.0
1.250–1.749 → 1.5	4.250–4.749 → 4.5
1.750–2.249 → 2.0	≥4.750 → 5.0
2.250–2.749 → 2.5	

MY2025 Projected Star Rating w/Adult CAHPS survey results:

Preliminary Overall Rating +.5 Bonus	3.56896552

HEDIS HealthPlan Accreditation Star Rating Scoring MY2025 With Adult CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2025	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points overall
Overall Rating (CAHPS + Accreditation Measures)	58	138	178	3.068965517	3.5
Patient Experience	6	8	12	2.000	2.0
Prevention and Population	23	66	82	3.565	3.5
Treatment	29	64	84	2.897	3.0

MY2024 Projected Star Rating w/Adult CAHPS survey results:

Final Overall Rating +.5 Bonus	3.19166667

HEDIS HealthPlan Accreditation Star Rating Scoring MY2024 With Adult CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2024	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)	60	133	161.5	2.691666667	3.0
Patient Experience	7.5	10	15	2.000	2.0
Prevention and Population	19.5	52	61.5	3.154	3.0
Treatment	33	71	85	2.576	2.5

8.0 MY2025 HEDIS HealthPlan Accreditation (HPA) – Measurement Set Descriptions

HEDIS Measure	Measure Indicator	Measure Definition
PREVENTION AND POPULATION		
Children and Adolescent Well-Care		
Childhood Immunization Status (CIS-E)	• Combination 10	• The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates. o Combination 10. Children who have had all ten indicators (DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV and Influenza).
Immunizations for Adolescents (IMA-E)	• Combination 2	• The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates. o Combination 2. Adolescents who have had all three indicators (meningococcal, Tdap and HPV).
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	• BMI Percentile Documentation	• The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year. o *BMI Percentile Documentation.* Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

HEDIS Measure	Measure Indicator	Measure Definition
PREVENTION AND POPULATION		
Well-Child Visits in the First 30 Months of Life (W30)	• Well-Child Visits in the First 15 Months • Well-Child Visits for Age 15 Months–30 Months	• The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: o *Well-Child Visits in the First 15 Months.* Children who turned 15 months old during the measurement year: Six or more well-child visits. o *Well-Child Visits for Age 15 Months–30 Months.* Children who turned 30 months old during the measurement year: Two or more well-child visits.
Child and Adolescent Well-Care Visits (WCV)	• Total	• The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
Women's Reproductive Health		
Prenatal and Postpartum Care (PPC)	• Timeliness of Prenatal Care • Postpartum Care	• The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these members, the measure assesses the following facets of prenatal and postpartum care: o *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in the organization. o *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

HEDIS Measure	Measure Indicator	Measure Definition
PREVENTION AND POPULATION		
Prenatal Immunization Status (PRS-E)	• Combination Rate	• The percentage of deliveries in the measurement period in which members had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.
Cancer Screening		
Breast Cancer Screening (BCS-E)	• Total	• The percentage of members 40–74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.
Cervical Cancer Screening (CCS-E)	• Total	• The percentage of members 21–64 years of age who were recommended for routine cervical cancer screening who were screened for cervical cancer using any of the following criteria: o Members 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years. o Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. o Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.
Colorectal Cancer Screening (COL-E)	• Total	• The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.

HEDIS Measure	Measure Indicator	Measure Definition
PREVENTION AND POPULATION		
Description of Membership		
Race/Ethnicity Diversity of Membership-(RDM)	• Race/Ethnicity Direct	• An unduplicated count and percentage of members enrolled any time during the measurement year, by race and ethnicity.
Language Diversity of Membership (LDM)	• Spoken Language Preferred • Preferred Language for Written Materials	• An unduplicated count and percentage of members enrolled at any time during the measurement year by spoken language preferred for health care and preferred language for written materials.
Other Preventative Services		
Chlamydia Screening (CHL)	• Total	• The percentage of members 16–24 years of age who were recommended for routine chlamydia screening, were identified as sexually active and had at least one test for chlamydia during the measurement year.
Adult Immunization Status (AIS-E)	• Influenza immunizations for adults • Td/Tdap immunizations for adults • Zoster immunizations for adults • Pneumococcal immunizations for adults	• The percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster, pneumococcal and hepatitis B.

HEDIS Measure	Measure Indicator	Measure Definition
TREATMENT		
Respiratory		
Asthma Medication Ratio (AMR)	• 5–64 years • Total	• The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	• Total	• The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event. ***Note**: This measure is reported as an inverted rate [1–(numerator/eligible population)]. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (i.e., the proportion for episodes that did not result in an antibiotic dispensing event).*
Diabetes		
Blood Pressure Control for Patients With Diabetes (BPD)	• Total	• The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.
Eye Exam for Patients With Diabetes (EED)	• Eye Exam for Patients With Diabetes	• The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.

HEDIS Measure	Measure Indicator	Measure Definition
TREATMENT		
Glycemic Status Assessment for Patients With Diabetes (GSD)	• Glycemic Status <8.0%	• The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: o *Glycemic Status <8.0%.* o *Glycemic Status >9.0%.* *Note: Organizations must use the same data collection method (Administrative or Hybrid) to report these indicators.*
Statin Therapy for Patients With Diabetes (SPD)	• Received Statin Therapy • Statin Adherence 80%	• The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported: o *Received Statin Therapy.* Members who were dispensed at least one statin medication of any intensity during the measurement year. o *Statin Adherence 80%.* Members who remained on a statin medication of any intensity for at least 80% of the treatment period.
Kidney Health Evaluation for Patients with Diabetes (KED)	• Kidney Health Evaluation for Patients With Diabetes—Total	• The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.

HEDIS Measure	Measure Indicator	Measure Definition
TREATMENT		
Heart Disease		
Statin Therapy for Patients With Cardiovascular Disease (SPC)	• Total • Received Statin Therapy • Statin Adherence 80%	• The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported: o *Received Statin Therapy.* Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year. o *Statin Adherence 80%.* Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.
Controlling High Blood Pressure (CBP)	• Total	• The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
Behavioral Health – Care Coordination		
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	• 7 days • Total	• The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service. o The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).
Follow-Up After Emergency Department Visit for Substance Use (FUA)	• 7 days • Total	• The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. o The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

HEDIS Measure	Measure Indicator	Measure Definition
TREATMENT		
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	• 7 days • Total	• The percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. o The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.
Behavioral Health – Medication Adherence		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	• Non-Medicare 80% Coverage	• The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.
Pharmacotherapy for Opioid Use Disorder (POD)	• Total	• The percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event. o *Intake period.* A 12-month period that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.
Behavioral Health – Access, Monitoring and Safety		
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	• Total	• The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: o The percentage of children and adolescents on antipsychotics who received blood glucose testing. o The percentage of children and adolescents on antipsychotics who received cholesterol testing. o The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.

HEDIS Measure	Measure Indicator	Measure Definition
TREATMENT		
Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase (ADD-E)	• Initiation Phase • Continuation and Maintenance (C&M) Phase	• The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 300-day (10 month) period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. o *Initiation Phase.* The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase. o *Continuation and Maintenance (C&M) Phase.* The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	• Diabetes Screening	• The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (APP)	• Total	• The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

HEDIS Measure	Measure Indicator	Measure Definition
TREATMENT		
Initiation and Engagement of Substance Use Disorder Treatment— (IET)	• Engagement of SUD Treatment • Total	• The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported: o Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days. o Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.
Risk-Adjusted Utilization		
Plan All-Cause Readmissions— (PCR)	• Observed-to-Expected Ratio • 18-64 years • Total	• For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. ***Note**: Members with dual Medicaid/Medicare enrollment "dual eligible" and with Medicare-Medicaid (MMP) enrollment may only be reported in the Medicare product line.*

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
1. QI Program Infrastructure											
1.a.	QI Program Documents	Continued	**Goal #1:** By July 2026, complete draft QI Program Description, QI Work Plan, and QI Evaluation revisions in preparation for August Quality Committee meetings.	**Deliverable #1:** Finalize 2026 - 2027 QI Program Description	10/1/2025	7/30/2026	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
1.a.				**Deliverable #2:** Finalize 2025 - 2026 QI Work Plan.	10/1/2025	7/30/2026	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.a.				**Deliverable #3:** Finalize 2025 - 2026 QI Evaluation.	10/1/2025	7/30/2026	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.a.				**Deliverable #4:** Complete Draft of 2026 - 2027 QI Work Plan	10/1/2025	7/30/2026	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.b.	Improve Partner Satisfaction	New	**Goal #1**: By November 2025, implement a post-training feedback survey for Trilogy participants to establish a baseline satisfaction score and identify two areas for improvement in future sessions.	**Deliverable #1**: By August 31, 2025: Draft survey questions and finalize with key team input.	6/30/2025	8/31/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
1.b.				**Deliverable #2**: By September 15, 2025: Pilot the survey with a small group and make revisions as needed.	7/30/2025	9/15/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.b.				**Deliverable #3**: By October 15, 2025: Launch the full survey to all recent Trilogy training participants.	8/1/2025	10/15/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.b.				**Deliverable #4**: By November 15, 2025: Analyze results.	10/30/2025	11/15/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.b.				**Deliverable #5**: By December 15, 2025: Share findings with the team.	11/15/2025	12/15/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
1.c.	Streamline QI Trilogy Document Processes	New	**Goal #1**: By June 30, 2026, partner with at least two stakeholders outside the Trilogy team to observe current workflows and identify two to three actionable improvements aimed at reducing administrative burden and manual work across the program.	**Deliverable #1**: By September 30, 2025: Identify and confirm two (or more) stakeholders to engage with.	7/1/2025	9/30/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
1.c.				**Deliverable #2**: By November 30, 2025: Schedule and complete observation sessions or process walk-throughs with each stakeholder	9/30/2025	11/30/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.c.				**Deliverable #3**: By January 31, 2026: Analyze findings and map out current pain points or redundancies.	11/30/2025	1/31/2026	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.c.				**Deliverable #4**: By March 31, 2026: Draft a summary of proposed process improvements and share with stakeholders for feedback.	1/31/2026	3/31/2026	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.c.				**Deliverable #5**: By June 30, 2026: Finalize two to three actionable improvement recommendations and develop an implementation plan.	3/31/2026	6/30/2026	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.d.	Enhance QI Trilogy Training Tools	New	**Goal #1**: By June 30, 2026, collaborate with the Training & Development team to revamp the QI Trilogy Training and develop at least two microlearning modules that reinforce key concepts in a more engaging and accessible format.	**Deliverable #1**: By August 30, 2025: Meet with T&D team to define project scope, responsibilities, and timeline.	6/30/2025	8/30/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
1.d.				**Deliverable #2**: By October 15, 2025: Gather and review current training materials; identify areas needing updates or replacement.	8/30/2025	10/15/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.d.				**Deliverable #3**: By December 31, 2025: Draft new or revised content and storyboard two microlearning modules.	10/15/2025	12/31/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.d.				**Deliverable #4**: By February 28, 2026: Complete development of microlearning modules and test internally.	12/31/2025	2/28/2026	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.d.				**Deliverable #5**: By March 31, 2026: Launch updated training and modules; collect initial user feedback.	2/28/2026	3/31/2026	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
1.e.	Physician Advisory Committee (PAC) Oversight of QI Program	New	**Goal #1:** By June 30, 2026, Ensure PAC oversight of Partnership's QI Program through semi-annual monitoring of the QI Work Plan	**Deliverable #1:** By September 30, 2024 QI Trilogy Documents to be reviewed for approval by PAC in September 2024, post-review of other Quality committees to include but not limited to: * FY 2024-25 - Work Plan * FY 2024-25 - Program Descriptions * FY 2023-24- QI Program Evaluation	9/10/2025	9/30/2025	Title: Chief Medical Officer Name: Robert Moore	Title: Executive Assistant Name: Sarah Browning	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2. Measurement, Analytics and Reporting											
2.a.	HEDIS® Reporting	Continued	**Goal #1:** By June 30, 2026, report HEDIS MY2025 final rate performance as required annually for NCQA Health Plan Accreditation (HPA) and the DHCS Managed Care Accountability Set (MCAS) and baseline Medicare data.	**Deliverable #1:** Annual Project Work Plans updated by 10/31/2025 to accommodate HPA, MCAS and Medicare unique activities/deliverables.	7/1/2025	10/31/2025	Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.a.				**Deliverable #2:** By June 30, 2026, report HEDIS MY2025 final rate performance as required annually for NCQA Health Plan Accreditation (HPA) and the DHCS Managed Care Accountability Set (MCAS).	1/1/2026	6/30/2026	Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.a.		Continued	**Goal #2**: By August 29, 2025, launch the HEDIS MY2025 Monthly Project in Inovalon to include data reporting for NCQA Health Plan Accreditation (HPA), the DHCS Managed Care Accountability Set (MCAS) and the Dual Eligible Special Needs Plan (D-SNP).	**Deliverable #1**: Create Monthly Project Work Plan updated by August 29, 2025 to include HPA, MCAS and D-SNP unique activities/deliverables.	7/1/2025	8/29/2025	Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.a.				**Deliverable #2**: By August 29, 2025, launch the HEDIS MY2025 Monthly Project which includes all populations for DHCS, HPA and D-SNP.	7/1/2025	8/29/2025	Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.a.				**Deliverable #3**: By August 29, 2025, send data exports for the HEDIS MY2025 Monthly Project which includes all populations for DHCS, HPA and D-SNP to the EDW & HA team's to create the PQD Monthly Dashboard.	7/1/2025	8/29/2025	Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.a.				**Deliverable #4:** Timely publication of the MY2025 HEDIS® Monthly Exploratory dashboard, based on efforts by HEDIS, EDW, and Health Analytics team member, to include enhancement requests. (Contingent on HRP® production implementation).	7/1/2025	10/15/2025	Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.a.		New	**Goal #3**: By June 30, 2026, submit supplemental data extracted from OCHIN Epic, eCW and NextGen for HEDIS Annual MY2025 from an NCQA certified data aggregator to support regulatory compliance required for NCQA Health Plan Accreditation (HPA) and the DHCS Managed Care Accountability Set (MCAS).	**Deliverable #1**: Submit ROADMAP Annual Audit Deliverable that includes an NCQA Certified Dav Aggregator for auditor(s) approval.	11/1/2025	3/31/2026	Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.a.				**Deliverable #2**: Integrate data from certified Dav Aggregator upon auditor(s) approval into the HEDIS MY2025 Annual project.	2/1/2026	5/31/2026	Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.b.		New	**Goal #1:** By June 30, 2026, in collaboration with the Finance Health Analytics team, design and implement an organization-wide patient experience performance visualization dashboard that will accomplish the 3 (three) deliverables.	**Deliverable #1:** Develop and approve a Business Requirements Document (BRD), to include the project scope and data that will be displayed as part of the NCQA-regulated CAHPS Survey Results, including; • NCQA Health Plan Star Ratings • Survey aggregate summary rates • Composite and rating measures • Quality Compass HEDIS benchmark comparisons • Star Rating performance by population segment	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.b.				**Deliverable #2:** Ensure stakeholder alignment and acceptance through: • Conducting regular stakeholder feedback sessions • Holding iterative design reviews with key department representatives • Documentation of stakeholder requirements and securing sign-off	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.b.				**Deliverable #3:** Validate functionality through: • User acceptance testing (UAT) with identified end-users • Data accuracy verification	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.b.	Member Experience Improvement	New	**Goal #2**: By June 30, 2026, the CAHPS® Team will collaborate with Press Ganey to develop both the Adult and Child CAHPS® non-regulated survey questions and standardized reporting templates. This effort will support clearer insights, establish a more consistent reporting framework, and reduce administrative burden, while informing improvement efforts.	**Deliverable #1:** By June 30, 2026, identify non-regulated survey questions that align with CAHPS H 5.1 core question framework; develop corresponding gateway questions to guide respondents appropriately, apply skip logic to improve streamline survey flow, and ensure the ability to drill down to actionable root causes.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.b.				**Deliverable #2:** By June 30, 2026, define the reporting logic, presentation guidelines, and analysis processes for final reporting, provided by Press Ganey's analytics team.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.b.				**Deliverable #3:** By June 30, 2026, develop and validate two distinct report templates: • A leadership-focused template designed to support strategic decision making by highlighting trends and key drivers for decision-makers • A consumer-friendly template designed for clear easy-to-understand comprehension.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.b.		New	**Goal #3**: By June 30, 2026, the CAHPS® Team will utilize the Association for Community Affiliated Plans (ACAP) CAHPS Best Practices Playbook to identify and prioritize actionable opportunities to improve member experience, focusing on alignment with proven strategies implemented by peer plans.	**Deliverable #1**: By June 30, 2026, complete a gap analysis comparing Partnership's CAHPS-related operations with the strategies outlined in the ACAP CAHPS® Best Practices Playbook to identify key areas for improvement.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.b.				**Deliverable #2**: By June 30, 2026, create an action plan to implement at least two high-priority improvement initiatives informed by the gap analysis findings that target favorable outcomes for both the Adult and Child populations.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.c.	Member Services Access	Continued	**Goal #1:** By June 30, 2026, ensure compliance of internal and delegated access standards as it relates to inbound call handling.	**Deliverable #1:** Monitor, Analyze and Recommend Corrective Action Plan(s) (CAP) when appropriate which includes: • Review internal call center performance stats monthly (performance benchmarks tracked quarterly) on several service level agreements (SLAs) • Plan to continue to track quarterly delegate call center performance (submitted quarterly by each respective delegate) against established performance thresholds (based on SLAs above) during Delegate Oversight quarterly meetings	7/1/2025	6/30/2026	Title: Senior Director of Member Services and Grievances Name: Edna Villasenor	Title: Associate Director of Member Services Name: Cyress Mendiola Title: Manager of Quality and Training Services Name: Kristen Clark	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.d.	Primary Care Provider Quality Incentive Program		**Goal #1:** By June 30, 2026, PCP QIP will continue to revise and ensure that the Data Validation Framework documents comprehensively support a robust and effective verification of payment accuracy. This involves confirming that data sources	**Deliverable #1:** Evaluate Data Validation Framework documents and examine the QIP specific validation procedures outlined in the documents to ensure they are robust and effective in verifying payment accuracy based on prior measurement years "lessons learned". Any enhancements to the process will be incorporated into the document as they are identified.	7/1/2025	12/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.d.	Quality Incentive Program (PCP QIP) Payment Processing Report	New	payment accuracy. This involves confirming that data sources are clearly defined, with proper lineage and ownership established, and that validation procedures include thorough checks for data completeness, accuracy, consistency, and timeliness.	**Deliverable #2:** Upon review of prior year validation, incorporate stakeholder process improvement changes into QIP Data Validation framework and document any suggested enhancements made by the Executive team during the Executive walk-through.	7/1/2025	12/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.e.	Web Based Member Information Assessment	Continued	**Goal #1:** By June 30, 2026, complete annual evaluation of the quality and accuracy of information provided to members via e-mail and telephone as stated in NCQA Standard ME 6 Element C: Quality and Accuracy of Information.	**Deliverable #1:** Complete annual evaluation of the quality and accuracy of information provided to members via e-mail and telephone as stated in ME 6 C: Quality and Accuracy of Information.	7/1/2025	6/30/2026	Title: Senior Director of Member Services and Grievances Name: Edna Villasenor Title: Associate Director of Member Services Name: Cyress Mendiola	Title: Manager of Quality and Training Services Name: Kristen Clark	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.f.	Primary Care Provider Quality Incentive Program (PCP QIP) eReports System	Continued *(Monitoring of previous issue)*	**Goal #1:** By June 30, 2026, PCP QIP will continue collaborating with the Partnership Web Team to align 2026 eReports with HRP® (Health Rules Payor) data elements in preparation for the launch of HRP®.	**Deliverable #1:** Review 2026 eReports scoping and development with Web Team to identify areas within eReports that need integration with HRP®. Finalize via annual Business Requirement Documents (BRD) approved by QI and IT management.	7/1/2025	11/1/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Teresa Lugo	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.f.				**Deliverable #2:** Complete User Acceptance testing (UAT), inclusive of HRP® integration testing, per approved 2026 eReports BRD, for on-time release to provider network.	11/1/2025	3/1/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Teresa Lugo	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.f.				**Deliverable #3:** Conduct weekly eReports check-in meetings with the Partnership Web Team to discuss project timeline, BRD revisions, application logic, UAT testing timelines, progress and bugs.	10/1/2025	3/15/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Teresa Lugo	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #1:** Complete an annual HEDIS® Monthly data user needs assessment for MY2026 Monthly Exploratory dashboard in PQD. In collaboration with the HEDIS® team and QMSI workgroup's leads and through use of the updated Master Measure List to confirm applicable measures.	7/1/2025	3/30/2026	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Director of Quality Management Name: James Devan Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.g.	Partnership Quality Dashboard (PQD)	Continued *(Monitoring of previous issue)*	**Goal #1:** By June 30, 2026, apply annual development updates of the MY2026 HEDIS® Monthly Exploratory Dashboard in accordance with identified stakeholder needs (Contingent on HRP® implementation).	**Deliverable #2:** Complete updated HEDIS® Monthly Exploratory business requirements documentation for MY2026 Month Exploratory dashboard in PQD in collaboration with the HEDIS® team.	7/1/2025	3/30/2026	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Director of Quality Management Name: James Devan Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.g.				**Deliverable #3:** Send data exports for the MY2026 HEDIS® Monthly Project to the EDW & Health Analytics teams to create the PQD Monthly Dashboard.	4/1/2026	6/30/2026	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Director of Quality Management Name: James Devan Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	
2.g.				**Deliverable #4:** Timely publication of the MY2026 HEDIS® Monthly Exploratory dashboard, based on efforts by HEDIS, EDW, and Health Analytics team members. (Contingent on HRP® production implementation).	4/1/2026	6/30/2026	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Director of Quality Management Name: James Devan Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.g.		Continued	**Goal #2:** By June 30, 2026, apply annual development updates of the PCP QIP Provider and Internal View Dashboards in accordance with identified stakeholder needs.	**Deliverable #1:** Work with representatives of the provider network to review all enhancement requests to be included in the Business Requirements Document (BRD) to be reviewed and approved by the Enterprise Data Warehouse (EDW) team for the new measurement year (MY).	7/1/2025	12/31/2025	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Director of Quality Management Name: James Devan	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.g.				**Deliverable #2:** Work with stakeholders to submit updated annual dashboard business requirements document (BRD) to developers for review and approval.	7/1/2025	1/31/2026	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Director of Quality Management Name: James Devan	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #3:** Gain agreements between developers and business owners for identified new business requirements.	1/31/2026	3/31/2026	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Director of Quality Management Name: James Devan	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.g.				**Deliverable #4:** Completion of user acceptance testing (UAT) of dashboards.	5/31/2026	6/30/2026	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Director of Quality Management Name: James Devan	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #5:** Timely publication of the dashboards in Partnership Quality Dashboard (PQD) for internal and external use.	5/1/2026	6/30/2026	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Director of Quality Management Name: James Devan	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.h.	Enterprise Information Management	Continue	**Goal #1:** By June 30, 2026, integrate the HRP® version of the HEDIS® project data into the Enterprise Data Warehouse and use this data to create the HRP® version of the HEDIS® PQD modules.	**Deliverable #1:** Integrate HEDIS® Health Rules Payor data in to Enterprise Data Warehouse environment and make necessary programming changes to populate Provider Quality Dashboard-HEDIS® tables.	9/1/2025	10/15/2025	Title: Senior Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☒ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	**No**
2.h.				**Deliverable #2:** Develop the HEDIS® PQD dashboards using the HRP® data and complete User Acceptance Testing (UAT).	10/16/2025	11/30/2025	Title: Senior Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☒ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	
2.h.		New	**Goal #2:** By June 30, 2026, Plan, Develop, Test, and have the files ready for Wakely to integrate the test data to their environment to help build STAR measures dashboard for Medicare Line of Business (LOB).	**Deliverable #1:** Complete assessment of all the datasets (both HEDIS & non HEDIS measures data) that need to be delivered to Wakely. Create metadata document and other necessary documentation to finalize the requirements	8/1/2025	10/15/2025	Title: Senior Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**No**
2.h.				**Deliverable #2:** Develop, Build and test the files for Wakely to integrate all necessary datasets to help build STAR measures dashboard.	10/16/2025	3/31/2026	Title: Senior Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	
2.h.		New	**Goal #3:** By June 30, 2026, develop, test, and have the 2025 HEDIS® monthly project live in production with the data available to users via the HEDIS® PQD modules.	**Deliverable #1:** Complete development and testing to deliver 2025 HEDIS® monthly files to the QI Team. This might require building Medi-Cal, Medi-Medi and Medicare population and catalogs on the Inovalon side.	7/1/2025	7/15/2025	Title: Senior Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.h.				**Deliverable #2:** Integrate 2025 HEDIS® data from monthly project into the Enterprise Data Warehouse.	7/16/2025	8/1/2025	Title: Senior Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.h.				**Deliverable #3:** Develop and test Partnership Quality Dashboard (PQD) HEDIS® dashboards using the 2025 HEDIS® monthly project data.	8/2/2025	8/15/2025	Title: Senior Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.h.		New	**Goal #4**: By June 30, 2026, Plan, Develop, Test, and have the test files ready for PCP QIP project to support Medicare Line of Business (LOB). Integrate the necessary datasets to Cozeva platform to support QIP measures.	**Deliverable #1**: Complete assessment of all the datasets that need to be delivered to Cozeva platform to support Medicare LOB. Create metadata document and other necessary documentation to finalize the requirements.	10/1/2025	1/31/2026	Title: Senior Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	**No**
2.h.				**Deliverable #2**: Develop and Build the test files for PCP QIP program and integrate all necessary datasets to Cozeva platform.	2/1/2026	6/30/2026	Title: Senior Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	
2.i.	Dual Eligible Special Needs Plan (D-SNP)	New	**Goal #1**: By June 30, 2026, develop the Quality Improvement framework to support the proposed Dual Eligible Special Needs Plan (D-SNP) program and monitoring of associated quality metrics.	**Deliverable #1:** By June 30, 2026, develop a training approach for D-SNP education specific to QI department staff for the ability to address anticipated low performing measures and initiate improvement activities ahead of D-SNP program launch in CY2027.	7/1/2025	6/30/2026	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Medicare Quality Name: Kimberly Robertello	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.i.				**Deliverable #2:** By February 15, 2026, complete the 2027 Model of Care document for submission to NCQA and DHCS.	7/1/2025	6/30/2026	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Medicare Quality Name: Kimberly Robertello	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.i.				**Deliverable #3:** By June 30, 2026, with collaboration from vendors Cirdan Wakely, Inovalon and Partnership internal stakeholders, develop the framework for data integration and analysis within the Stars analytics tool using baseline prospective Medicare member data.	7/1/2025	6/30/2026	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Medicare Quality Name: Kimberly Robertello	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	
2.j.	HEDIS Reporting to Support D-SNP Data Collection and Analysis	Continue	**Goal #1:** By August 29, 2025 provide first set of data for D-SNP Monthly MY2025 data to the QI D-SNP Team and, send data monthly thereafter after each data refresh.	**Deliverable #1:** By August 29, 2025, send first set of Monthly MY2025 data exports to the EDW & HA team's to create the PQD Monthly Dashboard, send the Monthly data to the QI D-SNP team.	7/1/2025	8/29/2025	Title: Director of Quality Measurement Name: Kristine Gual Title: Manager of Medicare Quality Name: Kimberly Robertello	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**No**
2.j.				**Deliverable #2:** By June 30, 2026, perform a comparative analysis of preliminary and final HEDIS MY 2025 data for the D-SNP baseline population against comparable Wakely HEDIS MY 2025 Medicare baseline data.	7/1/2025	6/30/2026	Title: Director of Quality Measurement Name: Kristine Gual Title: Manager of Medicare Quality Name: Kimberly Robertello	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☒ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.k.	Conduct Year Round Medical Record Review	New	**Goal #1**: By November 28, 2025 begin year-round medical record review to focus on priority measures identified.	**Deliverable #1**: Build Medical Record Project in the Prospective Monthly MY2025 Project. Utilize Inovalon's Electronic Record on Demand, and the supplemental data catalogs to support priority Admin measures.	7/1/2025	9/30/2025	Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.k.				**Deliverable #2**: Develop outline and intent of the W30 Kaizen, Schedule Kaizen session to include all applicable attendees. Present outcome of Kaizen to QI Leadership and applicable stakeholder within the organization.	7/15/2025	11/29/2025	Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
3. Value Based Payment Programs - QIP											
3.a.	Primary Care Provider Quality Incentive Program (PCP QIP)	New	**Goal #1:** By June 30, 2026, the PCP QIP Program will be leveraged to support existing and newly added low performing providers in the Modified QIP measure set. This support will include provider education and encouragement to increase on-line data platform usage and monitoring which results in improved engagement and performance improvement activities.	**Deliverable #1:** For both new and existing Modified QIP providers, the QIP team will partner with the assigned Improvement Advisor to determine overall QIP skill-set level amongst modified QIP staff. This assessment will inform the QIP team how to move forward and what level of engagement/training is needed. This may include the QIP teams involvement in monthly or quarterly practice facilitation meetings.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	**No**
3.a.				**Deliverable #2:** Create a survey specifically for Modified QIP provider which includes questions to check-in, assess needs and important reminders. Survey will be distributed on quarterly basis. Results will be reviewed and, if necessary, followed up with a 1:1 email.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	
3.a.				**Deliverable #3:** Assess survey results annually to determine effectiveness and ongoing distribution.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	
3.b.		New	**Goal #1:** By June 30, 2026, develop the 2026-2027 measurement year Hospital Quality Incentive Program (H-QIP) Measurement Set to support Hospital Performance Improvement.	**Deliverable #1:** Complete development of measures for 2026-27 H-QIP.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.b.		New	**Goal #2:** Develop Partnership's Hospital Quality Symposium	**Deliverable #1:** Select dates, venues, theme, topics, and tentative speakers for the event	7/1/2025	4/1/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☒ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	**No**

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
3.b.	Hospital Quality Incentive Program (H-QIP)	New	for the 2026-2027 H-QIP measurement year	**Deliverable #2:** Finalize agenda, complete speaker engagement, promote event with hospitals	1/1/2026	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☒ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	No
3.b.		New	**Goal #3:** By January 31, 2026, complete evaluation of the 2024-2025 HQIP and deliver summary to the Partnership Quality Committee meetings (IQI, QUAC, PAC).	**Deliverable #1:** Evaluate 2024-2025 hospital program performance by measure in comparison to prior measurement year.	7/1/2025	1/31/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.b.				**Deliverable #2:** Provide Evaluation summary to the Partnership Quality Committee meetings (IQI, QUAC, PAC).	7/1/2025	1/31/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
3.c.	Palliative Care Quality Incentive Program (PC QIP)	New	**Goal #1:** By December 31, 2025, develop a measurement set for the calendar year (CY) 2026 Palliative Care Quality Incentive Program (PC QIP), that supports quality improvement. On February 14, 2025, Palliative Care Quality Collaborative (PCQC), notified the Palliative Care QIP team that they were dissolving due to lack of funding to maintain operations and they were officially closing their doors on April 17, 2025. PCQC supplied the supplemental data required to calculate payment for measure III, Completion of Assessments and the Use of the PCQC tool. Due to PCQC no longer being able to provide the Palliative Care QIP team with this supplemental data, the creation of a new measure, Palliative Care Survey, is in development.	**Deliverable #1:** Complete measure development for CY 2026 PC QIP. This includes the creation of a new palliative measure, Palliative Care Survey, to replace measure III, Completion of PCQC Assessments and the Use of the PCQC tool.	7/1/2025	12/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Eva Lopez Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.c.		New	**Goal #2:** By June 30, 2026, complete CY 2025 PC QIP evaluation.	**Deliverable #1:** Complete evaluation of the program's CY 2025 measurement year to monitor performance.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Eva Lopez Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.c.		New	**Goal #3**: By June 30, 2026, the PC QIP will work to revise the Data Validation Framework document to include the payment process for the new measure, Palliative Care Survey, that will be replacing measure III, Completion of Assessments and Use of the PCQC Tool, along with making any necessary revisions to the payment processes for measure I, Avoiding Hospital and Emergency Room admissions, and measure II, Completion of a POLST, to ensure these processes reflect the enhanced validation that is conducted for payment processing accuracy and timeliness.	**Deliverable #1**: Review the Data Validation Framework document to map out the payment process for the new palliative measure, Palliative Care Survey, and the current payment processes for measures I and II to identify any revisions needed to be made to ensure the payment processes are robust and accurate.	7/1/2025	12/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Eva Lopez Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.c.				**Deliverable #2**: Implement the enhanced Data Validation Framework document processes during payment processing for the Palliative Care QIP measure periods 1 (Jan-June 2025), which will begin in September 2025, and measure period II (Jul-Dec 2025), which will begin in April 2026. The Palliative Care QIP team will monitor this process to identify any additional areas for improvements.	9/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Eva Lopez Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
3.d.	Perinatal Quality Incentive Program (PQIP)	New	**Goal #1:** By June 30, 2026, continue to develop Perinatal QIP Measurement set to support HEDIS® Score Improvement through May 30, 2026, and leverage support from Partnership's Population Health team and the Growing Together Program to improve scores for the Timely Prenatal Care measures.	**Deliverable #1:** Develop Perinatal QIP Measurement set to support HEDIS® Score Improvement through May 30, 2026 and leverage support from Partnership's Population Health team and the Growing Together Program to improve scores for the Timely Prenatal Care measure.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.d.		New	**Goal #2:** By June 30, 2026, continue to support provider on-boarding and ECDS implementation to satisfy programmatic gateway measure (ECDS).	**Deliverable #1:** For existing PQIP providers: Continue ECDS education and on-boarding for gateway measure compliance.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.d.				**Deliverable #2:** Support contracting with DataLink by providing education and one-on-one meetings with provider staff.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
3.d.		New	**Goal #3:** By June 30, 2026, complete PQIP program evaluation for FY 24-25.	**Deliverable #1:** Complete FY 24-25 PQIP program evaluation and deliver to internal committees; IQI, PAC, & QU/AC.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.e.	Enhanced Care Management Quality Incentive Program (ECM QIP)	Continued	**Goal #1:** By December 31, 2025, develop a measurement set for the calendar year (CY) 2026 Enhanced Care Management Quality Incentive Program (ECM QIP) that supports quality improvement and aligns with DHCS's requirements.	**Deliverable #1:** Complete measure development for CY 2026 ECM QIP measurement year.	7/1/2025	12/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.e.		Continued	**Goal #2:** By December 31, 2025, complete CY 2024 ECM QIP evaluation.	**Deliverable #1:** Complete evaluation of the program's CY 2024 measurement year to monitor performance	7/1/2025	12/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.e.		Continued	**Goal #3:** By June 30, 2026, improve provider engagement by offering one-on-one assistance through meetings and trainings, and annual Advisory Group.	**Deliverable #1:** Outreach to new ECM providers and offer one-on-one meetings to include an overview of the ECM QIP, review the detailed specifications and answer questions	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
3.e.				**Deliverable #2:** Outreach to low-performing ECM providers immediately after payment processing and offer one-on-one meetings to review the areas needing improvement, re-review relevant areas in the specifications, and share best practices for success.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
3.e.				**Deliverable #3:** Facilitate Advisory Group meeting for providers to review proposed CY 2026 measurement set and offer their feedback and suggestions for improvement.	7/1/2025	12/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
3.f.		New	**Goal #1:** By October 31, 2025, complete the Advance Care Planning and Annual Wellness Visit (AWV) measure development for inclusion in the 2027 D-SNP QIP measurement year.	**Deliverable #1:** Evaluate the current framework for Advance Care Planning (ACP) and Annual Wellness Visit (AWV) for inclusion in the D-SNP QIP.	7/1/2025	9/30/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan Title: Manager of Medicare Quality Name: Kimberly Robertello	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	**No**
3.f.				**Deliverable #2:** Present proposed ACP and AWV measures to Executive Leadership for approval.	7/1/2025	10/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan Title: Manager of Medicare Quality Name: Kimberly Robertello	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	
3.f.		New	**Goal #2:** By October 31, 2025, obtain a signed contract agreement with Partnership HealthPlan of California and our selected D-SNP system vendor, Cozeva.	**Deliverable #1:** I.T purchasing will submit vendor information, SOW/MSA, estimated purchasing price, contract term to Non-Contracting Provider team.	7/1/2025	7/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan Title: Manager of Medicare Quality Name: Kimberly Robertello	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**No**
3.f.				**Deliverable #2:** Review SOW/MSA with QI Leadership and I.T. stakeholders.	7/1/2025	8/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan Title: Manager of Medicare Quality Name: Kimberly Robertello	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
3.f.				**Deliverable #3**: Pricing and negotiation will be conducted by Finance, I.T, and Executive Leadership team. Cozeva will provide a detailed price breakdown for additional system enhancement which may include Advance Care Planning (ACP) and Annual Wellness Visit (AWV).	7/2/2025	09/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan Title: Manager of Medicare Quality Name: Kimberly Robertello	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
3.f.	Dual Eligible Special Needs Plan (D-SNP) Quality Incentive Program (QIP) Development			**Deliverable #4**: Finalize contract agreement will be signed by Partnership HealthPlan of California (PHC) and Cozeva on or before October 31, 2025.	7/3/2025	10/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan Title: Manager of Medicare Quality Name: Kimberly Robertello	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	
3.f.		New	**Goal #3**: By June 30, 2026, develop a detailed implementation plan and timeline (Project kick-off, Pre-Implementation phase, Implementation phase) with internal PHC teams and Cozeva.	**Deliverable #1:** Project scoping will begin after a executed contract has been signed. Scoping meetings with D-SNP IT stakeholders, QIP and Cozeva to begin November 1, 2025 through December 31, 2025.	11/1/2025	12/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan Title: Manager of Medicare Quality Name: Kimberly Robertello	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	**No**
3.f.				**Deliverable #2:** Pre-implementation phase: includes, but not limited to, setup SFTP/ECG file transfer, Data kick-off & requirement, finalization of key business decisions and hierarchy design, provide finalized measure set, QIP incentive data logic, and submission & validation of all transactional files.	1/1/2026	3/31/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan Title: Manager of Medicare Quality Name: Kimberly Robertello	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	
3.f.				**Deliverable #3**: Implementation phase: includes, but not limited to, incremental file delivery, weekly inbound & outbound feed days, QA testing, user access, scheduled training, deployment of incentive, regression testing, and UAT in CERT/PROD.	4/1/2026	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan Title: Manager of Medicare Quality Name: Kimberly Robertello	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	
3.f.				**Deliverable #1**: Cozeva will complete each requirement for go-live: 1) Generate outbound extract post historic load 2) Registries enable Cozeva UI 3) Analytics enable in Cozeva UI 4) Enterprise and Practice level Resource Page configured	1/1/2026	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan Title: Manager of Medicare Quality Name: Kimberly Robertello	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
3.f.		New	**Goal #4**: By June 30, 2026, the D-SNP Quality Incentive Program (QIP) will prepare Cozeva systems for the anticipated 2027 go-live.	**Deliverable #2**: Deployment of Quality Incentive Program to production, along with payment extract generation. Cozeva will perform measure set validation and score comparison against legacy system data, user training, utilizer interface walk-through, features & measures visibility and go-live sign-off.	1/1/2026	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan Title: Manager of Medicare Quality Name: Kimberly Robertello	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	**No**
3.f.				**Deliverable #3**: Post Go-Live phase. To include: incremental file self-validation by PHC Data warehouse team, configure time capsule, validate and load 2nd and 3rd incremental files, and automate load of subsequent weekly feeds.	1/1/2026	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan Title: Manager of Medicare Quality Name: Kimberly Robertello	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	
3.f.				**Deliverable #4**: Begin Provider Rollout/Onboarding in conjunction with EHR integration. EHR framework will consist of confirmation of configuration capabilities, embedded App, chart retrieval, diagnosis Writeback, and browser extension overlay.	5/1/2026	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan Title: Manager of Medicare Quality Name: Kimberly Robertello	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	
4. Improvement Projects and Programs, Clinical Quality											
4.a.	Quality Measure Score Improvement (QMSI)	Continued	**Goal #1:** By June 30, 2026, the Quality Measure Score Improvement (QMSI) group will complete all defined deliverables for each measure-specific workgroup. The goal the Quality Measure Score Improvement group is to improve Partnership's Quality performance over measurement years 2024 and 2025 under all required accountable and reportable quality measure sets under the DHCS Managed Care Accountability Measure Set as well as additional HEDIS measures required of accredited NCQA Medicaid health plans. There are 4 measure-specific workgroups: 1. Pediatrics 2. Behavioral Health 3. Chronic Diseases 4. Women's Health	**Deliverable #1:** Define 5 (five) specific deliverables for each measure-specific workgroup by December 1, 2025.	7/1/2025	12/1/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Director of Quality Management Name: James Devan Title: Improvement Advisor Name: Amanda Kim	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
4.a.				**Deliverable #2:** Successfully complete all required deliverables for each measure-specific workgroup by June 30, 2025.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Director of Quality Management Name: James Devan Title: Improvement Advisor Name: Amanda Kim	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
4.b.	Healthy Kids Growing	New	**Goal #1:** By June 30, 2026, 50% of the members who agreed to participate in the Healthy Kids Growing Together Program must attend their annual well-child visit prior to their 4th, 5th and 6th birthdays. This program includes any 3 - 6 year old who has never had a well-child visit in the last eleven (11) months and offers an incentive to members who have	**Deliverable #1:** Review claims data to verify attendance for a well-child visit. If the claim does not reflect a well-child visit, follow up with the Primary Care Provider (PCP) to confirm whether the visit occurred and obtain any necessary documentation.	7/1/2025	6/30/2026	Title: Associate Director of Population Health Name: Monika Brunkal	Title: Supervisor of Population Health Name: Cynthia Galicia-Huizar	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
4.b.	Together Program	New	months and offers an incentive to members who have birthdays within the upcoming 120 days and complete a well-child visit within 90 days of the outreach. This will be completed by sending reminder mailers to the entire eligible population and conducting two outbound phone calls to members with birthdays within the upcoming 120 days.	**Deliverable #2:** Include results of this intervention in the 2026 Impact Analysis report.	5/1/2026	6/30/2026	Title: Associate Director of Population Health Name: Monika Brunkal	Title: Supervisor of Population Health Name: Cynthia Galicia-Huizar	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
4.c.	Mobile Mammography Program	New	**Goal #1**: By June 30, 2026 the Mobile Mammography/Your Partner in Prevention team will schedule at least 60 mobile event days, including Women's Wellness Days, across the provider network, resulting in a minimum of 1,500 completed breast cancer screenings in support of reaching the 75th percentile benchmark	**Deliverable #1:** Complete at least 3 event days in the Auburn Region.	7/1/2025	6/30/2026	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
4.c.				**Deliverable #2**: Complete at least 9 event days in the Chico Region.	7/1/2025	6/30/2026	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
4.c.				**Deliverable #3**: Complete at least 20 event days in the Eureka Region.	7/1/2025	6/30/2026	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
4.c.				**Deliverable #4**: Complete at least 5 event days in the Fairfield Region.	7/1/2025	6/30/2026	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
4.c.				**Deliverable #5**: Complete at least 15 event days in the Redding Region.	7/1/2025	6/30/2026	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
4.c.				**Deliverable #6**: Complete at least 8 event days in the Santa Rosa Region.	7/1/2025	6/30/2026	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
4.c.		New	**Goal #2**: By June 30, 2026, complete at least 3 wellness days as part of the new Your Partner in Prevention Program (YPIP).	**Deliverable #1:** Complete at least 2 Women's Wellness Days.	7/1/2025	6/30/2026	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**No**
4.c.				**Deliverable #2**: Complete at least 1 Kids or Teen and Young Adult Wellness Days.	7/1/2025	6/30/2026	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	
4.c.				**Deliverable #3**: Develop workflows for successful event day planning.	7/1/2025	6/30/2026	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
4.c.				**Deliverable #4**: Conduct an evaluation to include lessons learned and areas for improvement.	7/1/2025	6/30/2026	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
4.d.	QI3 - Performance Improving Planning for low Scoring HPA measures	New	**Goal #1**: By June 30, 2026, the PI and HEDIS teams will meet the factor QI- 3 Factors B and C requirements for Health Plan Accreditation Renewal, including identifying low scoring measures, selecting measures of focus for improvement, and developing an improvement plan for remediation.	**Deliverable #1**: HEDIS team will provide Health Plan ratings scoresheet, which identifying measures performing at a score of 1 or 0.	7/1/2025	7/11/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
4.d.				**Deliverable #2:** The PI team will select a measure or measures of focus for improvement : " at least one required measure for which the organization received a rating of "1" or "0."	7/1/2025	8/1/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
4.d.				**Deliverable #3:** The PI team will develop an improvement plan related to the measure or measures of focus selected in deliverable two and documents "all actions the organization plans to take, or has already taken, to improve each measure's rating."	8/1/2025	8/30/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
4.d.				**Deliverable #4:** The PI team will Monitor progress through monthly check-ins and utilize PDSA cycles as needed	8/30/2025	12/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
5. Service and Patient Experience											
5.a.	Member Experience Data	Continued	**Goal #1:** By June 30, 2026, launch the annual CAHPS® survey for Measure Year (MY) 2025 Reporting Year (RY) 2026	**Deliverable #1:** By December 30, 2025, present Measure Year (MY) 2024 / Report Year (RY) 2025 CAHPS® and Member Experience results to internal and external committees.	7/1/2025	12/30/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
5.a.	Member Experience Data	Continued	survey for Measure Year (MY) 2025 Reporting Year (RY) 2026 and collect data results.	**Deliverable #2**: By June 30, 2026, confirm HEDIS® team Measure Year (MY) 2025 sample frame submission to Press Ganey, launch survey, and collect results as part of the NCQA member experience process.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
5.b.	Complex Case Management	Continued	**Goal #1:** By June 30, 2026, We will ensure that Partnership remains compliant with the National Committee for Quality Assurance (NCQA) Population Health Management Standard PHM5, Standards A-E, in preparation for our NCQA Renewal Survey in November 2026 and beyond. This will be demonstrated through the results of our upcoming NCQA renewal audit, as well as through ongoing quarterly internal compliance audits of Complex Case Management to maintain overall file compliance.	**Deliverable #1:** Submit evidence for the Mock Renewal Survey scheduled in October 2025.	8/1/2025	8/22/2025	Title: Senior Director of Care Management Name: Brigid Gast	Title: Manager of Care Coordination Name: Shannon Boyle Title: CC Regulatory Performance Manager Name: Alyssa Beard	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
5.b.				**Deliverable #2:** Update the annual HPA Workbook. • Work Plan and Evidence Submission Library	10/1/2025	10/24/2025	Title: Senior Director of Care Management Name: Brigid Gast	Title: Manager of Care Coordination Name: Shannon Boyle Title: CC Regulatory Performance Manager Name: Alyssa Beard	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
5.b.				**Deliverable #3:** Obtain a "yes" score on all assigned elements during the HPA Mock Renewal Survey. • Business Owners to submit an Action Plan to address recommendations. Note: Evidence to be corrected by the applicable look-back period, timelines, and/or expectations by NCQA. Any revised evidence will be reviewed by MHR for approval.	11/17/2025	12/5/2025	Title: Senior Director of Care Management Name: Brigid Gast	Title: Manager of Care Coordination Name: Shannon Boyle Title: CC Regulatory Performance Manager Name: Alyssa Beard	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
5.b.				**Deliverable #4:** Submit annotated evidence for the HPA Renewal Survey. • The NCQA Program Management Team to host evidence collection training and provide submission instructions in March 2026.	5/1/2026	5/29/2026	Title: Senior Director of Care Management Name: Brigid Gast	Title: Manager of Care Coordination Name: Shannon Boyle Title: CC Regulatory Performance Manager Name: Alyssa Beard	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
5.b.				**Deliverable #5:** Obtain a "yes" score on all assigned elements during the HPA Mock Renewal Survey. • Any modifications to approved evidence that affect NCQA requirements must be shared with the NCQA Program Management Team.	6/1/2026	6/30/2026	Title: Senior Director of Care Management Name: Brigid Gast	Title: Manager of Care Coordination Name: Shannon Boyle Title: CC Regulatory Performance Manager Name: Alyssa Beard	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
5.b.				**Deliverable #6:** Departments that oversee file review requirements will maintain strict oversight of Partnership and non-NCQA Accredited delegates' files to ensure compliance.	6/1/2026	6/30/2026	Title: Senior Director of Care Management Name: Brigid Gast	Title: Manager of Care Coordination Name: Shannon Boyle Title: CC Regulatory Performance Manager Name: Alyssa Beard	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
	6. Quality Assurance and Patient Safety										
6.a.				**Deliverable #1:** Review and update the PQI power point presentation to ensure the information is relevant for the staff/department receiving the information.	7/1/2025	6/30/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #2:** Offer and provide the PQI presentation to at least the Utilization Management department teams, Enhanced Health Services nurses, and Grievance & Appeals nurses.	7/1/2025	6/30/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
6.a.	Potential Quality Issues (PQI) (safety)	New	**Goal #1:** By June 30, 2026, QI Member Safety Quality Investigation team will provide in-services to at least two other Partnership Departments/teams to educate on Potential Quality Issues (PQI) and how to refer. In addition, the team will monitor referral track and trending reports to determine if inservice training results in an increase in PQI referrals from respective departments/teams.	**Deliverable #3:** Send a feedback questionnaire/survey to attendees for feedback on areas to consider for improvement.	7/1/2025	6/30/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
6.a.				**Deliverable #4:** Monitor referral track and trending reports to determine if inservice training results in an increase in PQI referrals from respective departments.	7/1/2025	6/30/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #5**: Edit and revise the PQI Referral Form Reference table to assist staff with determining if a concern or issue may be a PQI.	7/1/2025	12/31/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
6.a.		New	**Goal #2**: By June 30, 2026, the enhancement of Potential Quality Issue documentation system- SUGARCRM PQI app will be completed. Rationale: To enhance security by patching vulnerabilities, improve performance, maintain stability and efficiency, ultimately benefiting users and organizations. In addition, updates can optimize how systems utilize resources, like memory and processing power, leading to more efficient operations. By these enhancements, our DHCS and NCQA report should be improved.	**Deliverable #1:** With significant on-going requests and direction from the Member Safety Investigation team, IT will upgrade and enhance the SugarCRM PQI application from version 8 to version 14.	7/1/2025	8/31/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
6.a.				**Deliverable #2:** Member Safety Investigation team will continue to test, monitor, and provide feedback to IT for any problems and areas for additional improvement or enhancements.	7/1/2025	12/31/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
6.a.		New	**Goal #3**: By June 30, 2026, the Member Safety Investigations Team will have an effective Corrective Action Plan (CAP) monitoring tool.	**Deliverable #1:** Review and edit the current CAP desktop policy including the CAP template for providers/facilities and the CAP Monitoring Tool to align with current and more directive CAP procedures.	7/1/2025	10/1/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
6.a.				**Deliverable #2:** Review the updated CAP Monitoring Tool monthly, and as needed, to ensure all actions determined in Peer Review Committee are implemented, followed up, or completed.	7/1/2025	12/31/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #3**: To monitor if a CAP was effective in preventing a reoccurrence, the PQI Track and Trending reports will be monitored to determine if a subsequent PQI referral is received against any providers/facilities receiving a CAP.	7/1/2025	3/31/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #4**: On-going periodic re-evaluation of the CAP desktop policy, including the CAP template for providers/facilities and the CAP Monitoring Tool, to determine effectiveness. Edit and revise as needed.	3/31/2026	6/30/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
6.b.	Fluoride Varnish	New	**Goal #1:** By June 30, 2026, the Site Review Inspections team will create a detailed directory of dental providers in our service area, categorizing them by type of organization (e.g.,	**Deliverable #1:** Create a detailed directory of dental providers in our service area, categorizing them by type of organization (e.g., FQHC, RHC, Tribal health, dental group, private practice).	7/1/2025	6/30/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman Title: Supervisor of Clinical Compliance Name: Jackie Krznarich	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
6.b.	Fluoride Varnish	New	FQHC, RHC, Tribal health, dental group, private practice). We will begin with a small scope, and work on developing relationships.	**Deliverable #2:** Develop a desktop for maintaining and updating providers.	7/1/2025	6/30/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman Title: Supervisor of Clinical Compliance Name: Jackie Krznarich	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
6.c.	Initial Health Appointment	New	**Goal #1:** By June 30, 2026 the Site Review Inspections team will initiate a new process to monitor sites on two contact attempts to get members into the clinic within 120 days.	**Deliverable #1:** Create a method to document compliance for Initial Health Appointment attempts to get members into the clinic within 120 days.	7/1/2025	6/30/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman Title: Supervisor of Clinical Compliance Name: Jackie Krznarich	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
6.c.				**Deliverable #2:** Create a desktop on the new process for IHA monitoring attempts of providers.	7/2/2025	12/31/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman Title: Supervisor of Clinical Compliance Name: Jackie Krznarich	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
6.d.	Latent TB Infection Treatment (safety)	Continued	**Goal #1:** By June 30, 2026, a clinical pharmacist will conduct concurrent review of Latent Tuberculosis Infection (LTBI) medication treatments and provide timely notification of all identified potential LTBI treatment regimen gaps, which result from late refill, non-adherence, inappropriate prescribing, and/or inappropriate dispensing. The regimens to be monitored will include 30-doses of isoniazid/rifapentine (1HP), 12-doses of isoniazid/rifapentine (3HP), 90-doses of isoniazid/rifampin (3HR), and 120-doses of rifampin (4R).	**Deliverable #1:** Pharmacist will identify potential treatment gaps and provide notification to prescribers within two timeframes: day 16 and day 20. • Pharmacist will identify and notify providers (via fax) whose members are ≥14 days late in refilling their prescribed LTBI medication. • ≥ 80% of identified potential non-adherence cases will receive provider notification (via fax) no later than day 16 of their member not having their LTBI medication based on the last refill date. • ≤ 20% of the identified potential non-adherence cases will receive provider notification (via fax) no later than day 20 of their member not having their LTBI medication based on the last refill date. Pharmacist will verify gap and confirm member's prescribed LTBI regimen was not completed in the accepted timeframe. • Pharmacist will provide notification to prescribers (via fax) of their member's potential non-adherence to their prescribed LTBI regimen.	7/1/2025	6/30/2026	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
6.d.				**Deliverable #2:** Pharmacist will monitor for inappropriate prescribing / dispensing of 84-dose isoniazid/rifampin (3HR), 100-dose rifampin (4R regimen) and 112-dose (4R regimen) • Pharmacist will identify and provide information for correct prescribing of 3HR and 4R regimen. • Pharmacist will notify prescriber (via fax) that 84-dose isoniazid/rifampin, 100-dose rifampin, or 112-dose rifampin is insufficient and is not considered completion of 3HR or 4R regimen.	7/1/2025	6/30/2026	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
6.d.		New	**Goal #2:** By June 30, 2026, a clinical pharmacist will provide Latent Tuberculosis Infection (LTBI) summary updates to Partnership's Medical Directors and to the County Public Health Officers.	**Deliverable #1:** Pharmacist will provide semi-annual LTBI summary updates to Partnership's Medical Directors for tracked LTBI regimens (identified late fills, identified possible non-adherence to regimen, actions taken, and results of provider outreach).	7/1/2025	6/30/2026	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
6.d.				**Deliverable #2:** Pharmacist will provide quarterly update of Partnership members who are prescribed a LTBI regimen and the current status of that LTBI regimen to the County Public Health Officers.	7/1/2025	6/30/2026	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
	7. Quality Improvement Training and Coaching										

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
7.a.	QI Technical Assistance with Health Center Consortia	Continued	**Goal #1:** By June 30, 2026, collaborate with local consortia to bring Quality Improvement (QI) awareness and education to providers.	**Deliverable #1:** Northern: • Develop and post storyboards and infographics to demonstrate successful QI improvement projects over time • Host recurring forums for QI engagement • Develop measure best practices to share with Northern Region consortia members • Complete comprehensive organizational profiles (i.e. inclusive of QI, PCMH, Workforce, and Finance updates) for each Federally Qualified Health Center (FQHC) member to support Partnership's assessment of current performance and identification of key areas for partnering in improvement. • Develop at least two project storyboards outlining regional Quality Improvement (QI) projects and post on consortia websites. • Present Partnership updates and timely provider education at least 4 times via monthly QI and Chief Medical Officer (CMO) Peer Network Calls and in-person Rural Round Table events. • Develop materials that highlight best practices for focus HEDIS®/Quality Incentive Program measures and proactively share with Northern Region consortia members via consortia hosted webinars, its eNews, or its Peer Network.	7/1/2025	5/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
7.a.				**Deliverable #2:** Southern: • Identify, document, and publish at least 2 promising practices by consortia members that can be shared throughout the region and beyond to improve underperforming regional and/or plan-wide HEDIS measures. • Participate in consortia-led QI Peer Network meetings (attend at least 4 meetings per year) • Co-facilitate with consortia the Solano QIP Improvement (SQIP-I) meetings •Engage the consortia in supporting underperforming member health centers	7/1/2025	5/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.a.				**Deliverable #3:** Eastern: • Identify consortia coverage in Auburn and Chico region. • Identify opportunities for collaboration between consortia and Partnership HealthPlan's regional leadership and quality improvement.	8/30/2025	12/30/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.b.				**Deliverable #1:** By June 30, 2026, offer at least four (4) virtual training sessions on priority MCAS measures between January 2026 and June 2026 across the provider network.	7/1/2025	6/30/2026	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	Title: Senior Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
7.b.	Performance Improvement Training Offerings	Continued	**Goal #1:** By June 30, 2026, the Improvement Academy will offer multiple forms of Quality Improvement education to the Partnership provider network.	**Deliverable #2:** By June 30, 2026, offer at least two (2) in-person ABCs of Quality Improvement training series across the provider network. Targeted Regions: Fairfield - January 2026; Redding - March 2026; Auburn - May 2026	7/1/2025	6/30/2026	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	Title: Senior Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
7.b.				**Deliverable #3:** By June 30, 2026, offer at least two (2) Microlearnings focused on improving outcomes around priority measures for the provider network.	7/1/2025	6/30/2026	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	Title: Senior Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.b.		Continued	**Goal #2:** By December 30, 2025, the Improvement Academy will develop strategies to evaluate Microlearnings.	**Deliverable #1:** By December 30, 2025, develop evaluation for ePrompts and Preventive Care Reports utilizing surveys and coaching engagement feedback.	7/1/2025	12/30/2025	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	Title: Senior Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
7.b.				**Deliverable #2:** By December 30, 2025, explore website capabilities for tracking attendance.	7/1/2025	12/30/2025	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	Title: Senior Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.b.		New	**Goal #3**: By June 30, 2026, Improvement Academy will improve training attendance by 20% for in-person trainings and 15% for Improving Measure Outcomes virtual trainings.	**Deliverable #1**: By June 30, 2026, develop marketing strategies to include evaluation and outreach to sites to include criteria: •Sites with zero (0) attendance at ABCs of QI and/or IMOs with QIP scores <50% in MY 2023 and MY 2024. •Determine attendance barriers.	7/1/2025	6/30/2026	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	Title: Senior Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**No**

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
7.b.		New	**Goal #4**: By October 30, 2025, the Improvement Academy will conduct an evaluation to meet the training needs of the network.	**Deliverable #1**: By October 30, 2025, survey the provider network to gather insights on future training needs and preferred delivery modalities.	7/1/2025	10/30/2025	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	Title: Senior Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
7.c.	Provider Coaching and Engagement	New	**Goal #1:** By June 30, 2026, the Performance Improvement teams will launch interventions with 80 percent of provider organizations identified as low performing providers on the 2024 Primary Care Provider Quality Incentive Program (PCP QIP) assigned to Enhanced Provider Engagement or a Corrective Action Plan, aimed at improving performance on the Modified QIP.	**Deliverable #1:** By September 30, 2025, the Performance Improvement team will complete a Needs Assessment with 80 percent of provider organizations newly assigned to Enhanced Provider Engagement OR Corrective Action Plan in 2025.	7/1/2025	9/30/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	**Yes**
7.c.				**Deliverable #2:** By December 31, 2025, 80 percent of provider organizations with a completed Needs Assessment will select and begin implementation of at least 1 intervention aligned with a Needs Assessment recommendation provided by Partnership.	9/30/2025	12/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.c.				**Deliverable #3:** By June 30, 2026, the Performance Improvement team will evaluate the 2025 Enhanced Provider Engagement program, including the use of Corrective Action engagement and advance of QIP dollars for Phase 2 Modified QIP practices.	3/1/2026	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.c.				**Deliverable #4:** By June 30, 2026, the Performance Improvement team will partner with regional leadership to develop a strategy for including low performing providers, new to Partnership in 2024, for inclusion in the 2026 Enhanced Provider Engagement and Modified QIP programs.	3/1/2026	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.c.			**Goal #2:** By June 30, 2026, the Performance Improvement	**Deliverable #1:** By July 31, 2025, the Performance Improvement teams will identify the PCP practices of focus in each quality region and measures of focus for intervention.	7/1/2025	7/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
7.c.		New	teams will engage with at least two lower performing, mid-volume providers in each of the three regions on a high-priority HEDIS and PCP-QIP measure.	**Deliverable #2:** By December 31, 2025, the Performance Improvement team will plan and begin implementation of at least one intervention to impact at least one measure of focus with the six identified providers.	8/1/2025	12/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
7.c.		New	**Goal #3:** By December 31, 2025, the Performance Improvement teams will engage with all high-volume (greater than 15,000 members) Primary Care Provider (PCP) practices in each quality region on high-priority measures.	**Deliverable #1:** By July 31, 2025, the Performance Improvement team will identify the high-volume PCP practices of focus in each of the six Partnership regions and measures of focus for engagement.	7/1/2025	7/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
7.c.				**Deliverable #2:** By December 31, 2025, the Performance Improvement teams will establish a coaching relationship with two high-volume PCP practices in each sub-region and plan and implement at least one intervention to address high-priority measures. The intervention can be measure-specific or focused on foundational elements in the organization.	8/1/2025	12/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.d.				**Deliverable #1:** By June 30, 2026, PI will conduct at least four (4) meetings in each of the six regions.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
7.d.	Implementation of Regional Quality Meetings	Continued	**Goal #1:** By June 30, 2026, Performance Improvement (PI) will implement quarterly regional quality meetings in all six (6) operational regions to offer forums for regional dialogue to address quality improvement opportunities and barriers.	**Deliverable #2:** By June 30, 2026, PI will survey attendees at least once for feedback on quality forums and make adjustments as necessary.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
7.d.				**Deliverable #3:** By June 30, 2026, PI will inventory projects and activities identified through the regional forums to identify potential for scale and spread across the region(s).	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Director of Quality Management Name: James Devan Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.e.	QI Project Toolkit & Training Program	New	**Goal #1**: By December 31, 2025, successfully launch and complete a pilot of the QI Project Toolkit and Training Program, designed to test the curriculum, tools, and delivery model with invited participants.	**Deliverable #1**: Invite at least six (6) external participants, representing at least four (4) distinct organizations, to engage in the pilot.	7/1/2025	8/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Anwar Hugais Title: Project Manager I Name: Devan Wilson	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
7.e.				**Deliverable #2**: Collect structured feedback on content relevance, delivery format, and practical applicability from at least 80% of pilot participants.	7/1/2025	11/30/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Anwar Hugais Title: Project Manager I Name: Devan Wilson	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.e.				**Deliverable #3**: Produce a pilot summary report outlining lessons learned, participant feedback, and recommendations for refinement.	7/1/2025	12/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Anwar Hugais Title: Project Manager I Name: Devan Wilson	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.e.		New	**Goal #2**: By March 31, 2026, kick off the full-scale QI Project Toolkit and Training Program, making it available to eligible Partnership entities (e.g., counties, providers, CBOs, etc.).	**Deliverable #1**: Develop and launch a formal registration process and public-facing webpage housing program materials and sign-up details.	7/1/2025	12/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Anwar Hugais Title: Project Manager I Name: Devan Wilson	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
7.e.				**Deliverable #2**: Ensure 100% of program materials (Toolkit, curriculum outline, promotional content) are accessible via the public webpage.	7/1/2025	1/31/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Anwar Hugais Title: Project Manager I Name: Devan Wilson	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.e.				**Deliverable #3**: Develop a formal process for collecting session-specific participant feedback and recommendations, with a defined method for analyzing and apply results to support continuous improvement, including standardized feedback tools (e.g. surveys, in-person feedback sessions, etc.) for data collection.	7/1/2025	1/31/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Anwar Hugais Title: Project Manager I Name: Devan Wilson	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
7.e.				**Deliverable #4**: Enroll at least 10 participants (representing at least 5 distinct organizations) in the first full training cohort.	7/1/2025	3/31/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Anwar Hugais Title: Project Manager I Name: Devan Wilson	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
	8. Delegation Oversight										

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
8.a	QI Delegation Oversight	Continued	**Goal #1:** By June 30, 2026, demonstrate strong delegation oversight process in support of delegation standards and Partnership policies and procedures.	**Deliverable #1:** Quarterly and yearly review of delegation committee reports and delegated activities based on submitted documents. Present findings at the Delegation Oversight Committee (DORS) meetings with recommendations.	7/1/2025	6/30/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
8.a				**Deliverable #2:** Participation with the annual delegation audits by Partnership Compliance department. Submit audit findings within required timeframe.	7/1/2025	6/30/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
	9. NCQA Program Management										
9.a.	Compliance with NCQA HOA and Sustain Performance	New	**Goal #1:** By June 30, 2026, departments will maintain compliance of all assigned NCQA Health Outcomes Accreditation (HOA) Standards and Guidelines, following the 2026 HOA Standards and Guidelines once available, as measured by the three (3) deliverables listed. In addition, all Business Owners are required to review NCQA clarifications, including the Triannual Policy Updates and Monthly FAQs, and provide a timely acknowledgement. Subsequent edits to the evidence must be addressed as soon as possible to meet compliance in accordance to NCQA's look-back periods, timelines, and/or expectations. Any revisions to the final program documents (Work Plan, Report Schedule, and Evidence Submission Library) must be communicated to the NCQA Program Management Team within seven (7) calendar days.	**Deliverable #1:** By March 6, 2026, Business Owners will update the annual HOA Workbook (Work Plan and Evidence Submission Library): • Review and/or update the HOA Work Plan information based on the 2026 HOA Standards and Guidelines; collect attestations from newly identify key stakeholders and contributors if applicable. • Review and/or update the Evidence Submission Library based on the 2026 HOA Standards and Guidelines changes and learnings from the Health Equity Accreditation (HEA) Initial Survey. All evidence must be produced and dated based on the date(s) listed under the Evidence Submission Library. Any date changes or document revisions must be reviewed and agreed upon by the NCQA Program Management Team in collaboration with the NCQA Consultant. • Contributors identified from FY 24-25 should share their questions with Business Owners for further evaluation and discussion. Submissions of HOA Workbooks that do not follow the instructions are considered incomplete. The NCQA Program Management Team will request the Business Owner make corrections and resubmit, which may cause a delay in meeting the submission deadline. The NCQA Program Management Team will share the annual HOA Workbook by February 17, 2026.	2/17/2026	3/6/2026	Title: Director of Quality Measurement Name: Kristine Gual	Compliance, Health Equity, Population Health, Quality Improvement, Human Resources, Network Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue McMurray	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	**No**
9.a.				**Deliverable #2:** By January 16, 2026, complete the 2026-2028 HEA Report Schedule by indicating the contributors involved, the reporting period of the data sources, when data sources will become available, and the targeted approval date of the analysis reports. • Submit the analysis reports based on the draft report date provided under the 2026-2028 HEA Report Schedule. All reports must be submitted to the NCQA Consultant for review. All edits must be incorporated in a timely manner prior to any committee review and/or approval, or by the production date as agreed upon under the 2026-2028 HEA Report Schedule. Submissions of 2026-2028 HEA Report Schedules that do not follow the instructions are considered incomplete. The NCQA Program Management Team will request the Business Owner make corrections and resubmit, which may cause a delay in meeting the submission deadline. The NCQA Program Management Team will share the 2026-2028 HEA Report Schedule by December 12, 2025.	2/17/2026	3/6/2026	Title: Director of Quality Measurement Name: Kristine Gual	Compliance, Health Equity, Population Health, Quality Improvement, Human Resources, Network Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue McMurray	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
9.a.				**Deliverable #3:** All Business Owners must confirm and/or submit the following to meet the look-back period for each assigned standard: • Documented Processes: By March 3, 2026 (tentative; date may vary, pending assignment of HEA Renewal Survey date in 2028), provide acknowledgement that documented processes meet the scope of review throughout the look-back period. Any revisions that impact NCQA requirements must be finalized in May 2026, including timely review by the NCQA Consultant and approval at committee meetings. No edits should be made without review and/or assessment by the NCQA Consultant. • Materials: By May 15, 2026 (tentative; date may vary, pending assignment of HEA Renewal Survey date in 2028), submit all applicable screenshots as indicated under the Evidence Submission Library to demonstrate that compliance is met.	2/17/2026	4/17/2026	Title: Director of Quality Measurement Name: Kristine Gual	Compliance, Health Equity, Population Health, Quality Improvement, Human Resources, Network Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue McMurray	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
9.b.				**Deliverable #1:** By August 22, 2025, Business Owners will submit all annotated evidence for the Mock Renewal Survey based on the dates listed in the Evidence Submission Library for Year 1 of the look-back period, and the submission guidelines provided by the NCQA Program Management Team.	7/7/2025	8/22/2025	Title: Director of Quality Measurement Name: Kristine Gual	Behavioral Health, Care Coordination, Compliance, Grievance & Appeals, Health Equity, Human Resources, Member Services, Network Services, Pharmacy, Population Health, Quality Improvement, Utilization Management Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue McMurray	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
9.b.				**Deliverable #2:** By October 24, 2025, Business Owners will update the annual HPA Workbook (Work Plan and Evidence Submission Library): • Review and/or update the HPA Work Plan information based on the 2026 HPA Standards and Guidelines; collect attestations from newly identify key stakeholders and contributors if applicable. • Review and/or update the Evidence Submission Library based on the 2026 HPA Standards and Guidelines changes and recommendations from the HPA Mock Renewal Survey. All evidence must be produced and dated based on the date(s) listed under the Evidence Submission Library. Any date changes or document revisions must be reviewed and agreed upon by the NCQA Program Management Team in collaboration with the NCQA Consultant. • Contributors identified from FY 24-25 should share their questions with Business Owners for further evaluation and discussion. Submissions of HPA Workbooks that do not follow the instructions are considered incomplete. The NCQA Program Management Team will request the Business Owner make corrections and resubmit, which may cause a delay in meeting the submission deadline. The NCQA Program Management Team will share the annual HPA Workbook by September 30, 2025.	10/1/2025	10/24/2025	Title: Director of Quality Measurement Name: Kristine Gual	Behavioral Health, Care Coordination, Compliance, Grievance & Appeals, Health Equity, Human Resources, Member Services, Network Services, Pharmacy, Population Health, Quality Improvement, Utilization Management Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue McMurray	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
9.b.	Compliance with NCQA HPA and Sustain Performance	New	**Goal #1:** By June 30, 2026, departments will maintain compliance of all assigned NCQA Health Plan Accreditation (HPA) Standards and Guidelines, and prepare for the HPA Renewal Survey in September 2026, as measured by the six (6) deliverables listed.	**Deliverable #3**: Complete subset of analysis reports based on the approval dates outlined under the 2024-2026 HPA Report Schedule: • By June 30, 2026, submit edits to the 2024-2026 HPA Report Schedule, if applicable. This would include any changes related to the reporting period of the data sources, when data sources will become available, and the targeted approval date of the analysis reports. • Submit the analysis reports based on the draft report date provided under the 2024-2026 HPA Report Schedule. All reports must be submitted to the NCQA Consultant for review. All edits must be incorporated in a timely manner prior to any committee review and/or approval, or by the production date as agreed upon under the 2024-2026 HPA Report Schedule.	10/1/2025	6/30/2026	Title: Director of Quality Measurement Name: Kristine Gual	Behavioral Health, Care Coordination, Compliance, Grievance & Appeals, Health Equity, Human Resources, Member Services, Network Services, Pharmacy, Population Health, Quality Improvement, Utilization Management Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue McMurray	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
9.b.				**Deliverable #4**: Obtain a "yes" score on all assigned elements during the HPA Mock Renewal Survey. If gaps are identified on Year 1 evidence, Business Owners will: • By December 5, 2025, submit an Action Plan (AP) to address any applicable recommendations. • Correct evidence by the applicable look-back period, timelines, and/or expectations by NCQA. Any revised or new evidence must be submitted to MHR for review and approval and must align with the timeline of committee meetings for review. No edits should be made without review and/or assessment by the NCQA Consultant. • After the Mock Survey, any modifications to approved evidence that affect NCQA requirements, including documented processes, must be shared with the NCQA Program Management Team for review and further assessment prior to the effective/production date. The NCQA Program Management Team will share the AP document by November 13, 2025.	11/14/2025	6/30/2026	Title: Director of Quality Measurement Name: Kristine Gual	Behavioral Health, Compliance, Grievance & Appeals, Care Coordination, Population Health, Utilization Management, Pharmacy, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue McMurray	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
9.b.				**Deliverable #5**: Departments that oversee file review requirements will maintain strict oversight of Partnership and non-NCQA Accredited delegates' files to ensure compliance. The departments are Network Services, Utilization Management, Pharmacy, Grievance and Appeals, and Care Coordination: • Participate in a Mock File Review with the NCQA Consultant. Additional follow-up activities and subsequent monitoring may be required. At the discretion of the NCQA Steering Committee, ad hoc file review audits with the NCQA Consultant may follow. • Continue the quarterly file review audit of Partnership files and share results with the NCQA Program Management Team, who will provide regular updates to the NCQA Steering Committee. Business Owners will implement an AP for files that do not score "yes" on each factor. • Continue ongoing monitoring of files from non-NCQA Accredited delegates. Business Owners will provide regular updates, including the annual audit results and risks identified, with the NCQA Program Management Team. More frequent monitoring may be required, if applicable. These updates will be shared with the NCQA Steering Committee.	7/1/2025	6/30/2026	Title: Director of Quality Measurement Name: Kristine Gual	Behavioral Health, Compliance, Grievance & Appeals, Care Coordination, Population Health, Utilization Management, Pharmacy, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue McMurray	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	

2025-26 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
9.b.				**Deliverable #6:** By May 29, 2026 Business Owners will submit all annotated evidence for HPA Renewal Survey based on the dates listed in the Evidence Submission Library for Year 1 (if applicable) and Year 2 of the look-back period, and the submission guidelines provided by the NCQA Program Management Team.	4/3/2026	5/29/2026	Title: Director of Quality Measurement Name: Kristine Gual	Behavioral Health, Compliance, Grievance & Appeals, Care Coordination, Population Health, Utilization Management, Pharmacy, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue McMurray	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
	10. Grand Analysis										
10.a.	Grand Analysis - Member Experience (ME7) Report	Continued	**Goal #1:** By August 31, 2026, complete the annual Member Experience Grand Analysis (ME7) report. (Note, the ME 7 report is dependent on CAHPS data results, which are managed by an external vendor (Press Ganey) and not available until after the goal period ends).	**Deliverable #1:** By June 30, 2026, continue the fiscal/quarterly year process to collect and analyze Grievance & Appeals data. Ensure stakeholders at a minimum meet quarterly or as needed to review data compared to prior and current year CAHPS® survey results.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
10.a.				**Deliverable #2**: By June 30, 2026, collect and analyze CAHPS® regulated Measure Year (MY) 2025 survey results, 2025 Grievance & Appeals annual filings, and other data sources.	7/1/2025	6/30/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
10.a.				**Deliverable #3**: By August 31, 2026, complete the Member Experience Grand Analysis Report (ME7).	7/1/2025	8/31/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
10.a.	Grand Analysis - Pharmacy and Utilization Management (UM1G) Report	Continued	**Goal #1:** By June 30, 2026, complete annual Pharmacy & Utilization Management Grand Analysis (UM1G) report per NCQA Health Plan Accreditation standards.	**Deliverable #1:** Complete annual Pharmacy & UM Program Evaluation (UM1G) for 2025.	7/1/2025	6/30/2026	Title: Chief Health Services Officer Name: Katherine Barresi	Title: Clinical Pharmacist Name: Andrea Ocampo Title: Associate Director of UM Regulations Name: Tony Hightower	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
10.a.	Grand Analysis - Access and Availability (NET3) Report	Continued	**Goal #1:** By June 30, 2026, the 2025 NET 3 Report will be complete.	**Deliverable #1:** Complete the NET 3 Report	7/1/2025	6/1/2026	Title: Director of Provider Relations Name: Priscila Ayala	Title: Manager of Network Services Compliance Name: Renee Trosky	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**

Grievance & Appeals Department Annual Report

CY 2025

June 2026

Kory Watkins, MBA-HM

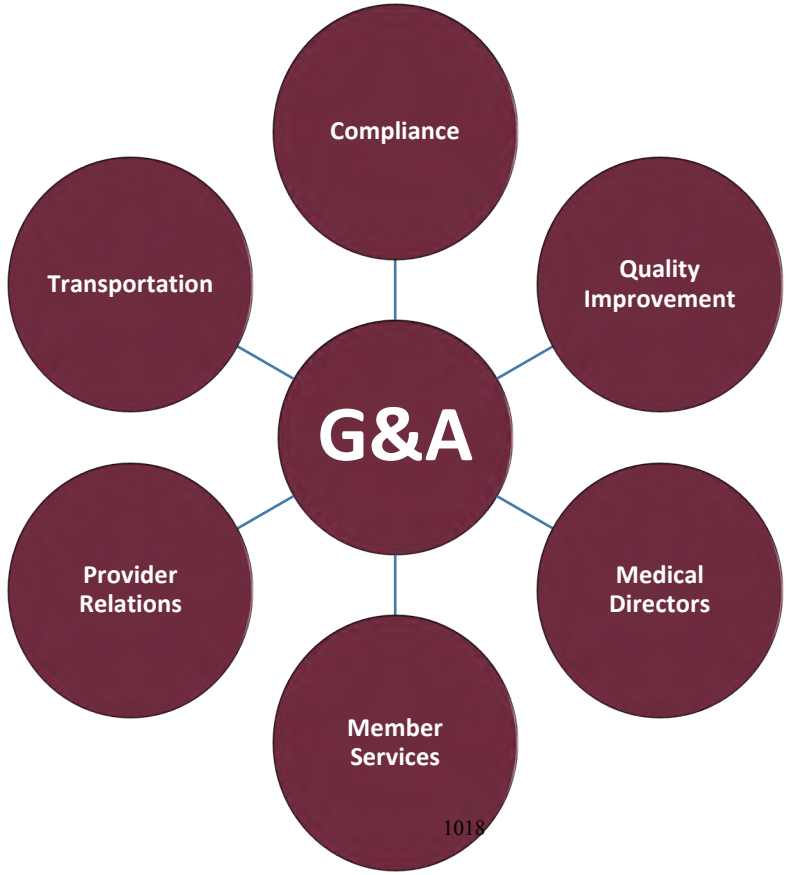
Director, Grievance & Appeals

Agenda

- Department Overview
- Case Volume and Trends
- Case Intake and Classification
- Member Demographics
- Grievance Trends and Categories
- Civil Rights Allegations
- Appeals and Outcomes
- Performance Metrics
- Challenges and 2026 Goals

Department Overview

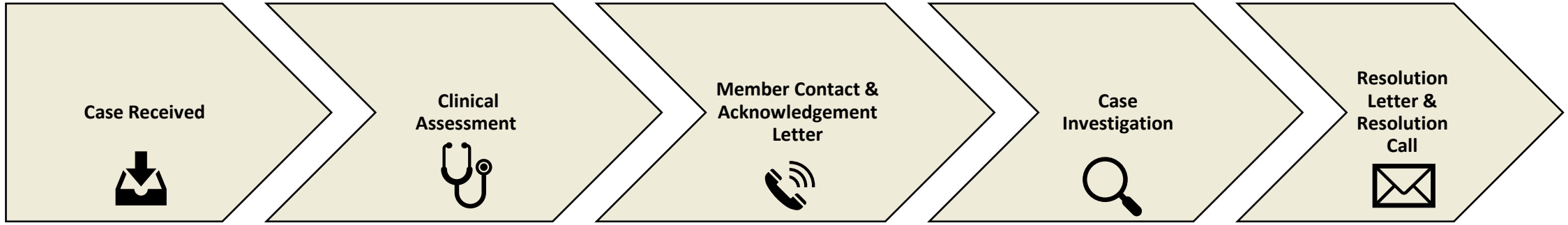
The Grievance & Appeals (G&A) department ensures that members concerns are heard, addressed, and resolved in alignment with regulatory standards and health plan policies. We manage member grievances and appeals with a focus on timeliness, fairness, and improving the overall member experience.



Interdepartmental Collaboration: Transportation Dept.

- Enhanced transportation grievance tracking by capturing driver-specific information to support trend analysis and oversight.
- Developed detailed transportation grievance reports that identify compliance trends by transportation provider and service issue.
- Partnered with the Transportation Department to share grievance findings and support ongoing service improvements for members.

Overview of Process

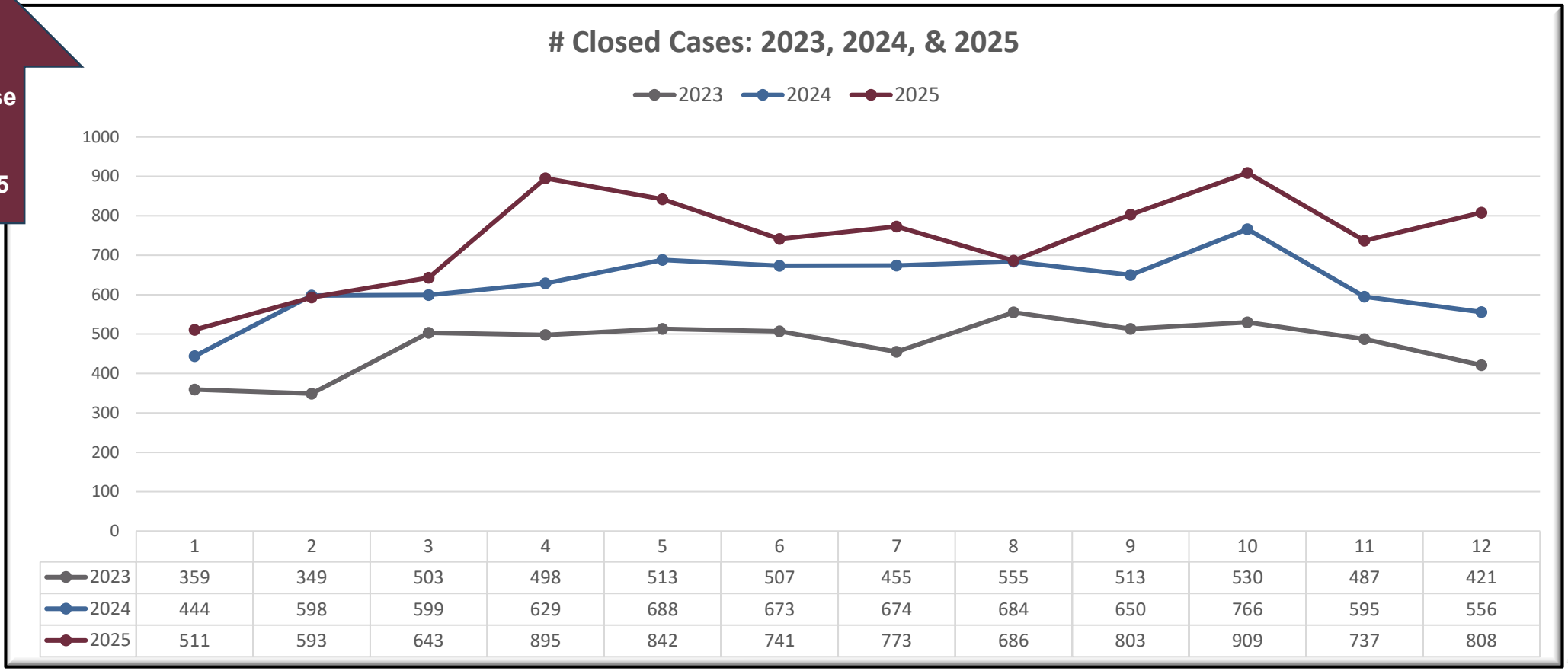


Case Types We Process:

- **Standard Grievances -** Member complaints about dissatisfaction with services, care, or experiences
- **Exempt Grievances -** Member concerns that are resolved quickly without the formal grievance process
- **Appeals -** Member disagreement with a denied service or treatment
- **State Fair Hearings -** Formal requests for a hearing before an administrative law judge regarding a denied service

Annual Case Volume – 3 Year Comparison

18% Increase from 2024 to 2025



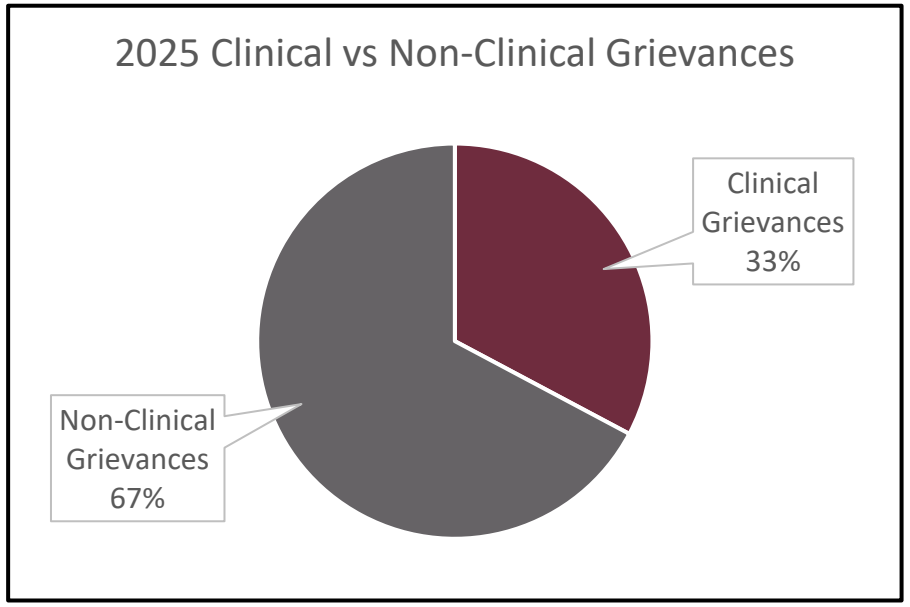
	1	2	3	4	5	6	7	8	9	10	11	12
2023	359	349	503	498	513	507	455	555	513	530	487	421
2024	444	598	599	629	688	673	674	684	650	766	595	556
2025	511	593	643	895	842	741	773	686	803	909	737	808

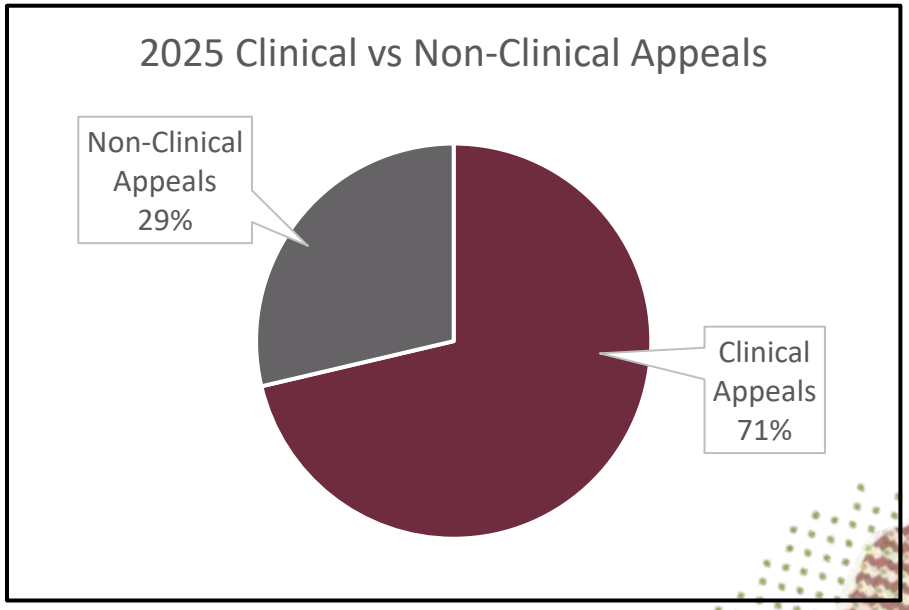
Annual Cases Closed/Cases per 1,000 Members:
2025 – 8,941/9.91
2024 – 7,556/8.34
2023 – 5,690/8.39

Case Intake and Classification

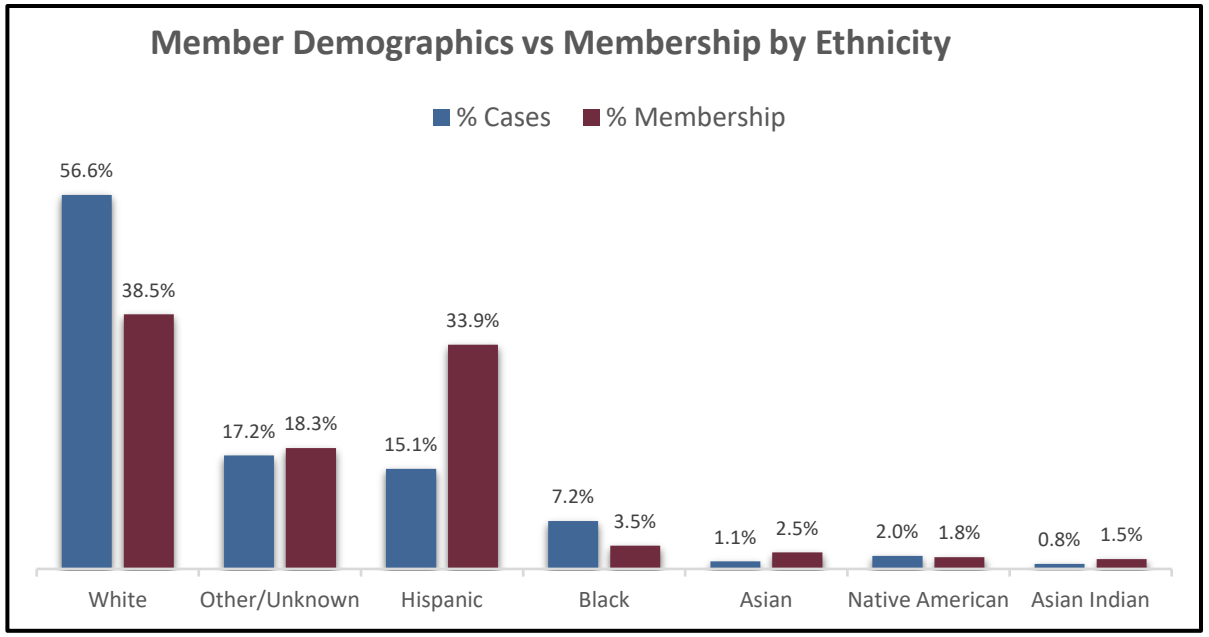
How Cases Were Received	
Phone	90.9%
Online/Email	6.4%
Mail	1.8%
Fax	0.8%
In-Person	0.1%

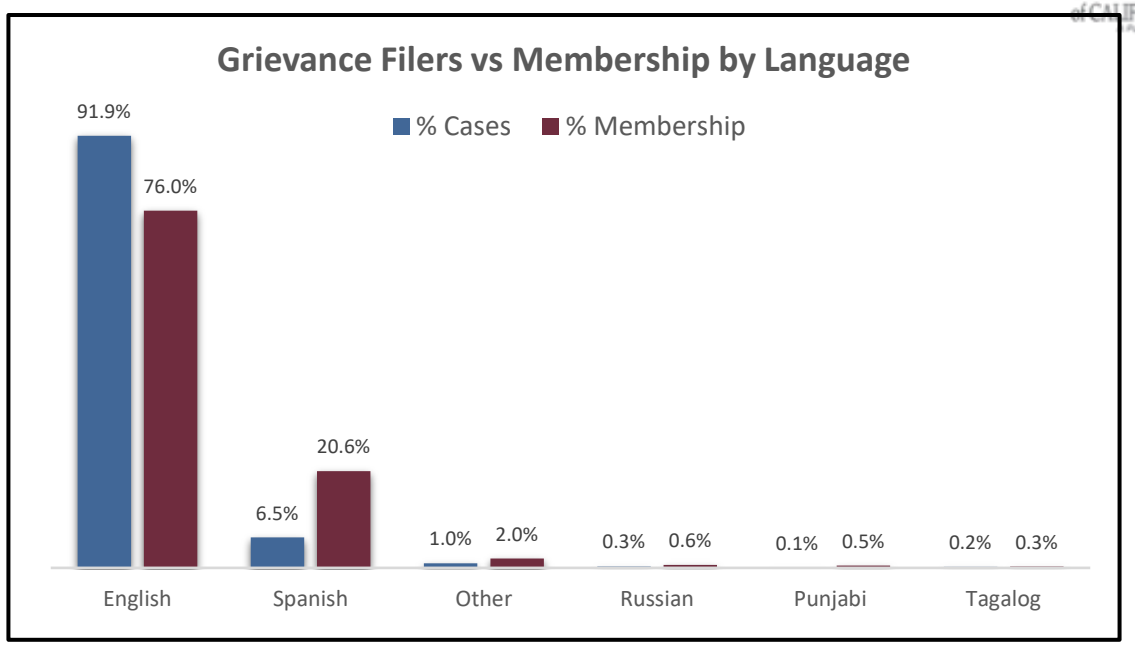
Only 0.5% of all cases (44 total) were classified as expedited in 2025

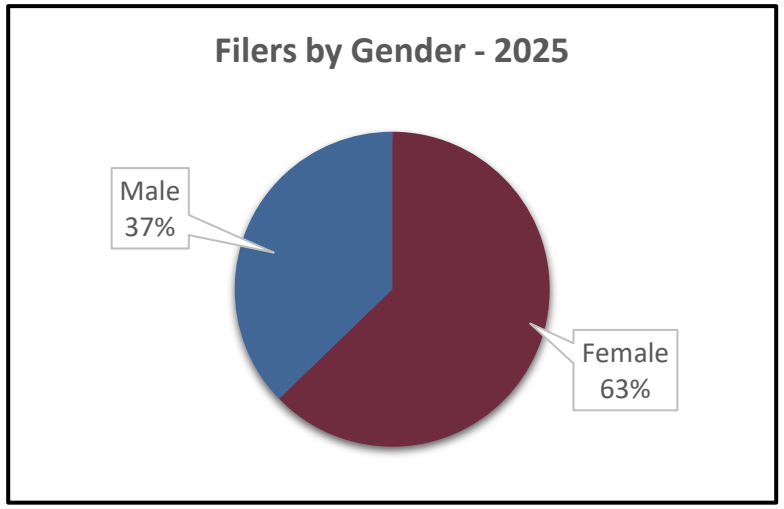


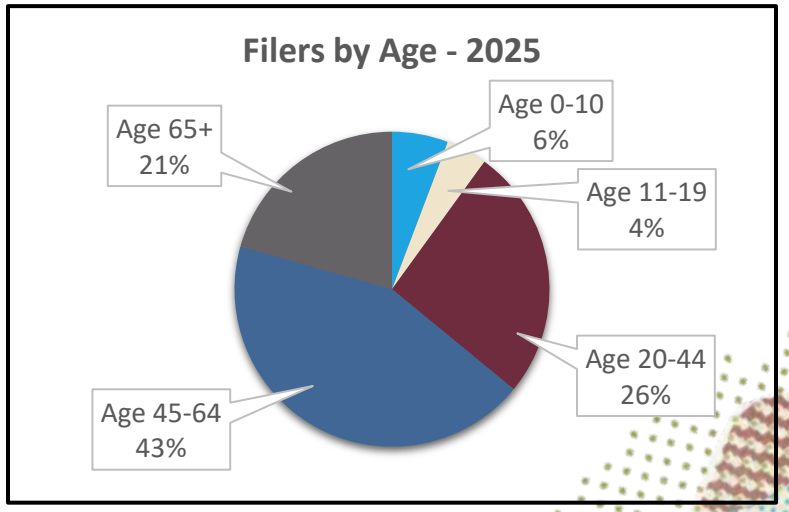


Member Demographics

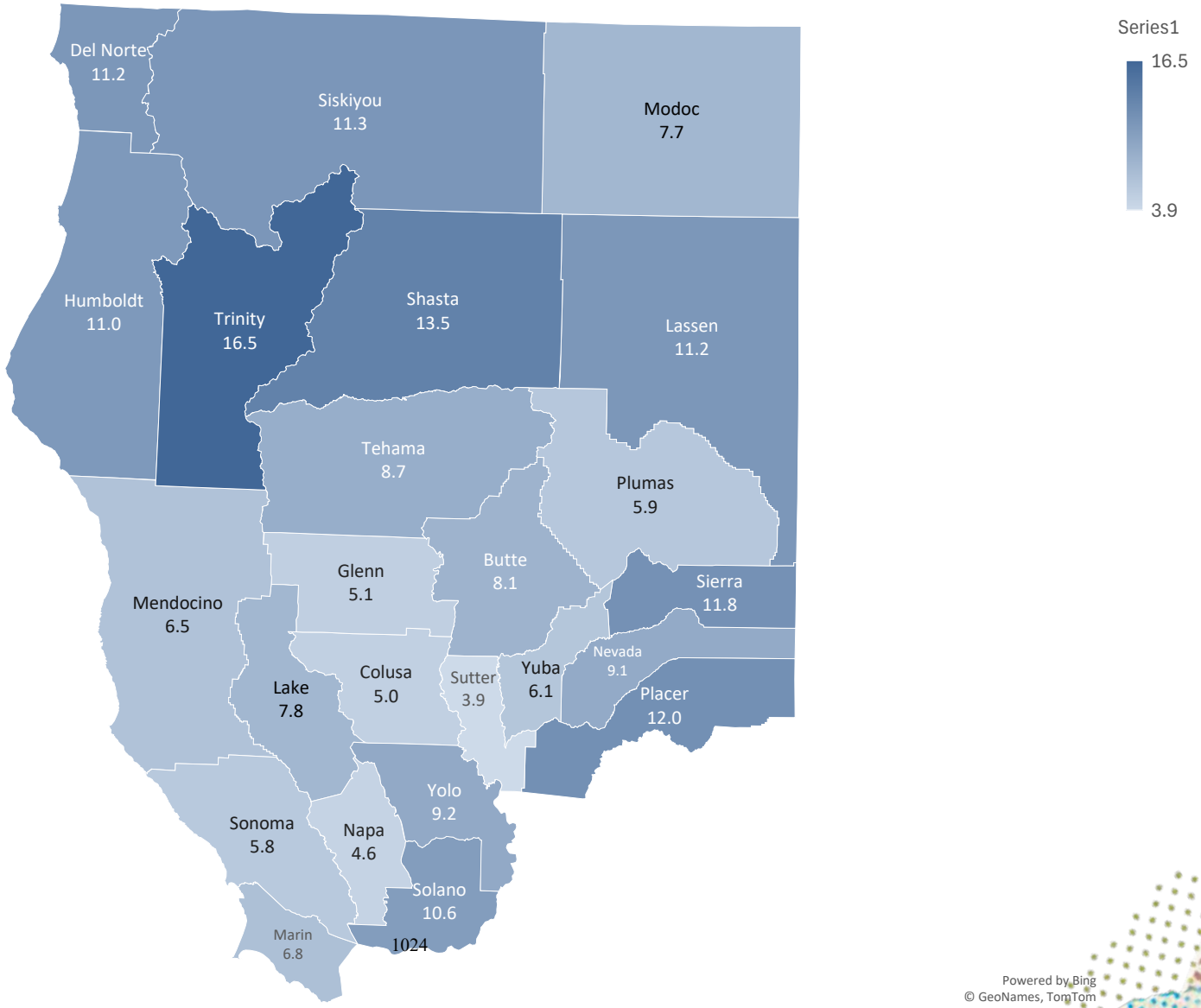








Where Members Experience Problems



Top 3 Counties by Grievances
Per 1,000 members:

- Trinity – 16.5
- Shasta – 13.5
- Placer – 12.0

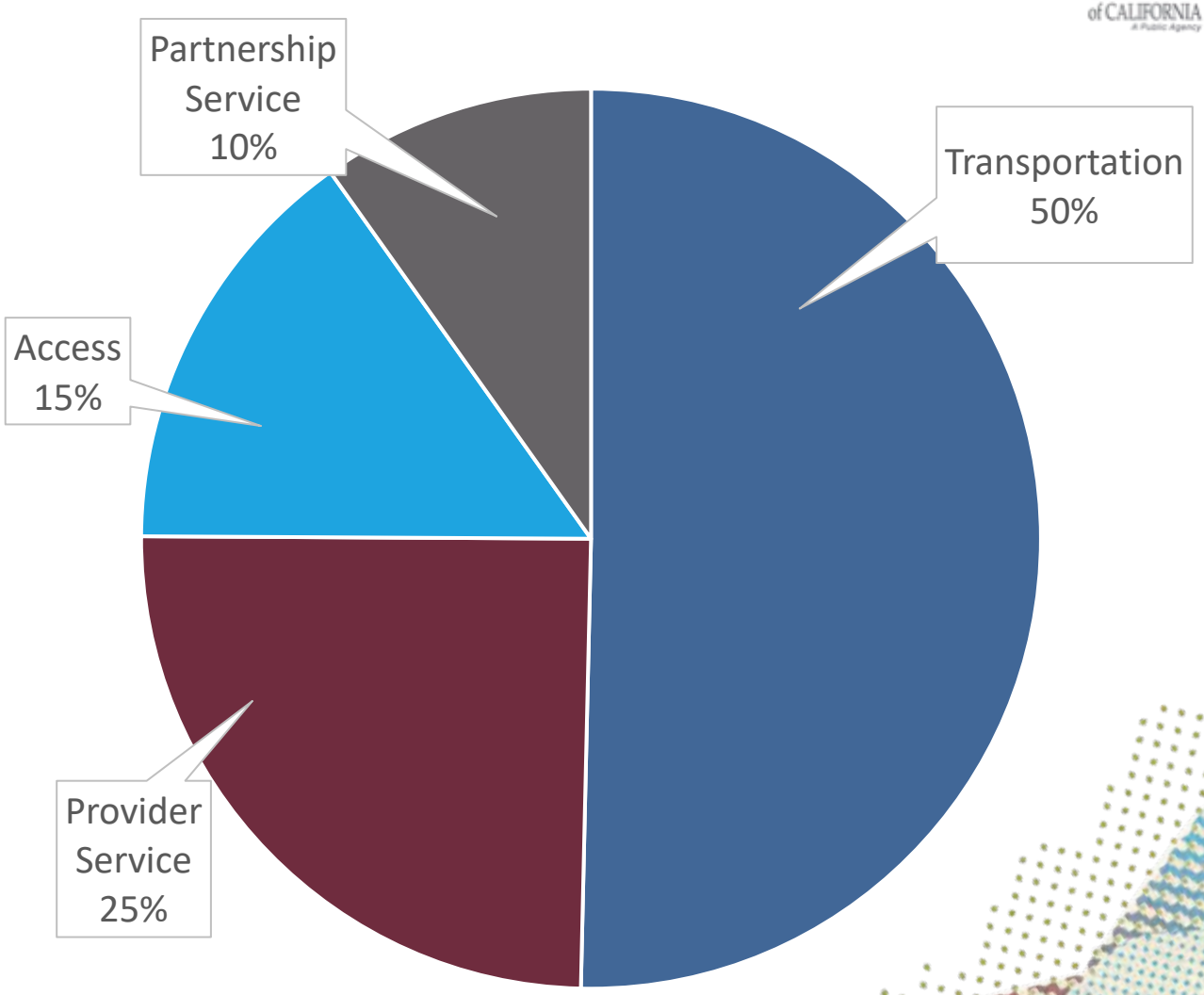
Top Grievance Concerns by Category

Transportation – includes missed rides, driver arriving late, driver behavior, scheduling issues, and vehicle conditions

Provider Service – includes treatment plan disputes, communication issues, poor attitude, office conditions, and allegations of misconduct

Access – includes long wait times to be seen, delayed referrals/authorizations, and lack of provider availability

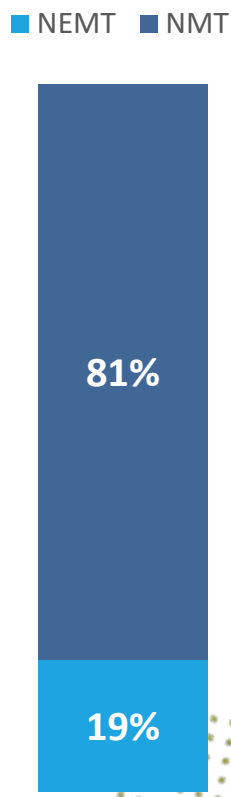
Partnership Service – includes staff complaints, advise nurse line, escalation process, website, phone system, and member mailings



Transportation Related Grievance Concerns

Non-Medical Transportation (NMT) accounted for 81% of the transportation-related concerns

Non-Emergency Medical Transportation (NEMT) accounted for 19% of the transportation-related concerns



5 most common issues in both categories

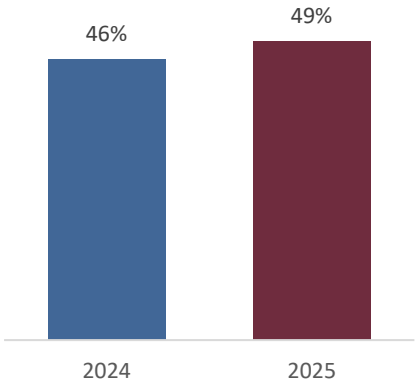
- Missed rides (17%)
- Late driver arrivals (12%)
- Driver behavior issues (11%)
- Poor transportation company customer service (8%)
- Scheduling difficulties (8%)

Partnership provided 1,562,928 rides in 2025 and received 5,947 transportation related concerns, representing less than 0.4% of total rides

Breakdown of Service-Related Grievances (Excluding Transportation)

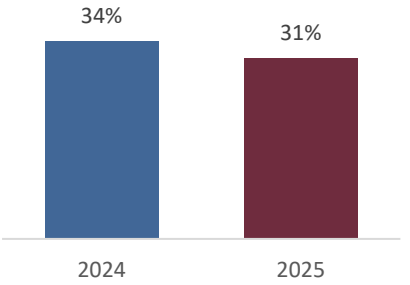
Provider Services (49%) ⬆

- o Treatment Plan Disputes (42%)
- o Communication (29%)
- o Poor Attitude (26%)

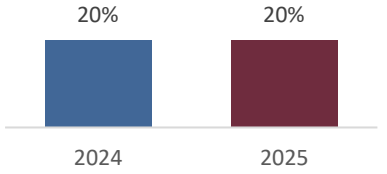


Access Issues (31%) ⬇

- o Long Wait Time for Appointments (25%) ⬇
- o Provider Refusal of Care (15%)
- o Provider Network Adequacy (13%)

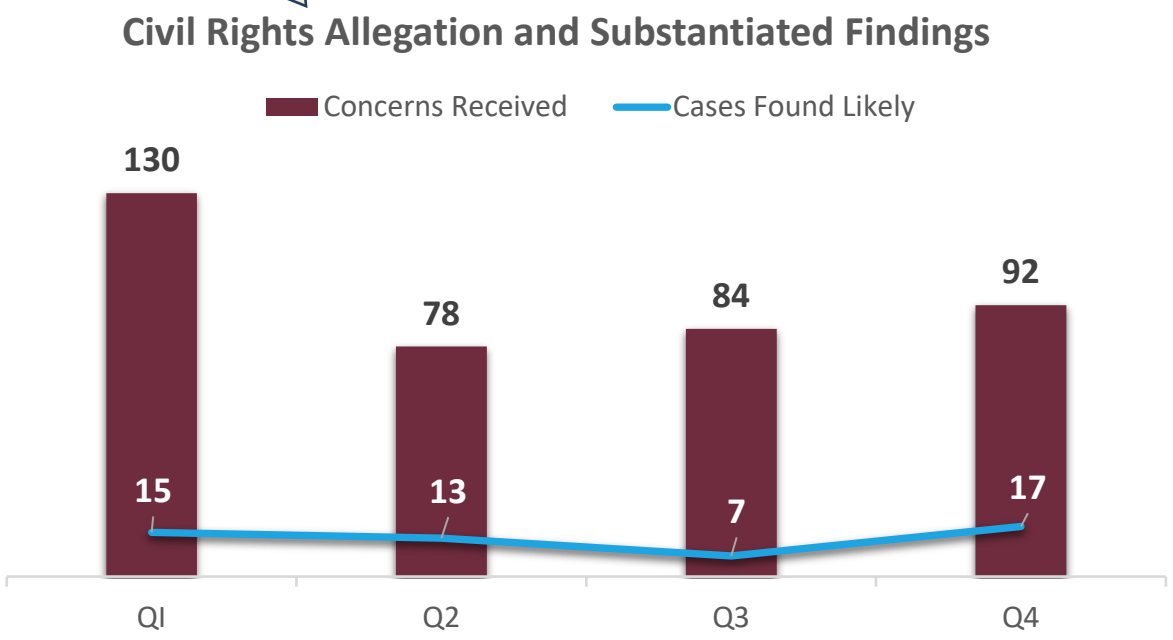


Partnership Services (20%)



Discrimination Allegations - Civil Rights Focus

14% of civil rights allegations were substantiated in 2025, up from 10% in 2024



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.

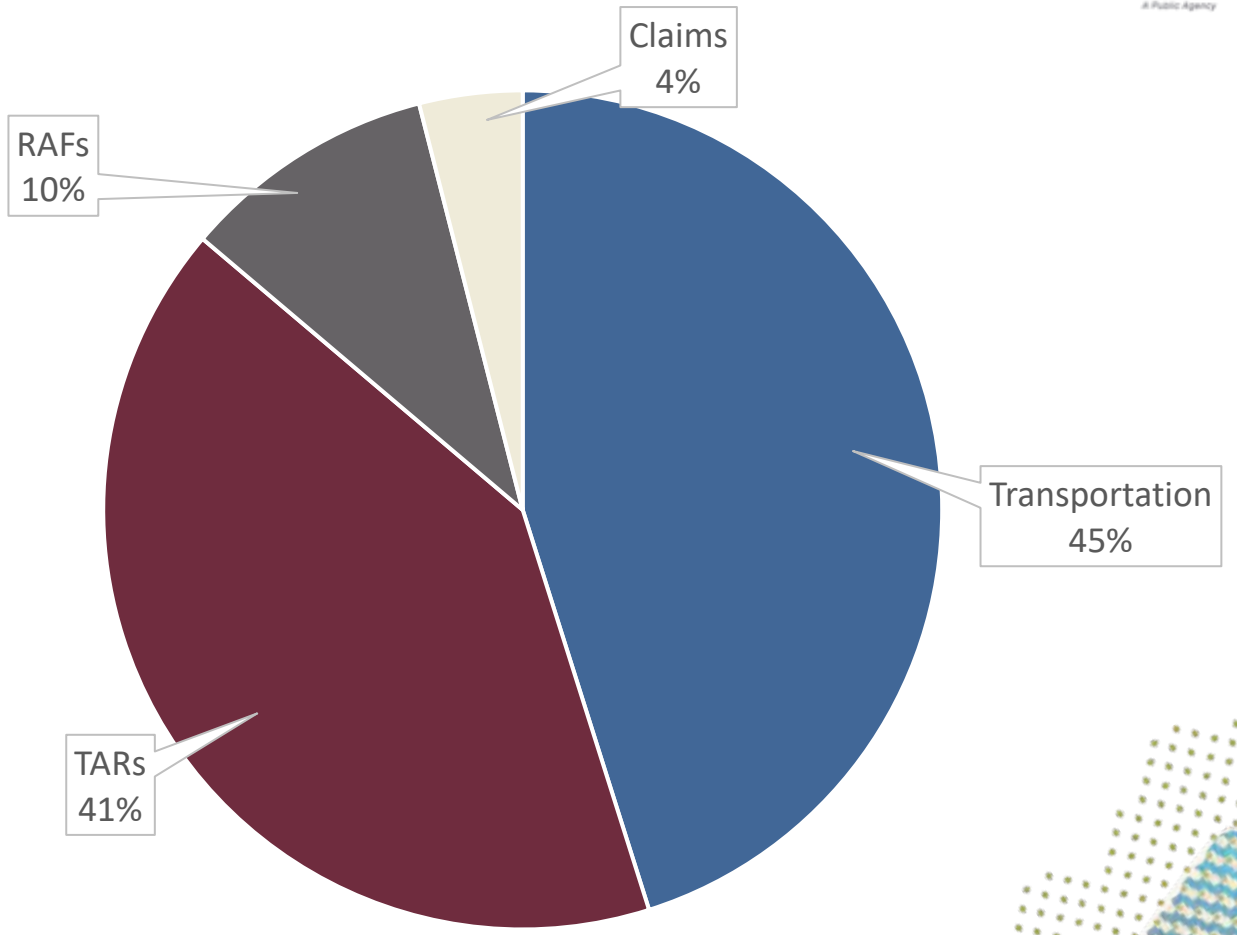
Top Appeals by Category

Transportation – includes meals, lodging, rides, and gas mileage reimbursement

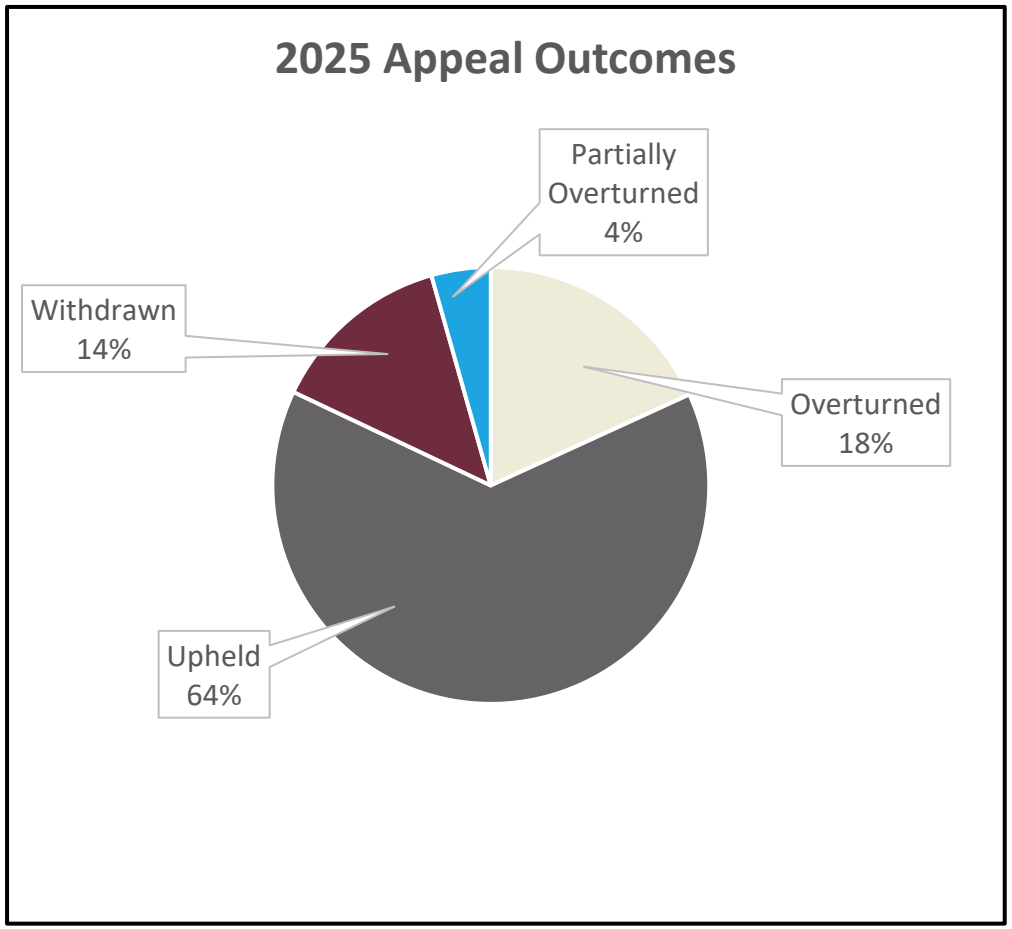
Treatment Authorization Request (TARs) – includes DME, surgery, diagnostic testing, and ancillary services

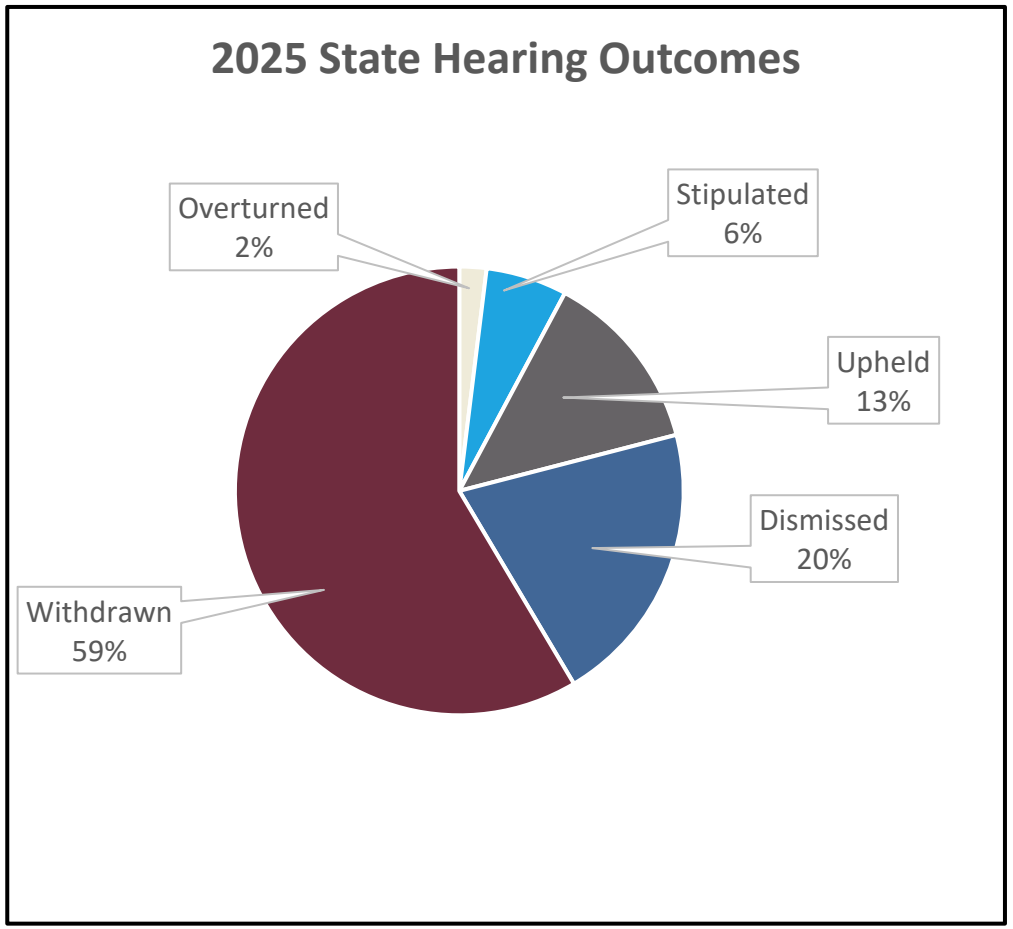
Referral Authorization Forms (RAFs) – includes out-of-network requests

Claims – includes requests for reimbursement of services paid out of pocket



Outcomes and Dispositions





2025 Department Performance

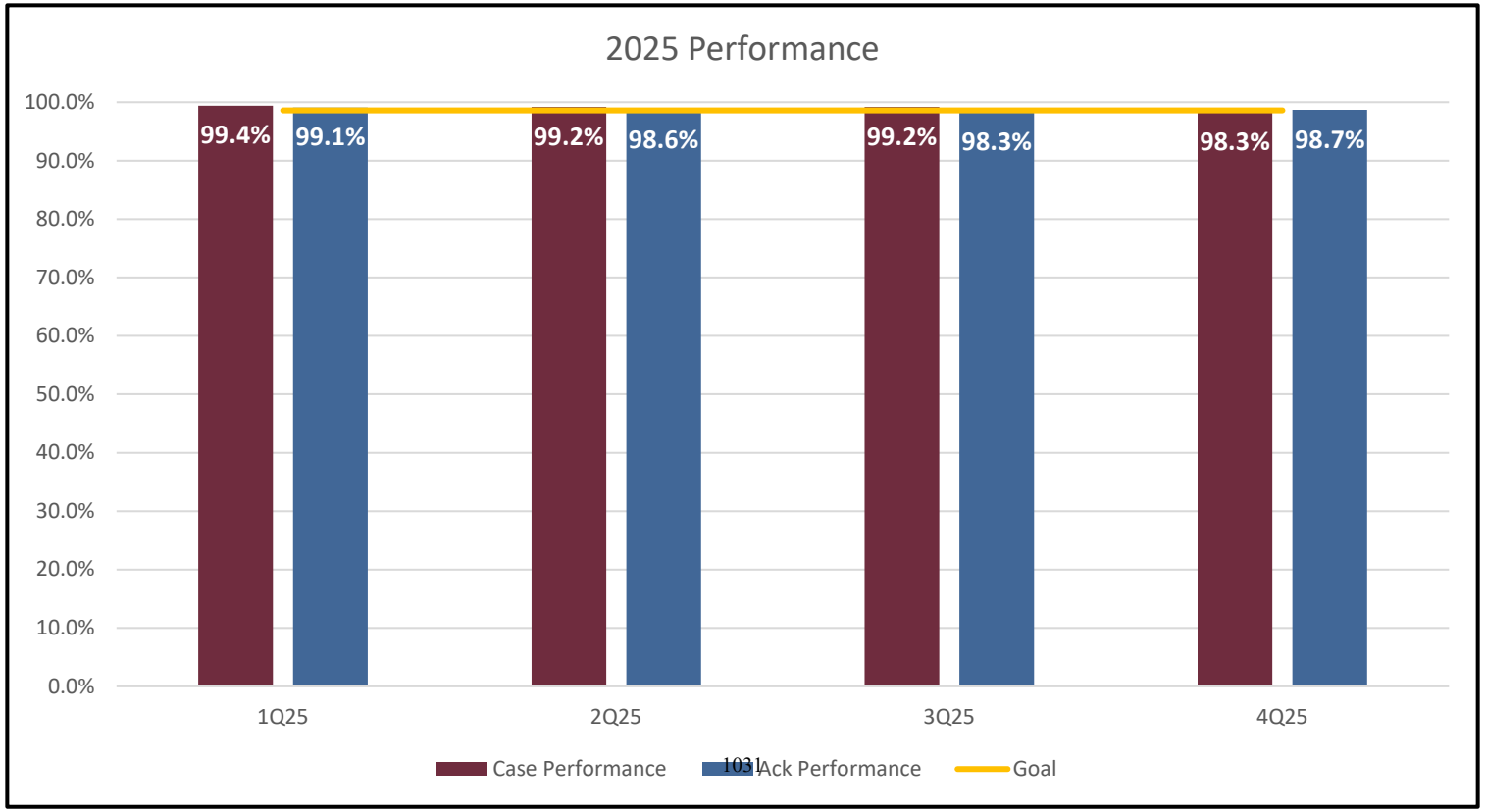
Performance Goals

Case Closure

- Expedited Cases – Investigate 98.6% of cases within 72 hours
- Standard Cases – Investigate 98.6% of cases within 30 days

Acknowledgment Letters

- Letters sent on or before the fifth calendar day after case received



Challenges and Lessons Learned

Challenge	Lesson Learned
Continued Growth in Case Volume • Increased grievance and appeal volume required the department to balance workload demands while maintaining regulatory compliance and service standards.	• Ongoing monitoring of staffing needs is critical to sustain performance as case volume grows. • Expanded cross-training and workload balancing strategies to improve operational flexibility and support timely case resolution. • **Action Planned**: Implement comprehensive appeals training for all case workers
Member Transportation Service Issues • Transportation continued to be a significant source of member dissatisfaction, requiring increased coordination with operational partners.	• Detailed compliant trend analysis provides valuable insights into provider performance and recurring service issues. • **Action Taken:** Implemented enhanced transportation grievance reporting and strengthened collaboration with the Transportation Department to support service improvement efforts.
Resolution Letter Quality • Letter quality is not optimal. Unable to support secondary review of letters before they are mailed.	• Establishing a peer review process for resolution letters before mailing helps catch errors and ensures clear, consistent member communication. • **Action Planned:** Develop a quality assurance review step prior to mailing a resolution letter.

Goals and Focus Areas for 2026

- **Jiva Implementation** – Prepare for and support the implementation of the Jiva case management system to improve workflow efficiency, reporting capabilities, and case oversight.

- **Quality Oversight Expansion** – Continue building the department's internal audit and training functions to strengthen quality assurance, improve consistency, and identify opportunities for process improvement.

- **Partnership Advantage Readiness** – Collaborate with organizational stakeholders to support planning and operational readiness activities for the future Partnership Advantage implementation.

- **Data-Driven Process Improvements** – Leverage grievance and appeal trend data to identify root causes, strengthen interdepartmental collaboration, and improve the member experience.

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Questions?

2026-27 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
1. QI Program Infrastructure											
1.a.	QI Program Documents	Continued	**Goal #1:** By July 2027, complete draft QI Program Description, QI Work Plan, and QI Evaluation revisions in preparation for August Quality Committee meetings.	**Deliverable #1:** Finalize 2027 - 2028 QI Program Description	10/1/2026	7/30/2027	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
1.a.				**Deliverable #2:** Finalize 2026 - 2027 QI Work Plan	10/1/2026	7/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
1.a.				**Deliverable #3:** Finalize 2026 - 2027 QI Evaluation	10/1/2026	7/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
1.a.				**Deliverable #4:** Complete Draft of 2027 - 2028 QI Work Plan	10/1/2026	7/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
1.b.	Physician Advisory Committee (PAC) Oversight of QI Program	New	**Goal #1:** By June 30, 2027, Ensure PAC oversight of Partnership's QI Program through semi-annual monitoring of the QI Work Plan	**Deliverable #1:** By September 30, 2026. QI Trilogy Documents to be reviewed for approval by PAC in September 2026, post-review of other Quality committees to include but not limited to: * FY 2026-27 - Work Plan * FY 2026-27 - Program Descriptions * FY 2025-26 - QI Program Evaluation	9/1/2026	9/30/2026	Title: Chief Medical Officer Name: Robert Moore	Title: Executive Assistant Name: Sarah Browning	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2. Measurement, Analytics and Reporting											
2.a.	HEDIS® Reporting	Continued	**Goal #1:** By June 30, 2027, report HEDIS measurement year (MY) 2026 final rate performance as required annually for NCQA Health Plan Accreditation (HPA) and the DHCS Managed Care Accountability Set (MCAS), including county level reporting for all 24 counties.	**Deliverable #1:** Annual Project Work Plans updated by 10/31/2026 to accommodate HPA, MCAS unique activities/deliverables.	7/1/2026	10/31/2026	Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.a.				**Deliverable #2:** By January 15, 2027, launch the HEDIS MY2026 Annual project for HEDIS MY2026 rate performance as required annually for NCQA Health Plan Accreditation (HPA) and the DHCS Managed Care Accountability Set (MCAS).	1/2/2027	1/15/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.a.		Continued *(Monitoring of previous issue)*	**Goal #2**: By April 30, 2027, launch the HEDIS MY2027 Monthly Project in Inovalon to include data reporting for NCQA Health Plan Accreditation (HPA) and DHCS Managed Care Accountability Set (MCAS) to include all (24) county level reporting.	**Deliverable #1**: Create MY2027 Prospective Project Work Plan updated by December 31, 2026 to include HPA, MCAS and County Level unique activities/deliverables.	7/1/2026	12/31/2026	Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.a.				**Deliverable #2**: By April 30, 2027, launch the HEDIS MY2027 Monthly Project which includes all populations for DHCS, HPA and County level. (Contingent on HRP Go-Live)	12/1/2026	4/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.a.		New	**Goal #3**: By June 30, 2027, apply supplemental data from an NCQA certified data aggregator from all (24) counties within the Partnership network to support MY2026 HEDIS rate reporting for NCQA Health Plan Accreditation (HPA) and the DHCS Managed Care Accountability Set (MCAS).	**Deliverable #1**: Submit ROADMAP Annual Audit Deliverable that includes an NCQA Certified Aggregator for auditor(s) approval.	11/1/2026	3/31/2027	Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.a.				**Deliverable #2**: Receive clinical data from NCQA Certified Aggregator into Partnership's data warehouse from practices in (24) counties for use in MY2026 HEDIS Annual Project.	7/1/2026	2/28/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.a.				**Deliverable #3**: Integrate data from NCQA Certified Aggregator upon auditor(s) approval into the HEDIS MY2026 Annual project.	3/1/2027	5/31/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.b.				**Deliverable #1:** Present a draft set of Member Experience KPIs to the Board by or before end of FY Q2	7/1/2026	12/31/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2026-27 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.b.	Member Experience Improvement	New	**Goal #1:** By December 31, 2026, Enhance Member Experience (CAHPS) Program structure. Outcomes/Deliverables: • Establish Key Performance Indicators (KPIs) operational influence drivers linked to CAHPS survey domains (i.e. Access, HealthPlan and HealthCare Ratings). • Expand cross-department CAHPS governance framework.	**Deliverable #2:** Written plan focused on cross-team coordination to include, but not limited to: o Defined workgroups, individuals, RACI and collaboration cadence (frequency and topics) o Establishment of necessary positions within the committee structure. o Identified Roles and Responsibilities for committee. o Determination of proper departments to include. o Clear purpose set for established committee. o Communication plan created to establish frequency and length of committee meetings. o Committee leader/owner identified to lead meetings, communicate updates, and designate scribe(s) for committee meeting notes	7/1/2026	12/31/2026	Title: Director of Member Experience Name: Irem Conery	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.b.				**Deliverable #3:** Document at least 1-2 meetings per workgroup by end of December (demonstrate activation, not just design)	7/1/2026	12/31/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.b.		New	**Goal #2**:By June 30, 2027, address at least 1 opportunity to enhance Partnership's Telehealth strategy and approach. Outcomes/Deliverables: • Written summary of activities, outcomes, next steps and future considerations.	**Deliverable #1:** Identify opportunities to enhance the existing telemedicine program.	7/1/2026	9/30/2027	Title: Director of Member Experience Name: Irem Conery	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.b.				**Deliverable #2:** • Selection and implementation of at least one (1) identified enhancement • Use existing survey insights and provider utilization reports to inform targeting (member interest, access, and provider behavior)	10/1/2026	12/31/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.b.				**Deliverable #3:** Written summary of activities, outcomes, next steps and future considerations.	1/1/2027	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.c.	Member Services Access	New	**Goal #1:** By June 30, 2027, ensure compliance of internal and delegated access standards as it relates to inbound call handling.	**Deliverable #1:** Monitor, Analyze and Recommend Corrective Action Plan(s) (CAP) when appropriate which includes: • Review internal call center performance stats monthly (performance benchmarks tracked quarterly) on several service level agreements (SLAs) • Plan to continue to track quarterly delegate call center performance (submitted quarterly by each respective delegate) against established performance thresholds (based on SLAs above) during Delegate Oversight quarterly meetings	7/1/2026	6/30/2027	Title: Senior Director of Member Services and Grievances Name: Edna Villasenor Title: Associate Director of Member Services Name: Cyress Mendiola	Title: Supervisor of Member Services Name: Chelsea Breshears	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.d.	Primary Care Provider Quality Incentive Program (PCP QIP) Payment Processing Report	Continue	**Goal #1:** By June 30, 2027, PCP QIP will continue updating the Data Validation Framework to support accurate payment verification. The team is focused on improving documentation, clarifying data sources and ownership, and strengthening validation checks for completeness, accuracy, consistency, and timeliness. These efforts will help reduce risk, improve transparency, and support confidence in payment accuracy, while also helping maintain operational and audit readiness.	**Deliverable #1:** PCP QIP will hold internal payment debrief meetings to review what worked well, discuss lessons learned, and identify opportunities for process improvement in future payment cycles. PCP QIP will also review and update supporting payment process documentation, including checklists, workflows, data reporting, and timelines, to help improve clarity, and overall tracking of payment activities.	7/1/2026	3/31/2027	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.d.				**Deliverable #2:** PCP QIP will develop payment checklists to ensure all processes are followed. We will finalize and implement these checklists, then meet with contributors to confirm that validation processes are in place. The checklists were created based on the Data Validation Framework document.	7/1/2026	3/31/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.d.				**Deliverable #3:** Incorporating VLOOKUP functionality into payment files will improve accuracy and reduce manual discrepancies. We will also embed the supplemental data used to calculate payments within the master payment file. These enhancements will streamline the validation process, improve accuracy, and better prepare our files for DHCS audits.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.e.	Web Based Member Information Assessment	New	**Goal #1:** By June 30, 2027, complete annual evaluation of the quality and accuracy of information provided to members via e-mail and telephone as stated in NCQA Standard ME 6 Element C: Quality and Accuracy of Information.	**Deliverable #1:** Complete annual evaluation of the quality and accuracy of information provided to members via e-mail and telephone as stated in ME 6 C: Quality and Accuracy of Information.	7/1/2026	6/30/2027	Title: Senior Director of Member Services and Grievances Name: Edna Villasenor Title: Associate Director of Member Services Name: Cyress Mendiola	Title: Manager of Quality and Training Services Name: Kristen Clark	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.f.	Primary Care Provider Quality Incentive Program (PCP QIP) eReports System	Continued *(Monitoring of previous issue)*	**Goal #1:** By June 30, 2027, PCP QIP will continue collaborating with the Partnership Web Team to align 2027 eReports with HRP® (Health Rules Payor) data elements in preparation for the launch of HRP®.	**Deliverable #1:** Review 2027 eReports scoping and development with Web Team to identify areas within eReports that need integration with HRP®. Finalize via annual Business Requirement Documents (BRD) approved by QI and IT management.	7/1/2026	11/1/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Teresa Lugo	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.f.				**Deliverable #2:** Complete User Acceptance testing (UAT), inclusive of HRP® integration testing, per approved 2026 eReports BRD, for on-time release to provider network.	11/1/2026	3/1/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2026-27 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.f.				**Deliverable #3:** Conduct weekly eReports check-in meetings with the Partnership Web Team to discuss project timeline, BRD revisions, application logic, UAT testing timelines, progress and bugs.	10/1/2026	3/15/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.g.	Partnership Quality Dashboard (PQD)	Continued	**Goal #1:** By June 30, 2027, apply annual development updates of the PCP QIP Provider and Internal View Dashboards in accordance with identified stakeholder needs.	**Deliverable #1:** Work with representatives of the provider network to review all enhancement requests to be included in the Business Requirements Document (BRD) to be reviewed and approved by the Enterprise Data Warehouse (EDW) team for the new measurement year (MY).	7/1/2026	12/31/2026	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Director of Quality Management Name: James Devan Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #2:** Work with stakeholders to submit updated annual dashboard business requirements document (BRD) to developers for review and approval.	7/1/2026	12/31/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #3:** Gain agreements between developers and business owners for identified new business requirements.	1/31/2027	3/31/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #4:** Completion of user acceptance testing (UAT) of dashboards.	5/1/2027	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.g.				**Deliverable #5:** Timely publication of the dashboards in PQD for internal and external use.	5/1/2027	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.h.	Enterprise Information Management	New	**Goal #1:** By June 30 2027, Expand the scope of the datalink to include data for other HEDIS/QIP measures, add additional provider sites and integrate these datasets to PCP QIP and Perinatal QIP programs.	**Deliverable #1:** Work with Datalink to expand the scope of the datasets to include all the HEDIS/QIP measures and add additional provider sites as needed.	7/15/2026	12/31/2026	Title: Senior Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.h.				**Deliverable #2:** Consume the data from datalink to Enterprise Data Warehouse (EDW) and Integrate the same to PCP QIP and Perinatal QIP programs.	8/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.h.		New	**Goal #2:** By June 30, 2027, Extract, Integrate and Automate the HEDIS monthly data from Inovalon Datalake to Enterprise Data Warehouse (EDW) and make the data available for downstream applications & Finance/Other departments.	**Deliverable #1:** Work with HEDIS team & Inovalon vendor to extract, integrate and automate the HEDIS monthly data to Enterprise Data Warehouse (EDW).	8/1/2026	10/31/2026	Title: Senior Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.h.				**Deliverable #2:** Create necessary staging/datamart tables to consume the HEDIS monthly data for downstream applications & Finance/Other departments.	11/1/2026	2/28/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.i.	Dual Eligible Special Needs Plan (D-SNP)	New	**Goal #1**: By June 30, 2027, the Medicare Quality team will compete deliverables associated with initiating a D-SNP product for launch in 2028 including necessary department assessments and development planning.	**Deliverable #1:** By May 31, 2027, the Medicare Quality team will complete the Model of Care (MOC) document for submission to RAC and NCQA/DHCS including serving as subject matter specialists in the MOC 4 draft, tracking and defining changing MOC requirement for Business Owners, and final document preparation.	1/1/2027	5/31/2027	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Manager of Medicare Quality Name: Kimberly Robertello	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.i.				**Deliverable #2:** By June 30, 2027, the Medicare Quality team will develop a comprehensive management plan for DSNP integration across the QI department addressing HEDIS reporting, performance improvement and QIP functionality.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.j.	Conduct Prospective Medical Record Review	Continue	**Goal #1**: By August January 15, 2027, begin and conclude the prospective medical record review to focus on priority measures identified.	**Deliverable #1**: Build Medical Record Project in the Prospective Monthly MY2026 Project. Utilize Inovalon's Electronic Record on Demand, and the supplemental data catalogs to support priority Admin measures.	7/1/2026	8/31/2026	Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.j.				**Deliverable #2**: Update Prospective Medical Record workplan to accommodate new timeline focused on priority measures. Conclude Prospective Medical Record Review Project by Jan. 15, 2027.	7/1/2026	1/15/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2026-27 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
2.k.	Organization-wide Use of HEDIS Data	New	**Goal #1:** By June 30, 2027, QI, EDW, Health Analytics and Fiscal departments will collaborate to give Partnership stakeholders access to HEDIS data through Inovalon's DataLake to support the organization's need to use HEDIS data to drive measure improvement.	**Deliverable #1:** Grant licenses and access to DataLake to the EDW, Health Analytics and Fiscal teams and provide overview of the DataLake structure to ensure and protect data integrity and data interpretation.	7/1/2026	7/31/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho Title: Director of Data Warehouse Name: Arun Saligame Title: Director of Health Analytics Name: Liat Vaisenberg	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.k.				**Deliverable #2:** Create Project Management process to support planning efforts around organization-wide use of HEDIS data to ensure all activities, roles and responsibilities are defined and documented.	7/1/2026	12/31/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
2.k.				**Deliverable #3:** Launch key dashboards built over DataLake that drive HEDIS measure improvement. Provide consultations on HEDIS data as needed.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3. Value Based Payment Programs - QIP											
3.a.	Primary Care Provider Quality Incentive Program (PCP QIP)	New	**Goal #1:** By June 30, 2027, PCP QIP will be leveraged to support identified low-performing providers within the EPE (Enhanced Provider Engagement) program. This support will include provider education, as well as encouragement to increase use of the online data platform monitoring tools, resulting in stronger engagement and improved performance improvement activities.	**Deliverable #1:** The QIP team will partner with the assigned Improvement Advisor to support fulfillment of the EPE program requirements. The team will continue to provide engagement and training as needed, which may include participation in monthly or quarterly practice facilitation meetings.	7/1/2026	6/30/2027	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.b.	Hospital Quality Incentive Program (H-QIP)	New	**Goal #1:** By June 30, 2027, develop the 2028 measurement year Hospital Quality Incentive Program (H-QIP) Measurement set to support Hospital performance Improvement.	**Deliverable #1:** Complete Measure development for 2028 HQIP through tech workgroup meetings and collaboration with hospital representatives and obtain committee approval of the measurement set.	7/1/2026	6/30/2027	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.b.		New	**Goal #2:** By June 30, 2027, develop Partnership's Hospital Quality Symposium for the 2027 H-QIP measurement year.	**Deliverable #1:** Set HQS date, secure venues, caterers, and agenda topics and finalize details of guest speakers, catering, venue details, and registration for event.	7/1/2026	6/30/2027	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.b.		New	**Goal #3:** By June 30, 2027, complete evaluation of the 2025-26 and the 2026 6-Month Bridge H-QIPs.	**Deliverable #1:** Evaluate 2025-26 hospital program performance by measure in comparison to prior measurement years.	7/1/2026	6/30/2027	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.b.				**Deliverable #2:** Evaluate the 6-Month Bridge measurement period in comparison to the prior measurement year.	1/1/2027	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.b.				**Deliverable #3:** Provide Evaluation Summaries for both measure periods to IQI, QUAC, and PAC.	1/1/2027	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.c.	Palliative Care Quality Incentive Program (PC QIP)	New	**Goal #1:** By December 31, 2026, develop a measurement set for the calendar year (CY) 2027 Palliative Care Quality Incentive Program (PC QIP), that supports quality improvement.	**Deliverable #1:** Complete measure development for the CY 2027 PC QIP, including Measure III: Completing a Patient Symptom Assessment, a new measure. This work also includes reviewing the measure logic and provider data reporting process to incorporating any necessary revisions to the specifications manual.	7/1/2026	12/31/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Eva Lopez Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.c.		New	**Goal #2:** By June 30, 2027, complete CY 2026 PC QIP Program Evaluation.	**Deliverable #1:** Complete evaluation of the program's CY 2026 measurement year to monitor performance.	7/1/2026	6/30/2027	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Eva Lopez Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.c.		New	**Goal #3**: By June 30, 2027, the PC QIP will continue to review the Data Validation Framework document to include the payment process for the new measure III, Completion of a Patient Symptom Assessment, along with making any necessary revisions to the payment processes for measure I, avoiding Hospital and Emergency Room admissions, and measure II, Completion of a POLST, to ensure these processes reflect the enhanced validation that is conducted for payment processing accuracy and timeliness.	**Deliverable #1**: Review the Data Validation Framework document to map out the payment process for the new palliative measure, completion of a Patient Symptom Assessment, and the current payment processes for measures I and II to identify any revisions needed to be made to ensure the payment processes are robust and accurate.	7/1/2026	12/31/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager I Name: Eva Lopez Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.c.				**Deliverable #2**: Implement the enhanced Data Validation Framework document processes during payment processing for the Palliative Care QIP measure periods 1 (Jan-June 2026), which will begin in August 2026, and measure period II (Jul-Dec 2026), which will begin in February 2026. The Palliative Care QIP team will monitor this process to identify any additional areas for improvements.	8/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2026-27 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
3.d.	Perinatal Quality Incentive Program (PQIP)	New	**Goal #1:** By June 30, 2027, continue to support ECDS connectivity for all existing and new perinatal QIP providers to complete the DataLInk implmementation process.	**Deliverable #1:** Support contracting with and completing DataLink connection activities by offering education and one-on-one meetings, ensuring all new providers are connected by the end of the 2026 six-month bridge measurement period.	7/1/2026	12/31/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.d.				**Deliverable #2:** In conjunction with other Partnership staff, develop the process for accurately reporting counts of timely prenatal visits with depression screenings extracted from the DataLink data set and reported within the PQIP Perinatal Quality Dashboard.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.d.		New	**Goal #2:** By June 30, 2027, develop the 2028 PQIP measurement set to support perinatal providers to improve timeliness and comprehensive prenatal and postpartum care.	**Deliverable #1:** Meet with internal stakeholders in PQIP Tech Workgroups to develop a comprehensive set of measures for 2028 and obtain committee approval of measurement set.	7/1/2026	6/30/2027	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.d.		New	**Goal #3:** By June 30, 2027, complete evaluation of the FY2025-26 and 2026 6-Month Bridge Perinatal-QIPs.	**Deliverable #1:** Evaluate FY2025-26 Perinatal QIP program performance by measure in comparison to prior measurement years.	7/1/2026	6/30/2027	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.d.				**Deliverable #1:** Evaluate the 6-Month Bridge measurement period in comparison to the prior measurement year.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.d.				**Deliverable #3:** Provide Evaluation Summaries for both measure periods to Internal Quality Improvement (IQI) Committee, Quality and Utilization Advisory Committee (Q/UAC), and Physician Advisory Committee (PAC).	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.e.	Enhanced Care Management Quality Incentive Program (ECM QIP)	New	**Goal #1:** By December 31, 2025, develop a measurement set for the calendar year (CY) 2026 Enhanced Care Management Quality Incentive Program (ECM QIP) that supports quality improvement and aligns with DHCS's requirements.	**Deliverable #1:** Complete measure development for CY 2026 ECM QIP measurement year.	7/1/2026	6/30/2027	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.e.				**Deliverable #2:** Facilitate advisory group meetings with ECM providers who are part of the advisory group to review and offer feedback on new measurement set proposal.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.e.		New	**Goal #2:** By June 30, 2027, support ECM provider training activities to improve provider engagement and performance in the program	**Deliverable #1:** Offer virtual group onboarding trainings monthly to new ECM providers and offer refresher trainings quarterly.	7/1/2026	6/30/2027	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.e.				**Deliverable #2:** Outreach to low-performing ECM providers to offer one-on-one assistance through one-on-one meetings and training, as needed.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.e.		New	**Goal #3:** By June 30, 2027, complete CY 2026 ECM QIP evaluation.	**Deliverable #1:** Complete evaluation of the program's CY 2026 measurement year to monitor performance.	7/1/2026	6/30/2027	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.f.	Dual Eligible Special Needs Plan (D-SNP) Quality Incentive Program (QIP) Development	New	**Goal #1:** By June 30, 2027, the D SNP Quality Incentive Program (QIP) will develop and deliver a comprehensive measure specification, system alignment, and operational readiness.	**Deliverable #1:** Develop a comprehensive measure set that incorporates D SNP programmatic language and detailed measure rationale. Measures will be updated in alignment with CMS guidelines, including replacements or revisions issued by CMS.	7/1/2026	6/30/2027	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Director of Quality Management Name: James Devan Title: Manager of Medicare Quality Name: Kimberly Robertello	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.f.				**Deliverable #2:** Determine the D-SNP QIP system design and assess whether it will be developed internally within PHC or delivered through an outsourced vendor solution. Approval from all stakeholders will be required before proceeding.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.f.				**Deliverable #3:** Define the strategic direction of the D SNP program, establishing clear scope, stakeholder responsibilities, system needs, and detailed measure requirements to guide alignment, and downstream implementation.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2026-27 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
3.g.	Extended Care Center Quality Incentive Program (EXT QIP)	New	**Goal #1:** By June 30, 2027, develop a measurement set for the calendar year (CY) 2027 Extended Care Center Quality Incentive Program (EXT QIP) that supports quality improvement.	**Deliverable #1:** Complete measure development for CY 2027 EXT QIP measurement year.	7/1/2026	6/30/2027	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Program Manager I Name: Deanna Watson Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.g.				**Deliverable #2:** Facilitate advisory group meetings with selected EXT providers to review and offer feedback on proposed measurement set.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.g.		New	**Goal #2:** By June 30, 2027, support EXT provider training to improve provider engagement and performance in the program.	**Deliverable #1:** Host kick-off webinar and one-on-one training, as needed, to assist EXT providers with program questions.	7/1/2026	6/30/2027	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Program Manager I Name: Deanna Watson Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.g.				**Deliverable #2:** Outreach to low-performing EXT providers to offer one-on-one virtual meetings and training, as needed.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.g.		New	**Goal #3:** By June 30, 2027, participate in Skilled Nursing Facility (SNF) workgroup with a focus to engage providers and improve performance and quality.	**Deliverable #1:** Perform mid-year good standing review to share with SNF workgroup with a goal to outreach to low-performing providers	7/1/2026	6/30/2027	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Program Manager I Name: Deanna Watson Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
3.g.				**Deliverable #2:** Outreach to low-performing EXT providers to offer assistance, as needed.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4. Improvement Projects and Programs, Clinical Quality											
4.a.	Healthy Kids Growing Together Program	Continued	**Goal #1:** By June 30, 2027, 50% of the members who agreed to participate in the Healthy Kids Growing Together Program must attend their annual well-child visit prior to their 3rd,4th, 5th and 6th birthdays. This program includes any 3 - 6 year old who has never had a well-child visit in the last eleven (11) months and offers an incentive to members who have birthdays within the upcoming 120 days and complete a well-child visit within 90 days of the outreach prior to their next birthday. This will be completed by sending reminder mailers to the entire eligible population and conducting up to two outbound phone calls to members with birthdays within the upcoming 120 days.	**Deliverable #1:** Continue workflow practice of reviewing claims data to verify attendance for a well-child visit in the last 11 months for program eligibility.	7/1/2026	6/30/2027	Title: Director of Population Health Name: DeLorean Ruffin, DrPH, MPH	Title: Manager of Population Health Name: Cynthia Galicia-Huizar	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.a.				**Deliverable #2:** Post engagement, if the claim does not reflect a well-child visit, follow up with the Primary Care Provider (PCP) to confirm whether the visit occurred and obtain any necessary documentation.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.a.				**Deliverable #3**: Include results of this program & interventions in the 2027 Impact Analysis report (reporting on data from 2026).	5/1/2027	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.b.	Mobile Mammography Program	New	**Goal #1**: By June 30, 2027, the Mobile Mammography/Your Partner in Prevention Team will identify and implement strategies for executing wellness days to close multiple care gaps through targeted events and cross-functional collaboration.	**Deliverable #1:** By December 31, 2026, collaborate with the Performance Improvement Team to develop a strategic plan for incorporating multiple measures into single wellness days to close multiple care gaps.	7/1/2026	12/31/2027	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Areli Carrillo Title: Project Manager I Name: Devan Wilson	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.b.				**Deliverable #2**: By March 31, 2027, implement at least one (1) of the developed strategies.	7/1/2026	3/31/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.b.				**Deliverable #3**: By June 30, 2027, evaluate the effectiveness of the implemented strategies using defining metrics, and develop a recommendation to adapt, adopt, abandon and scale the most effective approaches.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.b.		New	**Goal #1**: By June 30, 2027, the Mobile Mammography/Your Partner in Prevention Team will work to increase access to breast cancer screening (BCS).	**Deliverable #1:** By December 31, 2026, identify and partner with at least one (1) imaging center to develop standard criteria and workflows to support scalable partnerships (e.g., referral pathways, dedicated scheduling blocks, navigation support, etc.).	7/1/2026	12/31/2027	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Areli Carrillo Title: Project Manager I Name: Devan Wilson	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.b.				**Deliverable #2**: By June 30, 2027, collaborate with Partnership's Regional Administration Team to organize community-based Mobile Mammography events to engage at least two (2) provider organizations with breast cancer screening denominators too low to host their own event days.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2026-27 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
4.b.				**Deliverable #3**: By June 30, 2027, evaluate the effectiveness of imaging center and community-based event day strategies using defined metrics (e.g., screenings completed, appointment utilization, time-to-screening, and provider adoption), and develop a recommendation to adapt, adopt, abandon and scale the most effective approaches across additional counties with similar access constraints.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.c.	QI3 - Performance Improving Planning for low Scoring HPA measures	Continue	**Goal #1**: By June 30, 2027 the Performance Improvement (PI) and HEDIS teams will meet the factor QI - 3 Factors B and C requirements for Health Plan Accreditation Renewal, including identifying low scoring measures, selecting measures of focus for improvement, and developing an improvement plan for remediation.	**Deliverable #1**: HEDIS team will provide Health Plan ratings scoresheet, which identifying measures performing at a score of "1" or "0".	7/1/2026	7/11/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown	Title: Director of Quality Management Name: James Devan	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.c.				**Deliverable #2:** The PI team will select a measure or measures of focus for improvement : " at least one required measure for which the organization received a rating of "1" or "0".	7/1/2026	8/1/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.c.				**Deliverable #3:** The PI team will develop an improvement plan related to the measure or measures of focus selected in deliverable two and documents "all actions the organization plans to take, or has already taken, to improve each measure's rating".	8/1/2026	8/30/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
4.c.				**Deliverable #4:** The PI team will Monitor progress through monthly check-ins and utilize PDSA cycles as needed.	8/30/2026	12/31/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
5. Service and Patient Experience											
5.a.	Member Experience Data	Continued	**Goal #1:** By June 30, 2027, launch the annual CAHPS® survey for Measure Year (MY) 2026 Reporting Year (RY) 2027 and collect data to include G&A case filings by NCQA reporting categories.	**Deliverable #1:** By December 30, 2026, present Measure Year (MY) 2025 / Report Year (RY) 2026 CAHPS® and Member Experience result to internal and external committees.	7/1/2026	12/31/2026	Title: Director of Member Experience Name: Irem Conery	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
5.a.				**Deliverable #2**: By June 30, 2027, confirm HEDIS® team Measure Year (MY) 2026 sample frame submission to Press Ganey, launch survey, and collect results as part of the NCQA member experience process.	7/1/2026	1/29/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
5.a.				**Deliverable #2**: By June 30, 2027, continue the fiscal/quarterly year process to collect and analyze Grievance & Appeals data. Ensure stakeholders at a minimum meet quarterly or as needed to review data compared to prior and current year CAHPS® survey results.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
5.b.	Complex Case Management	Continued	**Goal #1:** By June 30, 2027, we will ensure that Partnership remains compliant with the National Committee for Quality Assurance (NCQA) Population Health Management Standard (PHM) 5, in support of achieving Accredited status by December 2026 and maintaining it thereafter. This will be demonstrated through the results of our upcoming NCQA renewal audit, along with ongoing quarterly internal compliance audits of Complex Case Management (CCM) to sustain overall file compliance.	**Deliverable #1:** Review and approve combined Year 1 and Year 2 evidence.	7/1/2026	7/31/2026	Title: Senior Director of Care Management Name: Brigid Gast	Title: Manager of Care Coordination Name: Shannon Boyle Title: CC Regulatory Performance Manager Name: Alyssa Beard	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
5.b.				**Deliverable #2:** Submit file universe.	8/19/2026	9/9/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
5.b.				**Deliverable #3:** Prepare, bookmark and annotate the files selected by NCQA on or before October 28, 2026.	9/1/2026	10/28/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
5.b.				**Deliverable #4:** Review the prepared files with the NCQA Surveyors during the Virtual File Review sessions on November 2-3, 2026	10/20/2026	11/3/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
5.b.				**Deliverable #5:** Review the 2027 HPA Standards and Guidelines, evaluate the updates, assess impact, and complete the Gap Analysis tied to assigned requirements. • 2027 HPA Summary of Changes • 2027 HPA November Triannual Policy Updates	12/11/2026	1/8/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
5.b.				**Deliverable #6:** Update the annual HPA Workbook (Work Plan, Evidence Submission Library and Report Schedule), based on the 2027 HPA Standards and Guidelines.	1/22/2027	2/19/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2026-27 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
5.b.				**Deliverable #7:** Achieve HPA compliance and maintain readiness as demonstrated by the following activities: • File Review: Maintain strict oversight of Partnership and non-Accredited delegates' files o To ensure compliance once the new Jiva is available, Care Coordination will participate at Mock File Review with the NCQA Consultant on or before Q2 2027. o Continue the quarterly audit of Partnership files and share results with the NCQA Program Management Team, who will provide regular updates to the NCQA Steering Committee. Business Owners will implement an Action Plan for files that do not score "yes" on each factor.	1/1/2027	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
	6. Quality Assurance and Patient Safety										
6.a.	Potential Quality Issues (PQI) (safety)	New	**Goal #1:** By June 30, 2027, QI Member Safety Quality Investigation team will provide in-services to at least two other Partnership Departments/teams to educate on Potential Quality Issues (PQI) and how to refer. In addition, the team will monitor referral track and trending reports to determine if inservice training results in an increase in PQI referrals from respective departments/teams.	**Deliverable #1:** Review and update the PQI PowerPoint presentation to ensure the information is accurate, current, and appropriately tailored and aligned with the needs of the target staff and department.	7/1/2026	12/31/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #2:** Offer and deliver the PQI presentation to at minumum two internal department teams (e.g. Utilization Management department teams-Inpatient/Outpatient/LTC, Care Coordination nurses, Enhanced Health Services nurses, and Grievance & Appeals nurses).	7/1/2026	6/30/2027	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #3:** Send a post-presentation survey to attendees to capture feedback and improvement opportunities.	7/1/2026	6/30/2027	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #4:** Evaluate referral tracking and trend data to determine if in-service education results in increased and appropriate PQI referrals from participating departments.	7/1/2026	6/30/2027	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #5**: Review and update the PQI Referral Form Reference Table to enhance staff ability to identify concerns or issues that may meet PQI criteria.	7/1/2026	12/31/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.a.		New	**Goal #2**: By June 30, 2027, the Member Safety Investigations Team will establish a categorized directory of Quality Contacts for providers across our service areas. Development will begin with a limited group of providers currently involved in PQI investigations, with plans to progressively expand the directory.	**Deliverable #1:** Create a directory of Quality Contacts within our service area, categorizing them by type of organization (e.g. Hospital, Primary Care Provider, Specialist).	7/1/2026	12/31/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.a.				**Deliverable #2:** Develop a desktop reference tool to facilitate the ongoing maintenance and updating of Quality Contact information.	7/1/2026	6/30/2027	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.b.	Focused Mini Audits	New	**Goal #1:** By June 30, 2027, the site review inspections team will create and implement a focused mini audit process. Complete 15 fluoride varnish focused mini audits.	**Deliverable #1:** Develop a desktop and eTool.	7/1/2026	12/31/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman Title: Supervisor of Clinical Compliance Name: Jackie Krznarich	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.b.				**Deliverable #2:** Complete 15 fluoride varnish focused mini audits.	7/1/2025	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.c.	OB Reporting Methodology	New	**Goal #1:** By June 30, 2027, the site review inspections team will create and implement an OB reporting methodology document.	**Deliverable #1:** Develop a desktop for running OB site review data.	7/1/2026	12/31/2026	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman Title: Supervisor of Clinical Compliance Name: Jackie Krznarich	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.c.				**Deliverable #2:** Ability to report, at site level, Facility Site Review (FSR) and Medical Record Review (MRR) scores.	7/2/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2026-27 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
6.d.	Latent TB Infection Treatment (safety)	Continued	**Goal #1:** By June 30, 2027, a clinical pharmacist will conduct concurrent review of Latent Tuberculosis Infection (LTBI) medication treatments and provide timely notification of all identified potential LTBI treatment regimen gaps, which result from late refill, non-adherence, inappropriate prescribing, and/or inappropriate dispensing. The regimens to be monitored will include 30-doses of isoniazid/rifapentine (1HP), 12-doses of isoniazid/rifapentine (3HP), 90-doses of isoniazid/rifampin (3HR), 120-doses of rifampin (4R), and 180-doses of isoniazid (6H).	**Deliverable #1:** Pharmacist will identify potential treatment gaps and provide notification to prescribers within two timeframes: day 16 and day 20. • Pharmacist will identify and notify providers (via fax) whose members are ≥14 days late in refilling their prescribed LTBI medication. • ≥ 80% of identified potential non-adherence cases will receive provider notification (via fax) no later than day 16 of their member not having their LTBI medication based on the last refill date. • ≤ 20% of the identified potential non-adherence cases will receive provider notification (via fax) no later than day 20 of their member not having their LTBI medication based on the last refill date. Pharmacist will verify gap and confirm member's prescribed LTBI regimen was not completed in the accepted timeframe. • Pharmacist will provide notification to prescribers (via fax) of their member's potential non-adherence to their prescribed LTBI regimen.	7/1/2026	6/30/2027	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.d.				**Deliverable #2:** Pharmacist will monitor for inappropriate prescribing of LTBI 1HP, 3HP, 3HR, 4R, and 6H regimens. • Pharmacist will identify and provide information for correct prescribing of LTBI regimen. • Pharmacist will notify prescriber (via fax) possible incorrect prescribing of LTBI regimen.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.d.		Continued	**Goal #2:** By June 30, 2027, a clinical pharmacist will provide Latent Tuberculosis Infection (LTBI) summary updates to Partnership's Medical Directors and to the County Public Health Officers.	**Deliverable #1:** Pharmacist will provide semi-annual LTBI summary updates to Partnership's Medical Directors for tracked LTBI regimens (identified late fills, identified possible non-adherence to regimen, actions taken, and results of provider outreach).	7/1/2026	6/30/2027	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
6.d.				**Deliverable #2:** Pharmacist will provide quarterly update of PHC members who are prescribed a LTBI regimen and the current status of that LTBI regimen to the County Public Health Officers.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
	7. Quality Improvement Training and Coaching										
7.a.	Improving Rural Upper Central Regional Performance	New	**Goal #1:** By December 31st, 2026 earn 72.5 points in the DHCS Withhold strategy for the Rural Upper Central (RUC) Financial Rating Region in MY 2026. This goal will be able to be measured with final data at the end of June, 2027.	**Deliverable #1:** By the end of MY 2026, at least 80% of the 2026 Enhanced Provider Organizations will improve by at least 10% points in 2 of the 4 chosen measures of focus in MY 2026 compared to MY 2025 PCP QIP scores.	7/1/2026	3/15/2027	Title: Director of Quality Management Name: James Devan	Title: Manager of Performance Improvement Name: Brandy Isola	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.a.				**Deliverable #2:** By the end of MY 2026, at least 80% of Provider Organizations that scored more than 25% of clinical points and had more than 1,000 members assigned in MY 2025 will increase their 2026 PCP QIP performance on their total, final clinical points by at least 5% points.	7/1/2026	3/15/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.a.				**Deliverable #3:** By December 1, 2026, pilot a provider engagement scoring methodology and integrate it into a Provider coaching tactical plan for all Chico and Auburn Region provider organizations that have more than 10,000 members assigned.	7/1/2026	12/1/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.a.				**Deliverable #4:** By May 30, 2027, iterate a second-generation provider engagement scoring methodology and coaching tactics for different levels of engagement.	7/1/2026	6/1/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.a.				**Deliverable #5:** By May 1, 2027 support leadership academy participants through the successful implementation of a Quality Improvement project.	7/1/2026	5/1/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.a.				**Deliverable #6:** By April 30th, 2027 hold at least one Joint Leadership Initiative meeting with the 4 largest Provider Organizations (measured by member assignment) that are earning less than 75% of clinical points.	7/1/2026	4/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.a.				**Deliverable #7:** By December 1, 2026, pilot a provider engagement scoring methodology and integrate it into a Provider coaching tactical plan for all Chico and Auburn Region provider organizations that have more than 10,000 members assigned.	7/1/2026	12/1/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.a.				**Deliverable #8:** Share a measure best practice toolkit at least 4 of the Regional Quality meetings from July 1, 2026 through June 30th, 2027.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2026-27 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
7.b.	Improving Rural Upper North Regional Performance	New	**Goal #1:** By June 30, 2027, increase the number of Upper Rural North counties achieving Tier1 performance from 0 to 2.	**Deliverable #1:** Meet with key providers performing <66.67th regarding barriers and improvement strategies.	7/1/2026	12/31/2026	Title: Director of Quality Management Name: James Devan	Title: Manager of Performance Improvement Name: Tiffany Tryan	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.b.				**Deliverable #2:** Explore coaching optimization by leveraging HANC/NCCN Provider Education, training resources, and improvement activity support for targeted measures.	7/1/2026	12/31/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.b.				**Deliverable #3:** Track measure-level and county level performance to ensure progress towards Tier 1 advancement and adjust strategies as needed.	7/1/2026	12/31/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.b.		New	**Goal #2:** By June 30, 2027, increase earned points under the Quality Withhold for MY2026 from 71 to 75.	**Deliverable #1:** Provide Measure-Specific education to regional provider network.	7/1/2026	12/31/2026	Title: Director of Quality Management Name: James Devan	Title: Manager of Performance Improvement Name: Tiffany Tryan	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.b.				**Deliverable #2:** Meet with key partners (under-performing practices and community stakeholders regarding barriers and strategies for improvement.	7/1/2026	12/31/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.b.				**Deliverable #3:** Explore coaching optimization by leveraging HANC/NCCN Provider Education, training resources, and improvement activity support for targeted measures.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.b.		New	**Goal #3:** By June 30, 2027, demonstrate the projected performance for MCAS clinical measures is on track to earn at least 80 final points under the Improvement Points criteria for MY2027.	**Deliverable #1:** Provide Measure-Specific Education to regional provider network.	1/1/2027	6/30/2027	Title: Director of Quality Management Name: James Devan	Title: Manager of Performance Improvement Name: Tiffany Tryan	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.b.				**Deliverable #2**: Meet with key partners (under-performing practices and community stakeholders regarding barriers and strategies for improvement.	1/1/2027	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.b.				**Deliverable #3:** Explore coaching optimization by leveraging HANC/NCCN Provider Education, training resources, and improvement activity support for targeted measures.	1/1/2027	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.c.	Improving North Bay Regional Performance	New	**Goal #1:** By June 30, 2027, maintain 78 points earned in the North Bay Rating Region for Clinical Withhold measures in Measurement Year 2026.	**Deliverable #1:** Provide at least 1 measure-specific strategy "toolkit" to the regional provider network to support improvement in a high risk/underperforming Withhold measure (WCV, GSD).	7/1/2026	6/30/2027	Title: Director of Quality Management Name: James Devan	Title: Sr. Manager of Performance Improvement Name: Jennifer Durst	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.c.				**Deliverable #2:** Meet with key partners (under-performing practices, hospitals, counties, etc.) regarding barriers and strategies for improvement.	7/1/2026	9/30/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.c.				**Deliverable #3:** Support key partners with implementation of improvement strategies.	7/1/2026	12/31/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.c.		New	**Goal #2:** By June 30, 2027, improve percentage of counties in the North Bay rating region who fall into the Tier 1 Community Reinvestment from 40% to 60% (as evidenced by HEDIS data from MY 2026) by focusing on improvements in high impact measures.	**Deliverable #1:** Collaborate with regional consortia on at least one strategy to improve an underperforming measure in a Tier 2 county.	7/1/2026	12/31/2026	Title: Director of Quality Management Name: James Devan	Title: Sr. Manager of Performance Improvement Name: Jennifer Durst	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.c.				**Deliverable #2:** Conduct or support improvement projects that have potential to improve high impact measures in Tier 2 Counties.	7/1/2026	12/31/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2026-27 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
7.c.				**Deliverable #3:** Publish at least one storyboard per Tier 2 county showcasing the impact of the improvement project in a high impact measure.	7/1/2026	6/30/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.d.	Performance Improvement Training Offerings	New	**Goal #1:** By June 30, 2027, pilot a multi-tiered Quality Improvement (QI) training framework -- foundational (ABCs of Quality Improvement); intermediate (Performance Improvement in Action), and advanced (QI Project Training Program) -- by successfully developing and delivering the first two training programs in the sequence.	**Deliverable #1:** By December 31, 2026, pilot the Performance Improvement in Action training program.	7/1/2026	12/31/2026	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Sr. Manager of Performance Improvement (SR) Name: Jennifer Durst Title: Manager of Performance Improvement (NR) Name: Tiffany Tryan	Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.d.				**Deliverable #2:** By June 30, 2027, develop a visual pathway and messaging framework to show the ideal learner progression sequence.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.d.				**Deliverable #3:** By June 30, 2027, earn an 80% extremely satisfied rating among surveyed ABCs of Quality Improvement participants. .	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.e.	QI Project Toolkit & Training Program	New	**Goal #1**: By June 30, 2027, the QI Project Training Team will evaluate, identify, and begin implementing a sustainable asynchronous solution for the QI Project Training Program to improve accessibility, scalability, and consistency of training delivery.	**Deliverable #1**: By December 31, 2026, identify and evaluate platform options and develop a structured transition plan for moving the current QI Project Training Program to an asynchronous format, including key requirements, constraints, and a proposed delivery structure.	6/1/2026	12/31/2026	Title: Senior Director of Quality and Performance Improvement Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Anwar Hugais Title: Project Manager I Name: Devan Wilson	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
7.e.				**Deliverable #2**: By June 30, 2027, based on the outcomes of the platform evaluation, execute the transition plan and launch the QI Training Program in an asynchronous format, including a defined go-live date and initial rollout.	1/1/2027	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
	8. Delegation Oversight										
8.a	QI Delegation Oversight	Continued	**Goal #1:** By June 30, 2027, demonstrate strong delegation oversight process in support of delegation standards and Partnership policies and procedures.	**Deliverable #1:** Quarterly and yearly review of delegation committee reports and delegated activities based on submitted documents. Present findings at the Delegation Oversight Committee (DORS) meetings with recommendations.	7/1/2026	6/30/2027	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
8.a				**Deliverable #2:** Participation with the annual delegation audits by Partnership Compliance department. Submit audit findings within required timeframe.	7/1/2026	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
	9. NCQA Program Management										
9.a.			**Goal #1:** By June 30, 2027, departments will maintain compliance with all assigned NCQA Health Outcomes Accreditation (HOA) Standards and Guidelines, following the 2027 HOA Standards and Guidelines once available, and prepare for the HOA Renewal Survey in May 2028, as measured by the five (5) deliverables listed below.	**Deliverable #1:** By October 23, 2026, Business Owners will review the 2027 HOA Standards and Guidelines, evaluate the updates, assess impact, and complete a Gap Analysis. The NCQA Program Management Team will share the Summary of Changes and the Gap Analysis by October 6, 2026.	10/6/2026	10/23/2026		Compliance, Health Equity, Human Resources, IT, Member Services, Network Services,	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
9.a.				**Deliverable #2:** By December 4, 2026, Business Owners will update the annual HOA Workbook (Work Plan, Evidence Submission Library, and Report Schedule), based on the 2027 HOA Standards and Guidelines: •Review and/or update the HOA Work Plan information; collect attestations from newly identified Contributors and/or Business Sponsors if applicable. •Review and/or update the Evidence Submission Library based on the standards' changes and clarifications. All evidence must be produced, dated, and aligned with NCQA's look-back period and timelines, and confirmed under the Evidence Submission Library. Any date changes or document revisions must be reviewed and agreed upon by the NCQA Program Management Team in collaboration with the NCQA Consultant. •Review and/or update the 2026-2028 HOA Report Schedule, if applicable. Submit the analysis reports for the NCQA Consultant's review, based on the draft report date confirmed under the HOA Report Schedule. All edits and recommendations from the NCQA Consultant must be incorporated in a timely manner prior to any committee review and/or approval, or by the production date as agreed upon under the 2026-2028 HOA Report Schedule. •Contributors identified from FY 25-26 should share their questions with Business Owners for further evaluation and discussion. Submissions of 2027 HOA Workbooks that do not follow the instructions are considered incomplete. The NCQA Program Management Team will request the Business Owner make corrections and resubmit the workbooks, which may cause a delay in meeting the submission deadline. The NCQA Program Management Team will share the annual HOA Workbook by November 4, 2026.	11/4/2026	12/4/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2026-27 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
9.a.	Compliance with NCQA HOA and Sustain Performance	New	In addition, all Business Owners are required to review NCQA clarifications, including the Triannual Policy Updates and Monthly FAQs, and provide a timely acknowledgement. Subsequent edits to the evidence must be addressed as soon as possible to meet compliance in accordance to NCQA's look-back period, timelines and/or expectations. Any revisions to the final program documents (Work Plan, Report Schedule, and Evidence Submission Library) must be communicated to the NCQA Program Management Team within seven (7) calendar days.	**Deliverable #3:** By February 4, 2027, Business Owners will submit all annotated evidence for the HOA Mock Renewal Survey (scheduled for March 22-23, 2027) based on the dates listed in the Evidence Submission Library for Year 1 of the look-back period, and the submission guidelines provided by the NCQA Program Management Team. The NCQA Program Management Team will communicate details, including sharing an Evidence Submission Tracker, by January 14, 2027.	1/14/2027	2/4/2027	Title: Director of Quality Measurement Name: Kristine Gual	Population Health, Quality Improvement Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue McMurray	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
9.a.				**Deliverable #4:** Obtain a "yes" score on all assigned elements during the HOA Mock Renewal Survey. If gaps are identified on Year 1 evidence, Business Owners will: •By April 27, 2027, submit an Action Plan (AP) to address any applicable recommendations. •Correct the evidence by the applicable look-back period, timelines, and/or expectations by NCQA. Any revised or new evidence must be submitted to MHR for review and approval and must align with the timeline of committee meetings for review. No edits should be made without review and/or assessment by the NCQA Consultant. •After the Mock Survey, any modifications to approved evidence that affect NCQA requirements, including documented processes, must be shared with the NCQA Program Management Team for review and further assessment prior to the effective/production date. The NCQA Program Management Team will share the AP by April 13, 2027.	4/13/2027	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
9.a.				**Deliverable #5:** All Business Owners must confirm and/or submit the following to meet the look-back period for each assigned standard: •Documented Processes: By February 4, 2027, provide acknowledgement that documented processes meet the scope of review throughout the Year-2 look-back period. Any revisions that impact NCQA requirements must be finalized in April 2027, including timely review by the NCQA Consultant and approval at committee meetings. No edits should be made without review and/or assessment by the NCQA Consultant. •Materials: By April 15, 2027, submit all applicable screenshots for the Year-2 look-back period, as indicated under the Evidence Submission Library to demonstrate that compliance is met.	1/14/2027	4/15/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
9.b.				**Deliverable #1:** Partnership obtains an Accredited status by December 2026. The deliverables include: •Review and approve combined Year 1 and Year 2 evidence on or before July 31, 2026 •Submit all annotated evidence for the selected credentialing delegates and PHM 1B Programs on or before August 26, 2026 (applicable to Network Services and Population Health only). •Submit file universe, including delegates, on or before September 9, 2026 (applicable to Network Services, Utilization Management, Pharmacy, Grievance and Appeals, and Care Coordination). •Participate in Survey Conference Call with NCQA, prepare responses and provide additional clarifying documentation, if applicable, based on the Initial Issues Report. •Prepare, bookmark and annotate the files selected by NCQA on or before October 28, 2026. •Review the prepared files with the NCQA Surveyors during the Virtual File Review sessions on November 2-3, 2026 (applicable to Network Services, Utilization Management, Pharmacy, Grievance and Appeals, and Care Coordination). •Prepare responses, if applicable, based on the Preliminary Report.	10/6/2026	10/23/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
9.b.				**Deliverable #2:** If the accreditation status is Provisional or Accredited under Corrective Action, Partnership will: •Option 1 (Accredited – Under Corrective Action): If Partnership does not meet the minimum threshold for one (1) or more must-pass requirements, impacted Business Owners will prepare a Corrective Action Plan (CAP), which is due to NCQA within 30 calendar days of receipt of the final Accreditation status, i.e. January 2027. The CAP must detail how Partnership intends to address the identified must-pass element deficiencies. NCQA advises the organization if the CAP is approved. Partnership must then undergo a CAP Survey that focuses on the failed must-pass elements. The CAP Survey often includes file review. Specific timeline details will be provided by NCQA. •Option 2 (Provisional): If Partnership scored above 55% but below 80% of the total applicable points in any standard category, it must undergo a Resurvey within 12 months of the Accreditation decision. NCQA resurveys and scores performance on all elements that received a score of Partially Met or Not Met. The Resurvey look-back period is six (6) months. Impacted Business Owners must implement action to address the identified findings and follow-up on areas of improvement on or before June 2027. •Option 3 (Provisional – under Corrective Action): If a CAP Survey (required if one or more must-pass elements are not scored "Met") and Resurvey (required if the organization's score is below 80% in any standards category following a Full Survey) are required at the same time, NCQA will review the completion of the CAP during the Resurvey. The required steps to complete the CAP Survey and Resurvey are outlined under Options 1 and 2.	11/4/2026	12/4/2026			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2026-27 Quality Improvement Work Plan											
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**
9.b.	Compliance with NCQA HPA and Sustain Performance	New	**Goal #1:** By June 30, 2026, departments will maintain compliance of all assigned NCQA Health Plan Accreditation (HPA) Standards and Guidelines, and prepare for the HPA Renewal Survey in September 2026, as measured by the six (6) deliverables listed.	**Deliverable #3**: By January 8, 2027, review the 2027 HPA Standards and Guidelines, evaluate the updates, assess impact, and complete the Gap Analysis tied to your assigned requirements. If further clarification is needed, please share your questions with the NCQA Program Management Team, who will support and facilitate follow-up discussion •2027 HPA Summary of Changes •2027 HPA November Triannual Policy Updates The NCQA Program Management Team will provide the Summary of Changes, November Triannual Policy Updates, and Gap Analysis by December 11, 2026.	1/14/2027	2/4/2027	Title: Director of Quality Measurement Name: Kristine Gual	Behavioral Health, Compliance, Care Coordination, Grievance & Appeals, Health Equity, Human Resources, IT, Member Services, Network Services, Pharmacy, Population Health, Quality Improvement, Utilization Management Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue McMurray	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
9.b.				**Deliverable #4**: By February 19, 2027, Business Owners will update the annual HPA Workbook (Work Plan, Evidence Submission Library and Report Schedule), based on the 2027 HPA Standards and Guidelines: •Review and/or update the HPA Work Plan information; collect attestations from newly identified Contributors and/or Business Sponsors if applicable. •Review and/or update the Evidence Submission Library based on the standards' changes and clarifications. All evidence must be produced, dated, and aligned with NCQA's look-back period and timelines, and confirmed under the Evidence Submission Library. Any date changes or document revisions must be reviewed and agreed upon by the NCQA Program Management Team in collaboration with the NCQA Consultant. •Review and/or update the 2027-2029 HPA Report, if applicable. Submit the analysis reports for the NCQA Consultant's review, based on the draft report date confirmed under the Report Schedule. All edits and recommendations from the NCQA Consultant must be incorporated in a timely manner prior to any committee review and/or approval, or by the production date as agreed upon under the 2026-2028 HOA Report Schedule. •Contributors identified from FY 25-26 should share their questions with Business Owners for further evaluation and discussion. Submissions of 2027 HPA Workbooks that do not follow the instructions are considered incomplete. The NCQA Program Management Team will request the Business Owner make corrections and resubmit, which may cause a delay in meeting the submission deadline. The NCQA Program Management Team will share the annual HPA Workbooks by January 22, 2027.	4/13/2027	6/30/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
9.b.				**Deliverable #5**: From July 1, 2026 – June 30, 2027, achieve HPA compliance and maintain readiness as demonstrated by the following activities: •File Review: Maintain strict oversight of Partnership and non-Accredited delegates' files •To ensure compliance once the new Jiva is available, Utilization Management, Pharmacy, Grievance and Appeals, and Care Coordination will participate at Mock File Review with the NCQA Consultant on or before Q2 2027. •To ensure compliance throughout the 36-month look-back period, the Network Services Department will participate at a Mock File Review with the NCQA Consultant on or before Q2 2027. •Continue the quarterly audit of Partnership files and share results with the NCQA Program Management Team, who will provide regular updates to the NCQA Steering Committee. Business Owners will implement an Action Plan for files that do not score "yes" on each factor. •Continue ongoing monitoring of files from non-Accredited delegates. Provide regular updates, including the annual audit results and risks identified, with the NCQA Program Management Team. More frequent monitoring may be required, if applicable. These updates will be shared with the NCQA Steering Committee. •Analysis Reports: Complete the reports based on the approval date indicated in the HPA Report Schedule. All reports must be submitted to Consultant for review, and all edits must be incorporated prior to its approval.	1/14/2027	4/15/2027			**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
	10. Grand Analysis										
10.a.	Grand Analysis - Pharmacy and Utilization Management (UM1G) Report	Continued	**Goal #1:** By June 30, 2027, complete the annual Pharmacy & Utilization Management Grand Analysis (UM1G) report per NCQA Health Plan Accreditation standards.	**Deliverable #1:** Complete annual Pharmacy & UM Program Evaluation (UM1G) for MY2026	7/1/2026	6/30/2027	Title: Chief Health Services Officer Name: Katherine Barresi	Title: Clinical Pharmacist Name: Andrea Ocampo Title: Associate Director of UM Regulations Name: Tony Hightower	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	
10.a.	Grand Analysis - Access and Availability (NET3) Report	Continued *(Monitoring of previous issue)*	**Goal #1:** By June 30, 2027, the 2025 NET 3 Report will be complete.	**Deliverable #1:** Complete the NET 3 Report	1/1/2027	6/15/2027	Title: Director of Network Services Name: Priscila Ayala	Title: Manager of Network Services Compliance Name: Renee Trosky	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☐ Terminated	

2026-27 Quality Improvement Work Plan - Monitoring of Previous Issues

Item #	Project/Program	26/27 Goal	Status	Monitoring of Previous Issues (FY 2025-26)
1. QI Program Infrastructure				
1.a.	QI Program Documents		N/A	
1.b.	Strengthen QI Trilogy Document Alignment		N/A	
1.c.	Physician Advisory Committee (PAC) Oversight of QI Program		N/A	
2. Measurement, Analytics and Reporting				
2.a.	HEDIS Reporting	**Goal #2:** By April 30, 2027, launch the HEDIS MY2027 Monthly Project in Inovalon to include data reporting for NCQA Health Plan Accreditation (HPA) and DHCS Managed Care Accountability Set (MCAS) to include all (24) county level reporting.	N/A	This goal is dependent on the timing of the HRP Implementation Go-Live date and may be adjusted due to impact.
2.b.	Member Experience Data		N/A	
2.c.	Member Services Access		N/A	
2.d	Primary Care Provider Quality Incentive Program (PCP QIP) Payment Process Reporting		N/A	
2.e.	Web Based Member Information Assessment		N/A	
2.f.	Primary Care Provider Quality Incentive Program (PCP QIP) eReports System	**Goal #1:** By June 30, 2027, PCP QIP will continue collaborating with the Partnership Web Team to align 2027 eReports with HRP® (Health Rules Payor) data elements in preparation for the launch of HRP®.	Continued	eReports team has been unsuccessful with launching eReports with HRP® (Health Rules Payor) data due to continued delays of HRP® implementation. Tentative date of HRP® go live is TBD.
2.g.	Partnership Quality Dashboard (PQD)		N/A	
2.h.	Enterprise Information Management		N/A	
2.i.	Dual Eligible Special Needs Plan (D-SNP)		N/A	
2.j.	HEDIS Reporting to Support DSNP Data Collection and Analysis		N/A	
2.k.	Conduct Year Round Medical Record Review		N/A	
3. Value Based Payment Programs (QIP)				
3.a.	Primary Care Provider Quality Incentive Program (PCP QIP)		N/A	
3.b.	Hospital Quality Improvement Program (H-QIP)		N/A	
3.c.	Palliative Care Quality Incentive Program (PC QIP)		N/A	
3.d.	Perinatal Quality Incentive Program (PQIP)		N/A	
3.e.	Enhanced Care Management Quality Incentive Program (ECM QIP)		N/A	
3.f.	Dual Special Needs Plan (D-SNP) Quality Incentive Program (QIP) Development		N/A	
3.g.	Extended Care Center Quality Incentive Program (EXT QIP)		N/A	
4. Improvement Projects and Programs, Clinical Quality				
4.a.	Healthy Kids Growing Together Program		N/A	
4.b.	Mobile Mammography Program		N/A	
4.c.	QI3 - Performance Improving Planning for Low Scoring HPA Measures		N/A	
5. Service and Patient Experience				
5.a.	Member Experience Data		N/A	
5.b.	Complex Case Management		N/A	
6. Quality Assurance and Patient Safety				
6.a.	Potential Quality Issues (PQI)		N/A	
6.b.	Focused Mini Audits		N/A	
6.c.	OB Reporting Methodology		N/A	
6.d.	Latent TB Infection Treatment		N/A	
7. Quality Improvement Training and Coaching				
7.a.	Improving Rural Upper Central Regional Performance		N/A	
7.b.	Improving Rural Upper North Regional Performance		N/A	
7.c.	Improving North Bay Regional Performance		N/A	
7.d.	Performance Improvement Training Offerings		N/A	
7.e.	QI Project Toolkit & Training Program		N/A	
8. Delegation Oversight				
8.a.	QI Delegation Oversight		N/A	
9. NCQA Project Management				
9.a.	Compliance with NCQA HOA and Sustain Performance		N/A	
9.b.	Compliance with NCQA HPA and Sustain Performance		N/A	
10. Grand Analysis				
10.a.	Grand Analysis - Pharmacy & Utilization Management (UM1B) Report		N/A	
10.a.	Grand Analysis - Access and Availability (NET3) Report	**Goal #1:** By June 30, 2027, the 2026 NET 3 Report will be complete.	Continued	The NET 3 report will be transitioning from Network Services to Provider Relations after the 2026 NCQA Renewal Survey.

Approval Signatures

Robert Moore, MD, MPH, MBA	8/19/2026
Quality/Utilization Advisory Committee Chairperson	*Date Approved*

Angela Brennan, DO	9/9/2026
Physician Advisory Committee Chairperson	*Date Approved*

Dean Germano	10/28/2026
Board of Commissioners Chairperson	*Date Approved*

Clinical Efficiency Adjustments

CY 2027 Rate Development – DHCS Final Decisions, July 2026

What DHCS adopted, what it removed, and what remains open

Kermit Jones, MD, Deputy Chief Medical Officer

Outcome: Final Decisions for CY 2027

DHCS will reevaluate TELs for CY 2028 with a view toward raising them where attainable.

Adopted

- Readmissions: 50% TEL
- Cesarean Mix: 50% TEL
- Potentially preventable admissions: 50% TEL, unchanged
- Low acuity non-emergent: Code definitions updates

TEL = target efficiency level

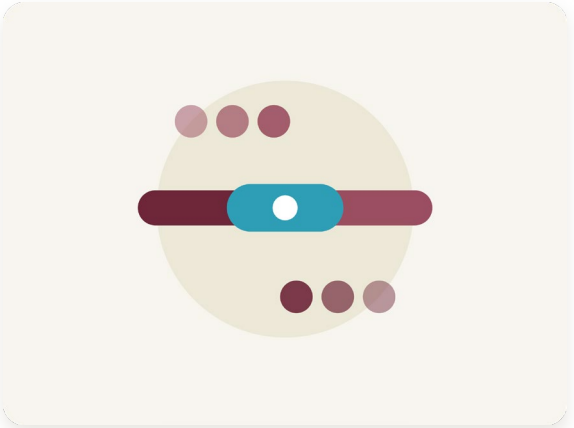
Not Implemented

- Cellulitis
- Short stay
- DME/radiology

Note: Two of the four analyses we reviewed in detail are not proceeding.

Process: Plan feedback changed the outcome

- Engagement ran from the February 2026 All-Plan CFO meeting through workgroups in March, May, June and July, plus multiple rounds of written feedback.
- Three proposed adjustments were dropped and the TEL was held rather than raised for now.
- California Children's Services (CCS) members and long-term care institutional members were added as readmissions exclusions in direct response to plan comment.
- De-duplication between inpatient adjustments was accepted as a concern and addressed.

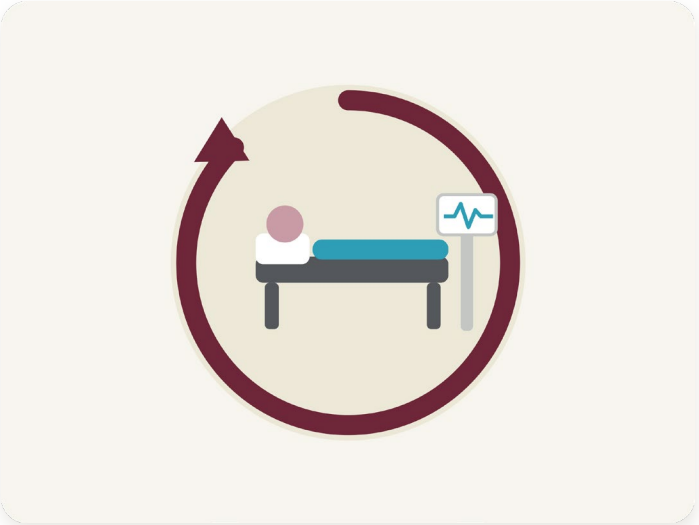


Adopted – 50% TEL: Readmissions

Physical health admissions within 30 days of a prior discharge, any facility, any DRG.

- Clinical global exclusions removed, plus ages under three and over 84 — now also CCS and long-term care members.
- Not avoidable: unrelated readmissions, elective admits, expired discharge status, against medical advice (AMA) discharge, or any professional visit beforehand.
- Flagged: readmissions related to the index stay with no documented outpatient visit before them.

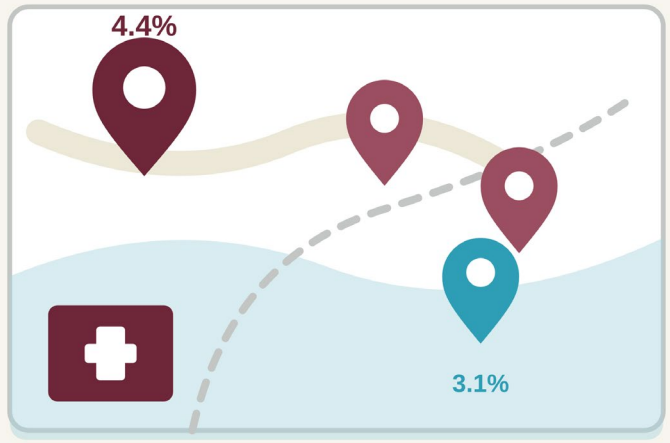
DRG = Diagnostis-Related Group



Impact: Readmissions – Regional Results

Adjustment as a percentage of hospital inpatient dollars.

Region	Before TEL	After TEL
Statewide	**3.5%**	**1.7%**
Bay Area	3.7%	1.9%
South Non-Coastal	3.2%	1.6%
Southern California	3.1%	1.5%
North Non-Coastal	4.4%	2.2%
Coastal	3.8%	1.9%



North Non-Coastal carries the highest adjustment of any region — about 45% above Southern California.

Is that a care-transitions difference, or encounter completeness and access geography?

Adopted – 50% TEL: Cesarean Mix

A benchmarked ratio that re-mixes delivery counts rather than subtracting encounters.

- Statewide cesarean rate is 29.4%. Of those, 10.3% were judged medically unnecessary.
- A portion of potentially avoidable cesareans is shifted to vaginal births, re-mixing the maternity supplemental payment.
- Estimated statewide reduction of $7.3M to CY 2027 maternity supplemental payment dollars.
- Mercer reviewed 437 diagnosis codes against NTSV and accepts eight conditions NTSV does not.

NTSV cesarean rate = Nulliparous, Term, Singleton, Vertex, the proportion of live term singleton births in first-time mothers delivered by cesarean section, a primary cesearan rate measure.

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Impact: Cesarean Mix – Results and a Known Gap

Region	Cesarean %	Avoidable %	PMPD impact
Statewide	**29.4%**	**10.3%**	**-0.7%**
Bay Area	25.3%	8.6%	-0.5%
South Non-Coastal	31.4%	10.3%	-0.8%
Southern California	29.5%	11.0%	-0.8%
North Non-Coastal	29.5%	10.1%	-0.8%
Coastal	26.8%	9.0%	-0.4%

- Known misclassification:
  - Placenta accreta and partial previa are NTSV-recognized indications but sit in the potentially avoidable pool for CY 2027. DHCS says they are under 1% of cases, were factored into the TEL, and will be added for CY 2028.

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Mechanism: What the target efficiency level does

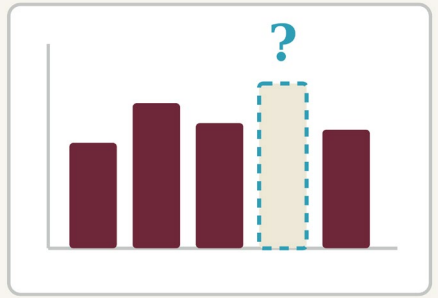
- Gross finding
  - Clinical review identifies inefficient spend – 3.5% of inpatient dollars for readmissions
- TEL discount
  - Only a set fraction is removed. At 50%, half comes out: 1.7% after TEL
- Why it exists
  - A deliberate buffer for review error, misclassification and implementation runway
- What is disclosed
  - The value — 50% across Readmissions, Cesarean Mix and PPA
- **What is not**
  - The derivation. No method is sown for why 50% rather than 35% or 65%

DHCS applies ASOP 49: adjustments only where attainable and achievable.

The Central Methodological Issue

Absence of documentation is treated as evidence of avoidability.

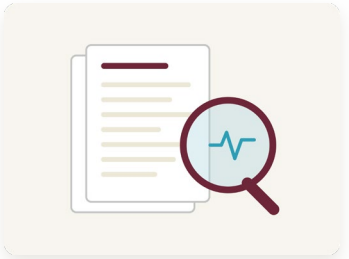
- The readmissions flag turns on whether an outpatient visit appears in the record — not on whether care occurred.
- Encounter completeness is not random. It tracks delivery system structure, Federally Qualified Health Center and subcapitated arrangements.
- The base period closed before the standard was set, and submission windows have passed.



Care delivered but not captured looks identical to care never delivered.

Reproducibility: What remains unresolved

- **TEL derivation**
  - The 50% value is public. How it was selected is not — and DHCS intends to raise it.
- **Clinical review standards**
  - No criteria set, reviewer credentials, dual review, or inter-rater agreement reported.
- **Encounter-level dispute**
  - Policy consultation exists. There is no path to contest a specific flagged admission.
- **Hierarchy run order**
  - PPA and readmissions can both claim the same admission. Sequence is undisclosed.
- **Sample versus census**
  - Not stated. Regional figures are smaller subsamples with wider uncertainty.
- **Operational thresholds**
  - Any professional visit exempts a readmission, regardless of relatedness or timing.



What to prepare for in CY 2028

- TELs are expected to rise where DHCS judges the reduction attainable. A 50% buffer should not be assumed to persist.
- Placenta accreta and partial previa move into the medically supported set, modestly shrinking the cesarean adjustment.
- Herpesvirus is slated for annual code review.
- Cellulitis, Short Stay and DME/Radiology were declined for CY 2027, not withdrawn permanently.
- Clinical efficiencies are expected to feature in the forthcoming Hospital Value Strategy, cascading to provider contracting.

Questions for DHCS and Mercer

- How was 50% derived, and what evidence would justify raising it for CY 2028?
- Was the regional spread tested against encounter data completeness?
- Is the clinical review a census or a sample, and with what precision?
- What is the run order between PPA and readmissions?
- What inter-rater agreement does the relatedness determination achieve?
- Can plans contest specific flagged admissions before rates are final?

The workgroup channel produced results this cycle. Use it early.

Context: NEJM on Pay for Performance

- **Chernew and Schneider (NEJM, August 2026):** after two decades, pay-for-performance has produced only moderate gains in care processes and outcomes, at substantial administrative cost.
- The shortcomings are structural, not fixable by refinement — measurement, scoring and financial incentives each have inherent limits.
- Performance tracks patient and social factors **absent from risk adjustment,** so programs penalize plans and organizations serving marginalized populations.
- Payment tied to measures **shifts effort toward documentation** and scoring rather than care delivery.
- **Recommended shift**: a narrow set of high-impact measures, targeted support for poor performers, and comfort with doing nothing when action will not close a gap.

CE Summary

- DHCS adopted Readmissions, Cesarean Mix and PPA at a 50% TEL; Cellulitis, Short Stay and DME/Radiology were dropped for CY 2027.
- Plan feedback through the workgroup channel changed the outcome — that channel is our leverage for CY 2028.
- North Non-Coastal carries the highest readmissions adjustment, most plausibly reflecting encounter completeness rather than care transitions.
- **Absence of documentation is treated as evidence of avoidability** — the surviving methodological critique.
- TEL derivation, clinical review standards, run order and a dispute path remain undisclosed, and TELs are expected to rise.
- **The NEJM critique applies here:** penalties tied to imperfect measures burden plans serving marginalized members without clear evidence of better care.

Questions?

Thank you

Kermit Jones, MD, Deputy Chief Medical Officer